2021
CFMS Recommendations for Student Health and Wellbeing

Canadian Federation of Medical Students
Committee for Student Health and Wellbeing
(National Wellness Committee)

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Approved:

CFMS Canadian Federation of Medical Students

FEMC Fédération des étudiants et des étudiantes en médecine du Canada

Dear Canadian medical school faculty and administrators,

As you know, recent years have seen medical learner wellbeing take a place in the spotlight for medical education in both undergraduate and postgraduate settings. We have watched in awe as students and faculty across the country have championed initiatives and projects dedicated to addressing the remarkably high rates of burnout and mental illness in medical students and residents. To start off, we thank you for this work.

The Canadian Federation of Medical Students has long supported efforts to address medical student mental health, stigma, and burnout across the country. Over past years, the CFMS has published several position papers pertaining to the wellness of medical students. Unfortunately, many of these position papers did not get widely disseminated or followed up on. This year, the CFMS is announcing a broader and more systematic approach to medical student wellbeing with the publication of this document: the CFMS Recommendations for Student Health and Wellbeing.

All past CFMS position papers pertaining to wellness were analyzed, the Canadian student body was consulted, and the literature was reviewed for us to put out this set of recommendations that reflects what we found to be the most addressable challenges facing the wellbeing of medical students today. This document will be revised and updated annually by the CFMS to reflect any changes in literature and student consultation.

We, the Canadian Federation of Medical Students, thank you for taking the time to review these recommendations. We hope they are received to be just, evidence-based, and achievable. Our representatives from across the country will be following up with your respective undergraduate offices to advocate and collaborate in considering implementation, and we greatly look forward to seeing tangible changes made to medical education in support of greater learner wellbeing. Again, thank you for your hard work on this endeavor. Any feedback regarding this document is welcome and may be directed to the CFMS National Officer of Wellness at wellness@cfms.org.

Sincerely,

Jack H. Yuan, MD
2020-2021 CFMS National Officer of Wellness
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I. INTRODUCTION

The selection process for medical undergraduate programs in Canada often matriculates a population of students who are intelligent, altruistic and well-rounded individuals. As a result, medical school cohorts are often composed of students who are high achieving and resilient. As evidence to this, American students who received admission into medical school were shown to have lower rates of burnout and depressive symptoms compared to the general population, even when controlled for age, race, relationship status, and sex.[1] However in spite of this, medical students further into their training have been shown to experience higher rates of psychological distress, depression, anxiety, burnout, and stress compared to their age-matched peers.[2] Numerous factors related to the medical education journey and healthcare field may contribute to these discrepancies, including substantial workload, sleep deprivation, financial burden, lack of control over one's time, and the psychological demands of a career in medicine, especially those pertaining to patient suffering and death. The environment in which medical students are trained to care for their patients tends to perpetuate a culture in which students, often led by the examples of their residents and staff attendings, prioritize their responsibilities and role as a physician often at the expense of their own wellbeing. Unfortunately, this culture may foster burnout and maladaptive coping strategies, ultimately producing physicians who may not be optimally equipped to succeed in their careers in medicine.

In recent years, Canadian medical schools have largely recognized the importance of addressing medical student wellbeing, with many schools providing programs and projects aimed specifically at supporting student wellness. While such initiatives are a positive shift from previous years and are very much welcomed by students, they often do not address the root causes of burnout and mental health challenges in students. These root causes, including the numerous systemic and structural factors that affect learner wellbeing, must also be a part of the solution. Policy changes specifically directed at supporting medical students and creating a culture where students, residents, and staff support their own and each other's wellbeing are crucial. Moreover, it is important that policy changes are made consistently across the country to ensure equity for students across Canada.

In this document, the CFMS recommends both evidence-based and student consultation-based policy changes to be adopted across all Canadian medical schools. Our goal is to enable involved students across Canada to collaborate with their Undergraduate Medical Education faculty to bring about policy changes that are focused on enabling, promoting, and prioritizing student wellness. The CFMS will revise and add to these recommendations annually, and our recommendations will be presented to Undergraduate Medicine Faculties annually by CFMS affiliated representatives at each respective school.

II. METHODS

This project was initiated by the Canadian Federation of Medical Students (CFMS) Committee for Student Health and Wellbeing, and led by the National Officer of Wellness. The project task force first conducted a comprehensive search of previous CFMS position papers pertaining to student wellbeing through the CFMS position paper database. Position papers relevant to medical student health and wellbeing were selected for further review. Recommendations from the selected position papers were compiled and assessed for utility with consideration for current medical school practices and culture.

Consultation with CFMS Stakeholders
The project task force consulted the CFMS Wellness Round Table on the utility, feasibility, and appropriateness of a new updated set of policy recommendations. Drafts were brought back to the CFMS Committee for Student Health and Wellbeing for review before finalizing a set of recommendations for broader CFMS consultation.

Literature Review
Project task force members completed a non-systematic review of literature relevant to all recommendations proposed. Evidence in the literature was used to either strengthen or eliminate recommendations.

