Medical Student Health and Wellbeing

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CFMS
Canadian Federation of Medical Students

FEMC
Fédération des étudiants et des étudiantes en médecine du Canad

Executive Summary

Becoming a physician has always been demanding. The volume of knowledge and skills to be acquired in a complex professional setting, with the additional emotional demands of working with ill people, is a challenge for many - if not all - medical students. Important professional bodies, such as the Royal College of Physicians and Surgeons of Canada and the Canadian Medical Association, are promoting the importance of physician health to optimize patient care. Further, medical faculties are becoming increasingly involved in the promotion of student wellness and addressing various catalysts for stress and distress in medical learning.

This position paper is underpinned by two assumptions. First, academic success, professional progress and quality patient care require good mental and physical health. Second, medical training and practice are inevitably demanding undertakings that bring trainees under significant stress. Listed below are the 11 principles upon which CFMS/FEMC advocacy around the wellness of medical students will be based.

1. Emotional, mental, physical, nutritional, spiritual and financial health are core elements of medical students' wellbeing.
2. Health and wellbeing are required for academic achievement, professional development and delivery of optimal patient care.
3. Systemic stressors are inherent to medical training and have the potential to influence students' health.
4. Collaboration among medical institutions on the prioritization of physician and learner health is necessary.
5. Understanding the nature and scope of the burden of mental illness experienced by undergraduate medical students through quality research is essential in creating evidence-based policy.
6. Equitable access to quality and appropriate health services, including mental health services, for which there are multiple entry points, high visibility and ensured confidentiality is crucial for all medical students.
7. All medical institutions must prioritize safe learning environments and implement strategies to minimize harassment and emotional abuse towards medical students.
8. All medical students should feel safe and be adequately accommodated to pursue physical health, mental health and wellness services, within and outside of their educational institution, without fear of professional or personal repercussions.
9. Reducing stigma around mental illness within medical professional culture is possible and necessary.
10. Access to quality, timely and comprehensive career planning services and academic advising is warranted for medical students of all levels at all medical faculties in Canada.
11. Peer support has a specific role within a comprehensive wellness and mental health program for medical learners.

Next, we offer and discuss recommendations on how specific organizations and regulatory bodies can further address the growing concerns around the wellness and mental health of medical students:

1. Canadian medical faculties, institutional partners in physician health and medical student-led organizations should develop formal and informal wellness and mental health support and awareness initiatives.
2. Canadian medical faculties should promote safe learning environments for all medical students.
3. Canadian medical faculties should develop and promote accessible, realizable and standardized accommodation policies for medical students in each phase of undergraduate medical training.
4. Canadian medical faculties should offer comprehensive and timely career planning services and academic advising for to all medical students.
5. Institutional partners in physician health should support research that explores wellness in medical learners and evaluating mental health and wellness initiatives.

As illustrated by the CanMEDS Conceptual Framework for Physician Health, physician self-development, interprofessional relationships and mental and physical health all intertwine into complex issues that one must learn to navigate throughout their education and career. With this position paper, we hope to elucidate key areas requiring attention, and to streamline our advocacy towards attainable and measurable outcomes in the areas of service provision and institutional policy.

Background

Student representatives, faculties and major medical organizations recognize that the wellbeing and mental health of medical learners is an important and relevant focus of the CFMS/FEMC. Although many faculties across Canada are now implementing wellness-focused initiatives throughout their undergraduate curriculum, the CFMS/FEMC deems it necessary to present this position paper framing key principles and recommendations on the topic of medical student health and wellness.

Many stressors are inherent to medical school, including, but not limited to the following(1):

- A large amount of knowledge to learn and apply in a clinical setting
- Adjustment to the medical school environment and the medical culture
- Long hours of studying and clinical duties
- Confrontation with death and human suffering
- Competitive application process to residencies
- Accumulation of student debt
- Ethical conflicts and the informal/hidden curriculum

While some students will go through medical school physically and mentally unscathed, research has shown that the vast majority of medical students will suffer from at least one form of distress during their studies, namely stress, fatigue, burnout, depression and reductions in their mental and physical quality of life (2). Addressing these forms of distress and understanding their root causes is paramount in finding solutions for the betterment of medical student health.

As per the CFMS/FEMC, core elements of medical student wellbeing include emotional, mental, physical, nutritional, spiritual and financial health.