CFMS Approval
The task force consulted with the Board of Directors and Office of Health Policy at the CFMS, with feedback brought back to the Committee for Student Health and Wellbeing for finalization. The recommendations were then passed at the 2021 CFMS Annual General Meeting.

Post-publication and Follow-up
Members of the CFMS Wellness Round Table will be connecting with UGME student representatives or directly with relevant faculty members in each respective medical school to initiate presentation of the CFMS recommendations, and to advocate for change. Feedback will then be brought back to the CFMS on an annual basis for review and yearly evolution of these recommendations.

III. PREVIOUS POSITION PAPERS

A. Champion C., DellaVedova J. , Johnston T., Rodin D., Zygmunt A., “Resources to Support the Learning Environment for Clinical Clerks”, Approved 2004; Revised 2010, 2014, https://www.cfms.org/files/position-papers/Clinical%20Clerk%20Learning%20Environment%20Sept%202014.pdf
B. Liu A., Mincer J., Far R., Talia J., “Building a Health Promoting Learning Environment in Canadian Undergraduate Medical Education”, 2020 https://www.cfms.org/files/meetings/agm-2020/resolutions/learning_environment/le_positionpaper.pdf
C. Yung E., Lagacé F., Zhong Y., Tabry V., Sarkis B., Sun-Drapeau L., Jin S., “CFMS Position Paper on Responding to Medical Student Suicide”, 2018, https://www.cfms.org/files/meetings/agm-2018/resolutions/resolution4/CFMS%20Position%20Paper%20on%20Medical%20Student%20Suicide.pdf
D. Bassi J., Bethune R., Do V., Everard K., Lam J-Y., Ou K., Paddle H., Ripsman D., Virdee M., Wang., “Support for medical Students Experiencing Student Mistreatment”, 2019, https://www.cfms.org/files/position-papers/5.%20CFMS%20Position%20Paper%20on%20Support%20for%20Medical%20Students%20Experiencing%20Student%20Mistreatment.pdf
E. Mazze, N., Silverberg, S., Wang, T., Minnings, K., Norlund, S., Daniel, M., Fatima, S., Ibrahim, T., Leurer, C., Mahmood, T., Sayal, P., “Support of Parents in Undergraduate Medical Education”, CFMS Repository of Position Papers (2017), https://cfms.org/files/position-papers/agm_2017_support_of_parents.pdf
F. Apramian, T., Ramazani, F., Lee, D., Patel, P., Chandna, N., Jajarmi, Y., Gossack-Keenan, K., Sohi, G., “Support for Unmatched Canadian Medical Students”, CFMS Repository of Position Papers (2017), https://cfms.org/files/position-papers/agm_2017_support_unmatched.pdf
G. Bastrash, M., Holbrid, S., Yan, H., White, A., Champion, C., Johnston, T., Rodin, D., Tepper, J., “Medical Student Health and Wellbeing”, CFMS Repository of Position Papers (2015), https://www.cfms.org/files/position-papers/Wellness%20Position%20Paper_Aug19.pdf
H. White, A., Champion, C., Johnston, T., Rodin, D., Tepper, J., “Mental Health for Medical Students”, CFMS Repository of Position Papers (2014), https://www.cfms.org/files/position-papers/Mental%20Health%20for%20Medical%20Students%20Sept%202014.pdf

IV. SUMMARY OF RECOMMENDATIONS

Student Workload and Scheduling Recommendations

1. **Scheduling**
    a. Students should be scheduled no more than:
        i. **11** hours per day when not on call
        ii. **26** hours maximum for call shifts
        iii. A weekly limit of **80** hours *including* call
    b. Scheduling to maximum limits at all times should not be standard practice
2. **Call**
    a. Call schedules should be provided at minimum 2 weeks before the start of rotation to facilitate life planning
    b. Overnight call the night before day-time learning should be avoided
    c. Call should not be scheduled on an assessment day (Exam or OSCE)
    d. Students must be guaranteed a call room for overnight call
3. **Travel time**
    a. Students should receive a designated travel period before and after rural rotation
        i. A minimum of 24 hours should be provided for travel and settling time for all rural rotations
        ii. Up to 48 hours should be provided for rotations >8 hours driving time from a student's home site
4. **Policy Accountability**
    a. Workload guidelines should be disseminated in an accessible and readable way to all preceptors and students
    b. An anonymous reporting mechanism should be available to report breaches in workload and scheduling policies

Attendance and Absences Recommendations

5. **Personal or Flex days**
    a. Pre-clinical students should be entitled to, minimum 3 personal days (or half day equivalents) per year to take at their own discretion
    b. Clinical students should be entitled to, at minimum, an allotment of personal days equal to 1 personal day for every 12 weeks of clinical time, rounded up to the nearest day (For example, 4 days for a 48-week clerkship, or 2 days for an 18-week elective year)
    c. Students should not be required to provide rationale for personal days
    d. Minimal blackout periods should be placed on personal day use
    e. Students should provide 2 weeks advance notice for these absences and approval should be given within a reasonable time frame
    f. Days taken off for mental health reasons should be considered sick days rather than personal days, and should not require any advance notice
6. **Negotiated Absences**
    a. Eligibility for a negotiated absence should be expanded to reflect the diversity of life events with strong importance to students.

Clinical Environment Recommendations

7. **Mistreatment**
    a. Students should be provided an anonymous online mistreatment reporting system
    b. Students should receive education on what constitutes mistreatment, how to submit reports, and how reports are handled, both during early Year 1, and prior to starting clinical work
    c. Schools should offer visiting elective students a portal with access to local wellness resources and mistreatment reporting forms for their respective schools
    d. De-identified statistics of mistreatments rates and actions in response should be presented to students annually, and made available to students and faculty
8. **Safety**
    a. Rotations should offer safe areas to store student belongings. Rotations without a safe place to store belongings should be indicated in introductory emails, however this should not be standard practice

Administrative Recommendations

9. **Communication**
    a. Email communication to students should be respectful and collaborative, with the understanding that medical students are self-motivated adult learners. Punitive or threatening tones should be avoided. Particular attention should be paid when citing potential professionalism flags
    b. Efforts should be made to decrease email burden, and make electronic communication with students more efficient
10. **Site administration**
    a. Site administrative staff for clinical rotations should communicate with students at minimum 2 weeks ahead of time, with the following minimum information:
        i. Reporting location, time, and contact phone number and time for the first day of rotation
        ii. Shift or call schedule for the rotation
        iii. Location to store belongings and where to obtain scrubs if applicable along with access codes necessary

Curriculum Recommendations

11. **Wellbeing Education**
    a. Schools should include dedicated in-curriculum sessions for wellness education
    b. Wellness education should be evidence-based, and highlight key topics such as burnout, time management, resilience, history of and state of current physician health, policy factors that influence physician health, and the culture of medicine.
    c. Schools should explore anonymous and objective assessment of wellbeing outcomes, to quantify interventions in objective wellness-related measures

V. DETAILED RECOMMENDATIONS AND RATIONALES

1. Scheduling

A. *Students should be scheduled no more than:*
   i. ***11*** *hours per day when not on call*
   ii. ***26*** *hours maximum for call shifts*
   iii. *A weekly limit of* ***80*** *hours including call*

B. *Scheduling to maximum limits at all times should not be standard practice*

Discussions of duty hour restrictions occur most commonly in the context of postgraduate medical education, and are largely driven by patient safety concerns. In 2011, residency programs in Quebec were mandated to limit in-hospital shifts to 16 hours or less, following feedback from residents, stating that shifts over 24 hours were endangering patients and residents alike.[1] The idea that reduced duty hours improves resident performance and patient outcomes appears to be supported in the literature. For instance, a randomized control trial in Brigham and Women's Hospital showed a significant reduction in medical errors among residents assigned to an alternative call regime and a work-week of 63 hours, compared to those who remained on a standard call schedule, averaging 80 hours per week.[3] Given that many Canadian clerkship students may at times work upwards of 80 hours a week, it is likely that their performance and learning can also be enhanced by appropriate duty hours.

Literature suggests that longer clinical hours do not appear to yield higher quality learning. One analysis of clerkship students' performance during surgery rotations revealed that the number of hours in a given week did not correlate with any of the learning outcomes assessed.[4] Similarly, Hinojosa-Gonzalez and colleagues report no adverse clinical or academic learning outcomes among clerkship students in a Mexican institution following a shift from a 1 in 3 (80-100 duty hours) to a 1 in 4 (70-80 duty hours) call schedule.[5] Such findings are consistent with Moonesinghe and colleagues, whose systematic review reveals no adverse patient or trainee outcomes associated with duty hour restrictions in residency training across several US programs.[6] Thus, it appears that in-hospital time ceases to be beneficial for medical trainees after a certain number of hours.

Long duty hours and frequent call shifts appear to be major barriers to trainee wellbeing during clinical education. A survey of US-based residents reveals that respondents perceived sleep deprivation associated with long clinical hours to be a major negative influence on their well-being and personal relationships.[7] Furthermore, reductions in call frequency and duty hours were shown to be associated with lower self-reported burnout scores among clerkship students and residents.[5,7] These findings suggest that scheduling in clinical training remains an important area of intervention in addressing the issues of trainee burn out and poor well-being.

Canadian medical schools often attempt to protect their students from excessive hours using standard scheduling policies. However, the weekly hourly limit is often stipulated without call hours. This distinction renders the weekly limit substantially less effective, as call can easily still result in a week of over 100 hours. Given the extent to which excessive in-hospital hours can

adversely impact trainee well-being along with their limited value from an educational standpoint, a modest 80-hour weekly cap has the capacity to substantially improve the learning and wellbeing of medical students across the country.

2. Call

A. *Call schedules should be provided at minimum 2 weeks before the start of rotation to facilitate life planning*
B. *Overnight call the night before day-time learning should be avoided*
C. *Call should not be scheduled on an assessment day (Exam or OSCE)*
D. *Students must be guaranteed a call room for overnight call*

We recommend that at minimum, call schedules should be given 2 weeks in advance, as schedules are necessary for adequate personal life planning so that clerks can more effectively balance educational needs with other domains of life. Previous studies have indicated that conflicts in work-life balance, time management, and inefficient scheduling are major sources of stress for medical students.[8] This lack of control over their time and not knowing their schedule in advance adds logistical pressure to the already compounding stress of clerkship work hours, commuting, studying for exams, and other demands of medical education. The rare weekend getaway or special event is an important contributor to maintaining balance during medical school. As we often hear from students that schedules are at times not provided until the weekend before a rotation, planning life events becomes increasingly difficult. As well, in the interest of inclusivity, it is essential that medical students have adequate advance notice of schedules to plan around child and family care, animal care, health appointments, and the like.

A decline in cognitive function and attention performance, associated with lower academic performance and lower retention of daytime learning has been observed in the literature following overnight call shifts.[5] While many schools currently attempt to avoid scheduling overnight call prior to a daytime learning activity (academic half day or full day), we have found that this guideline is poorly enforced and often is not the case. We recommend that medical schools create stronger policy making to address this issue. Accommodations that would permit students to complete the learning session at an alternate time, such as lecture recordings and provision of learning materials electronically could contribute to a solution.

We have seen that being scheduled for overnight call on an assessment day is among the most demoralizing situations in medical school. Although there is limited literature on this specific situation itself, we may draw from the above discussions of additional work hours failing to have a positive impact on medical student learning. Typically, clerkship exams are lengthy and are preceded by several days, if not weeks, of arduous studying. Finishing an exam is a moment of catharsis, and for most students, a celebration and an opportunity to share and connect with their colleagues who have shared this experience with them. However, this is with the exception of those who are scheduled for call on that day. Similarly to how the evidence points to limited learning capability after overnight call, our student consultation has also shown us the limited learning capability after long nights of studying and a lengthy exam. Combined with the sense that one is missing out on key medical school moments with their classmates, this particular

situation seems to be an accelerated fodder for burnout. For these reasons, we are recommending that medical schools protect students from being scheduled for overnight call on an assessment day.

Finally, under no circumstance should a medical student be scheduled for a call shift if there is not a guaranteed sleeping room for that student. Not having a call room removes the possibility of any rest overnight and can actually be quite distressful for students. In our student consultation we have heard countless instances of students sleeping on couches, chairs, and even vacant patient beds. We strongly recommend that medical schools work with administrators to ensure a safe sleeping place for each medical student on call, and establish a process should students they find themselves without a sleeping room for a call shift.

3. Travel time

A. *Students should receive a designated travel period before and after rural rotation*
   i. *A minimum of 24 hours should be provided for travel and settling time for all rural rotations*
   ii. *Up to 48 hours should be provided for rotations >8 hours driving time from a student's home site*

Many Canadian medical schools include mandatory and elective rural medicine experiences during clinical years. These enriching experiences can, at times, be substantial distances from a medical student's home site. One issue that we have identified through student consultation is the need for designated travel time to and from rural sites for both mandatory and elective experiences.

We have found that it is not uncommon for a student to be scheduled for a call shift or regular shift the weekend before or the weekend after a rural rotation, time that would generally have been spent travelling between the rural site and the student's home site. It is generally agreeable that travelling is complex, and at times for rural sites include multiple modalities of transport (car, train, plane, ferry, etc), along with packing for up to 4 weeks and settling into a temporary home. As such, we recommend that medical students be given designated travel time prior to, and after a rural rotation.

Students should be granted at minimum, a single full day (24 hours) to travel and settle into their temporary home. Examples of students scheduled for a shift on a Sunday, then expected to be at a rural site Monday morning are logistically impossible and generally demoralizing to students. Further, some rural sites are up to >18 hours of travel time, by car, from a student's home site. While some students may choose to fly in these cases, it is generally not advisable for this to be the expectation for students in a rural site, where vehicles are mainstay forms of transportation. In these cases, we recommend a full 48 hours to allow for the student to travel and settle into their temporary home.

Implementation of this designated travel time for mandatory clerkship rotations should be arranged by medical school administrators, who have standard clerkship "tracks" and can

foresee which students have an immediately upcoming rural rotation. In these cases, they may arrange for call protection or to amend the shift schedule accordingly. During elective rural experiences, the designated travel time would be the responsibility of the medical student, however schools should make it clear to students that this travel time is available. Program administrators should also be made aware that this travel time should be accomodated.

4. Policy Accountability

A. *Workload guidelines should be disseminated in an accessible and readable way to all preceptors and students*
B. *An anonymous reporting mechanism should be available to report breaches in workload and scheduling policies*

The proper dissemination of guidelines pertaining to student workload, mistreatment, and other domains is essential to ensure that students, preceptors, and staff have a shared understanding of their expectations, rules, and regulations.[9] In both clerkship and postgraduate training, there often lies a "hidden curriculum", with a pressure to take on more than what is expected to show interest in the field, pursue more learning, and clinical skills, even though no findings to support these ideas have been documented.[10,11] As the literature points out that medical students often perceive higher expectations of their skills, knowledge and preparation from preceptors than what is reality, it is increasingly important that workplace guidelines be disseminated and made accessible widely.[10,11]

Although appropriate dissemination of workload policies will not address the hidden curriculum, having all parties of the clerkship interaction made aware of the guidelines will support a strong working relationship. This may be a step in improving medical workplace culture, with resulting positive impacts to medical student wellbeing.[12]

For further accountability, infractions of workload policy guidelines set by medical schools should be reportable through an online reporting mechanism. The use of anonymous reporting mechanisms have been well validated for mistreatment, and most Canadian medical schools have adopted these systems for mistreatment concerns. We recommend that this system set in place should be either a separate mechanism from the now widely adopted anonymous mistreatment reporting systems, or to be integrated into the current reporting systems, so long as students are well notified that they may report workload infractions as mistreatment. Moreover, medical students should be educated on workload policies, when to report infractions, and how these reports are managed and acted upon. Reporting mistreatment can be intimidating, a 2018 study by Chung found that intimidation was the second most often cited reason for not reporting misconduct, following that "the incident did not seem important enough to report". Thus, medical schools should create systems that minimize potential barriers to workload policy overage reporting.

5. Personal or FLEX Days

A. *Pre-clinical students should be entitled to, minimum 3 personal days (or half day equivalents) per year to take at their own discretion*
B. *Clinical students should be entitled to, at minimum, an allotment of personal days equal to 1 personal day for every 12 weeks of clinical time, rounded up to the nearest day (e.g. 4 days for a 48-week clerkship, or 2 days for an 18-week elective year)*
C. *Students should not be required to provide rationale for personal days*
D. *Minimal blackout periods should be placed on personal day use*
E. *Students should provide 2 weeks advance notice for these absences and approval should be given within a reasonable time frame*
F. *Days taken off for mental health reasons should be considered sick days rather than personal days, and should not require any advance notice*

Personal days, or flex days as they are referred to at certain schools, allow students to assert a limited amount of control over their schedules by allowing a predetermined number of days off at their discretion. With the demands of a medical student schedule, these days allow students to support their wellbeing by taking a day off for reasons that may not fall under traditional absence policies, such as attending a wedding, allowing for a special trip, or simply to recharge or spend time with loved one(s).

While most Canadian medical schools already have variations of personal day policies in place, we find that they are quite inconsistent and often do not include clinical years. The transition to clinical learning, and a far more demanding schedule, is known to be among the most stressful times during medical school.[13,8] As such, we are recommending that personal days also be included for clinical students, albeit with different provisions. We have suggested an allotment of personal days, which are to be taken at the discretion of the student, relative to the number of clinical weeks in a year knowing that this varies between schools.

Personal days have been recommended and created for the purpose of student wellbeing with the idea that they can be taken for personal reasons, decided by and at the discretion of the student. Students should not have to indicate a reason for taking this day off, beyond stating they would like a personal day on a given date. Additionally, while it is recognized that some limitations may be necessary as are in place for other absences (ie. personal days may not be taken on days with mandatory assessments), in general there should be minimal to no limitations placed on personal day usage in order to allow students full autonomy over when they wish to take these days. Restrictions on their use may detract from the purpose of allowing students to choose when to take a personal day, and the overall aim of promoting student wellbeing. Medical students are adult learners who can be expected to take personal responsibility for their learning and make appropriate choices about when to take these days.

Providing 2 weeks of advance notice, and more where possible, will allow for their colleagues and medical school staff to adjust to any absences as needed. More advance notice should not be required as this will again limit student's ability to use their personal days for reasons which

may not always provide multiple months of advance notice. Students should also receive timely responses to their personal day requests, so that they can inform their peers and teachers where necessary, as well as make whatever arrangements are necessary with respect to their reason for requesting the personal day. If for some reason a personal day request is unable to be approved, students should be respectfully provided with a reason why and should be provided with an opportunity to alter the request for a different day if possible.

6. Negotiated Absences

A. *Eligibility for a negotiated absence should be expanded to reflect the diversity of life events with strong importance to students.*

The absence policies of many Canadian medical schools can often be restrictive in what events and activities are considered acceptable for an absence request to be approved. For example, there is often a stipulation that students may have a request approved to take time off only for a significant life event (ie. wedding, funeral, graduation) of an immediate family member. These policies are exclusive and alienating to students for whom the most significant people in their life may not be their immediate family. Similarly, presentation at academic conferences is often an approved reason for absences. However, other similarly highly regarded events, such as for athletics, artistic, or entrepreneurial pursuits, are typically not listed as approved reasons for an absence. This excludes the diverse interests and experiences which were rewarded by the medical school applicant selection process.

Although personal days are a step in addressing the discrepancies between medical student needs with regards to absence approval and actual medical school policy, the restrictive language often used during policy writing can still be alienating and exclusive to the diverse student populations that medical admissions committees strive to achieve. With broader and more open language in defining allowable negotiated absences and treating requests on a case-by-case basis, students are given the respect and autonomy to choose the life events most important to them.

7. Mistreatment

A. *Students should be provided an anonymous online mistreatment reporting system*
B. *Students should receive education on what constitutes mistreatment, how to submit reports, and how reports are handled, both during early Year 1, and prior to starting clinical work*
C. *Schools should offer visiting elective students a portal with access to local wellness resources and mistreatment reporting forms for their respective schools*
D. *De-identified statistics of mistreatments rates and actions in response should be presented to students annually, and made available to students and faculty*

Medical student mistreatment is a significant contributor to student burnout, has deleterious effects on emotional and mental well-being of students, and can lead to an increase in medical error.[14,15] On a systems level, a lack of mistreatment reports despite a high number of mistreated students likely perpetuates that these behaviours are tolerated.[15] Thus, the CFMS recommends the above set of policies and student resources to address mistreatment.
If there is a perception that reporting will have negative consequences on their career trajectory and inhibit their ability to succeed in a medical environment, students are far less likely to report their experienced mistreatment, which speaks to the significance of anonymizing the reporting process.[16] With supervisors having the ability to influence student evaluation, reference letters, and potentially residency matching success, it is paramount to protect the identity of the students during the reporting process. In addition, some current student mistreatment reporting systems are not easily accessible as certain schools require students to submit these reports in person, which poses a barrier due to lack of accessibility and lack of anonymity. Most Canadian medical schools have adopted anonymous online mistreatment reporting systems, however we recommend that all Canadian medical schools adopt this system for protection of medical students against mistreatment.

With the normalization of these mistreatment behaviours experienced by medical students through the "hidden curriculum", students can be desensitized to inappropriate behaviours, making it increasingly challenging for students to identify an experience as mistreatment.[14] When students experience a particular behaviour repeatedly, this delineation becomes even more hazy.[16] Students may have become acculturated that mistreatment is a rite of passage or necessary to develop the trust and confidence of their superiors, emphasizing the importance of educating students on how they should be treated during their medical education.[15,16] A lack of understanding of mistreatment poses a barrier for students reporting their experiences and receiving the support that they need. For these reasons, we recommend that students have dedicated education on what constitutes mistreatment, how to report mistreatment, and how reports are handled, both early on in medical school and again prior to clinical experiences. This should occur in the typical lecture setting, and should not be optional or extracurricular.

Mistreatment can occur regardless if a student is at their home site or visiting electives. Unfortunately, most visiting elective students do not currently have adequate resources from the school they are visiting on how to report mistreatment if it happens. For this reason, we recommend that schools offer visiting students a portal or similar resource from which they may access workload scheduling policies and mistreatment reporting information.

Additionally, the literature shows that observed experiences of other colleagues reporting mistreatment influences a student's choice to report mistreatment themselves (16). Presenting the outcomes of other student's reports, with a focus on tangible steps taken in response to those mistreatment reports will likely encourage students to have their voices heard and report any mistreatment that they experience personally.

8. Safety

A. *Rotations should offer safe areas to store student belongings. Rotations without a safe place to store belongings should be indicated in introductory emails, however this should not be standard practice*

Establishment of the designated areas for secure storage of personal belongings is an important component of an optimal clinical training environment. Lack of such accommodations has been cited as a significant stressor during clerkship training and a major contributing factor to students' negative learning experiences.[17] A quality improvement initiative at the University of Michigan revealed that assignment of personal lockers to clerkship students was an effective response to students' concerns regarding the lack of team integration during a surgery rotation.[18] As such, it appears that providing students with designated spaces to store personal belongings has the capacity to promote a sense of belonging within the clinical environment, in addition to the sense of security for one's personal belongings. As many students also keep valuable electronics with them during the day for studying or extracurricular purposes (meetings or presentations), the lack of a safe place to store belongings can be disruptive in the clinical environment. We recommend that medical schools strongly encourage each clinical rotation to have a designated safe location for students to store belongings.

9. Communication

A. *Email communication to students should be respectful and collaborative, with the understanding that medical students are self-motivated adult learners. Punitive or threatening tones should be avoided. Particular attention should be paid when citing potential professionalism flags*
B. *Efforts should be made to decrease email burden, and make electronic communication with students more efficient*

The medical school admissions process does a very successful job in selecting for students that are self motivated learners. Our student consultation informs us that students do often make their best reasonable attempts to stay on top of administrative tasks, however between filling out evaluations, doing small assignments, modules, dealing with IT difficulties, answering emails, the tasks add up quite quickly. Unfortunately, we have heard from several student representatives that threatening and punitive tones are often used to expedite students to complete administrative tasks quickly. These communications can often be discouraging to students, degrading the faculty-student relationship. We respectfully recommend that administrators make their best reasonable efforts to keep communications and reminders to students as respectful and collaborative as possible. Further, in the climate of unmatched students and increasing competitiveness in residency applications, professionalism flags can be career and life altering, and should not be used lightly, such as to motivate students to complete small administrative tasks. Our student consultation revealed multiple reports of students being labelled as "non-compliant" after being late to submit an administrative task and threatened with professionalism flags, which is both concerning and discouraging. We recommend that

these flags be reserved for serious offenses equitable to the serious consequences of a professionalism flag.

Another way to ensure that administrative tasks are completed on time is for email communication to be as efficient as possible. The CFMS is recommending that efforts be made by administrative teams to increase the efficiency of communication to students. For example, action items or to-do's may be indicated in the subject line of an email, rather than hidden in a long attached document that may be easily missed. Students would also appreciate ample notice for administrative tasks whenever possible.

As with many careers, email burden can be quite cumbersome and particularly for medical students, who must address emails outside of traditional (or extended) work hours. Our student consultation identified email burden as a target for wellbeing intervention. We are recommending that attempts be made to cut email burden for students in both number of emails sent and number of attachments. We often hear that administrative teams send medical students numerous emails within the same day, or emails with upwards 20 attachments, which can make it difficult to identify which attachments apply to them.

10. Site administration

A. Site administrative staff for clinical rotations should communicate with students at minimum 2 weeks ahead of time, with the following minimum information:
    i. Reporting location, time, and contact phone number and time for the first day of rotation
    ii. Shift or call schedule for the rotation
    iii. Location to store belongings and where to obtain scrubs if applicable along with access codes necessary

The first day of a rotation is reported to be a stressful time for students, who often must navigate a new hospital, new team, medical record, and access. In our consultation, we found the bare minimum information that a student should receive to optimize the start of a rotation includes reporting location and time, contact information for the preceptor or team, shift/call schedule, location to store belongings, where to obtain scrubs and any required access codes. We are recommending that students be notified with this information 2 weeks in advance of starting a rotation. Students often report that this information is provided late, or even not at all. A lack of information may lead students to feeling lost, causing undue additional stress related to being unprepared, as well as the fear they might receive a negative evaluation for not being prepared.

11. Wellness Education

A. Schools should include dedicated in-curriculum sessions for wellness education
B. Wellness education should be evidence-based, and highlight key topics such as burnout, time management, resilience, history of and state of current physician health, policy factors that influence physician health, and the culture of medicine.
C. Schools should explore anonymous and objective assessment of wellbeing outcomes, to quantify interventions in objective wellness-related measures

Fortunately, wellbeing is increasingly on the forefront of discussion in the realm of medical education. After all, taking care of oneself is listed as a professionalism competency under the CanMEDS competencies framework. Most Canadian medical schools do already dedicate curricular time to discussing wellbeing-related topics. While the implementation and length of these "wellness curriculums" vary across schools, the CFMS recognizes this important step in addressing medical learner wellbeing. We recommend that all schools have dedicated in-curriculum sessions for wellbeing education.

Although the literature around wellbeing in medical education is quite active, we do find that existing sessions often come across as superficial and repetitive. During our student consultation, we heard from multiple schools that repetitive messaging on ensuring adequate sleep, nutrition, and fitness becomes patronizing and lacks depth. Certain schools have implemented a peer-led wellness curriculum that covers topics not typically talked about, such as that led by the Wellness Initiative Network at UBC, which has seen success and is favored by UBC students anecdotally. Moreover, the CFMS is in the process of publishing an evidence-based wellness curriculum for implementation across Canadian schools. Currently, the CFMS recommends that medical schools take an evidence-based approach to wellness education, but also highlight key topics such as burnout, time management, resilience, determinants of physician health, history of physician health, the culture of medicine, the hidden curriculum, and policy factors that influence physician health. The role of sleep, nutrition, and physical activity is certainly integral, however is often currently over-represented as the etiology behind medical student burnout and distress.

During our search of the literature pertinent to medical learner wellbeing, we found that measures of learner wellbeing in medical students was a difficult metric to obtain or research, given the various confounders and variables involved with overall "wellness". However, wellbeing interventions need to be measured for efficacy in some way. Of the various validated methods out there, such as the Maslach Burnout Inventory, we recommend that medical schools explore an anonymous way to assess wellbeing outcomes to quantify wellness interventions, such as the policy changes recommended in this document.

VI. FUTURE DIRECTIONS

This year marks the first iteration of the CFMS Recommendations on Student Health and Wellbeing. Following publication of this guideline, our representatives across the country will advocate to all member Canadian medical schools to consider implementing these policy changes over the next year by presenting these recommendations to their respective UGME's. Recognizing that policy changes are a lengthy and arduous process, our representatives will work with relevant committees at each UGME in assessing the feasibility of these changes and to track any changes that occur over the coming year, in preparation for next year's iteration of this recommendation document.

Each year will bring a new iteration of our recommendations based on evolving literature and student consultation. Items that we wish to address in the future include provisions and recommendations for underrepresented groups (LGBTQ+, BIPOC, etc), students with dependents, and students with disability or chronic disease. We found that we did not have adequate student consultation with these populations of students for appropriate recommendations to be made over the course of the current year, however this will be a key goal for the 2022 iteration of our recommendations.

VII. CONCLUSION

Physician health remains a challenge in Canadian health care today, which we have seen exacerbated by the threat of the current global pandemic. The focused interventions and recommendations summarized here, based on literature and consultation with Canadian medical students, may serve to reduce burnout and promote a positive clinical environment in medical trainees. In turn, we hope that they will contribute to producing healthier physicians and a positive shift in culture in our Canadian health care system.

VIII. ACKNOWLEDGMENTS

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IX. REFERENCES

1. Pattani R, Wu PE, Dhalla IA. Resident duty hours in Canada: past, present and future. CMAJ. 2014 Jul 8;186(10):761–5. doi:10.1503/cmaj.131053.
2. Glauser W. Medical schools addressing student anxiety, burnout and depression. CMAJ. 2017 Dec 18;189(50):E1569–70. doi:10.1503/cmaj.109-5516.
3. Landrigan CP, Rothschild JM, Cronin JW, Kaushal R, Burdick E, Katz JT, et al. Effect of reducing interns' work hours on serious medical errors in intensive care units. N Engl J Med. 2004 Oct 28;351(18):1838–48. doi:10.1056/NEJMoa041406.
4. Barnum TJ, Halverson AL, Helenowski I, Odell DD. All work and no play: Addressing medical students' concerns about duty hours on the surgical clerkship. Am. J. Surg. 2019 Aug;218(2):419–23. doi:10.1016/j.amjsurg.2018.12.012.
5. Hinojosa-Gonzalez DE, Farias JS, Tellez-Giron VC, Aguirre-Villarreal D, Brenes-Castro D, Flores-Villalba E. Lower Frequency of Call Shifts Leads to Higher Attendance, Higher Academic Performance, and Less Burnout Syndrome in Surgical Clerkships. J Surg Educ. 2021 Apr;78(2):485–91. doi:10.1016/j.jsurg.2020.07.043.
6. Moonesinghe SR, Lowery J, Shahi N, Millen A, Beard JD. Impact of reduction in working hours for doctors in training on postgraduate medical education and patients' outcomes: systematic review. BMJ. 2011 Mar 22;342:d1580.4. doi:10.1136/bmj.d1580.
7. Papp KK, Stoller EP, Sage P, Aikens JE, Owens J, Avidan A, et al. The Effects of Sleep Loss and Fatigue on Resident–Physicians: A Multi-Institutional, Mixed-Method Study. Academic Medicine. 2004 May;79(5):394–406. doi:10.1097/00001888-200405000-00007.
8. Hill MR, Goicochea S, Merlo LJ. In their own words: stressors facing medical students in the millennial generation. Med Educ Online. 2018 Dec;23(1):1530558. doi:10.1080/10872981.2018.1530558.
9. Biagioli FE, Chappelle KG. How to be an Efficient and Effective Preceptor. Fam Pract Manag. 2010;17(3):18.
10. Barnum TJ, Halverson AL, Helenowski I, Odell DD. All work and no play: Addressing medical students' concerns about duty hours on the surgical clerkship. Am. J. Surg. 2019 Aug;218(2):419–23.
11. Wenrich M, Jackson MB, Scherpbier AJ, Wolfhagen IH, Ramsey PG, Goldstein EA. Ready or not? Expectations of faculty and medical students for clinical skills preparation for clerkships. Med Educ Online. 2010 Aug 6;15:10.3402/meo.v15i0.5295. doi:10.3402/meo.v15i0.5295.
12. Neville AJ. In the age of professionalism, student harassment is alive and well. Med Educ. 2008 May;42(5):447–8. doi:10.1111/j.1365-2923.2008.03033.x.
13. Malau-Aduli BS, Roche P, Adu M, Jones K, Alele F, Drovandi A. Perceptions and processes influencing the transition of medical students from pre-clinical to clinical training. BMC Med Educ. 2020 Aug 24;20:279. doi:10.1186/s12909-020-02186-2.
14. University of Toronto MD Program. 2019 Professionalism report [Internet]. Toronto: University of Toronto, MD Program; 2019 [cited 2021 Sep 12]. Available from: https://md.utoronto.ca/sites/default/files/2019_professionalism_report_v6.pdf
15. Chung MP, Thang CK, Vermillion M, Fried JM, Uijtdehaage S. Exploring medical students' barriers to reporting mistreatment during clerkships: a qualitative study. Med Educ Online. 2018 Jan 1;23(1):1478170. doi:10.1080/10872981.2018.1478170.

16. Bell A, Cavanagh A, Connelly CE, Walsh A, Vanstone M. Why do few medical students report their experiences of mistreatment to administration? Med Educ. 2021 Apr;55(4):462–70. doi:10.1111/medu.14395.
17. Cherry-Bukowiec JR, Machado-Aranda D, To K, Englesbe M, Ryszawa S, Napolitano LM. Improvement in acute care surgery medical student education and clerkships: use of feedback and loop closure. J Surg Res. 2015 Nov;199(1):15–22. doi:10.1016/j.jss.2015.05.062.
18. Gan R, Snell L. When the learning environment is suboptimal: exploring medical students' perceptions of "mistreatment." Acad Med. 2014 Apr;89(4):608–17. doi:10.1097/ACM.0000000000000172.