Physical health often decreases as medical students become busier with increased studying workloads, on-call duties and new professional responsibilities. Such reductions are detrimental to the health and wellbeing of students, as the benefits of physical activity have been well documented in the prevention of chronic diseases (3). In addition to the personal health benefits of physical activity for students, benefit for the patients of these future physicians needs to be considered. In 2009, The British Journal of Sports Medicine published an article that showed a strong association with physicians' personal practice of physical activity and their attitudes and counseling practices when recommending physical activity to their patients (4). Nutrition and physical health are also closely linked. The CanMEDS Physician Health Guide explains that factors such as the length of a work day, the frequency of on-call duties, the urgent nature of a practice, the patient expectations and influence from health care organizations' nutrition resources all affect nutrition in the workplace (5). Moreover, hospital and campus cafeterias are a major source of food for many students, complicating their task of eating healthy, balanced and sustaining meals.

The financial burden of undergoing medical studies is a known significant source of stress for many students. The 2012 National Physician Survey of medical students and residents found that only 10% of students expect to graduate medical school with no debt. Importantly, the number of students who expected to graduate with over $100,000 in debt doubled from 15% in 2004 to 30% in 2012 (6). The cost of tuition is especially considerable for medical students when compared to other university degrees. In the 2014-2015 school year, medical school tuition for the first year of studies in Ontario cost on average $22,744 (7). However, there are additional costs associated with attendance to medical school other than tuition, such as potentially moving from one's hometown, frequent travels and fees for electives and CaRMS as well as medical textbooks and equipment. In the United States, debt levels have even been shown to influence the choice of a medical specialty (8).

Special consideration should be given to mental health when addressing medical student wellness. For many trainees, the transition into medical education comes at the age where mental illness often presents (9). Additional individual

factors, such as ethnic, gender, sexual, religious and political diversity, past experiences of conflict, violence or trauma, as well as resilience have implications for mental health and overall wellness during undergraduate medical education. Currently in Canada, 12.5 per 100 000 persons per year between the ages of 20-24 commit suicide (10). Mood disorders data by age group show that 23 percent of reported cases per year in Canada are among 20-34 year olds, second only to 45-65 year olds in terms of prevalence (11). Among medical students, a 2006 systematic review of studies addressing depression, anxiety and burnout among U.S. and Canadian medical students showed "higher overall psychological distress among U.S. and Canadian medical students relative to both the general population and age-matched peers" (12). Another study done in U.S. medical students has shown that medical students experience high rates of burnout and suicidal ideation during their training (13). In 2008 "The Happy Docs Study" surveyed nearly 2000 Canadian resident physicians, and one-fifth of respondents reported their mental health as fair or poor and one-third reported their lives as being "quite a bit" or "extremely" stressful. Common perceived reported sources of stress were gender and training status, with the factors associated with stress being time, intimidation and harassment (14).

An important consideration when addressing mental health and wellbeing in the medical profession, is the stigma surrounding mental health (15). Stigma is a social process characterized by exclusion, rejection, blame or devaluation resulting from an adverse social judgement about a person or group (16). The Canadian Medical Association's *Physician Health Matters: A mental health strategy for physicians in Canada* addresses cultural endorsement of stigma towards mental illness, which also is also implicated in licensing and confidentiality concerns articulated by physicians with mental illness, "Physicians with mental illness tend to be treated differently than physicians with physical illness and an insufficient distinction is often made between mental illness and inability to practise medicine." The participation, as researchers and subjects, of medical students in mental health research related to the training environment is typically poor, for fear of breach of anonymity and/or confidentiality (14). Recognizing and addressing the stigma that often surrounds mental illness is paramount in moving forward in supporting physician and trainee health.

Mental health services can operate along a continuum, including proactive, anticipatory and reactive approaches. In public health vernacular, the continuum spans from health-promoting environments to tertiary prevention. Proactive approaches ensure that students are aware of entry points to care before they need it. Anticipatory approaches are targeted towards periods of stress in undergraduate medical training, including the first week, the first exam period, the transition to clerkship and clinical rotations, CaRMs applications and interviews as well as the LMCC exam (14). The reactive approach addresses crises, personal or *en masse*, such as injury or fatality of a student community member. All three approaches have a role in a comprehensive mental health service program.

Medical student-specific wellness and mental health support initiatives, as well as those available for the general student body, represent multiple entry points for self-care and care seeking. Formal programs, as typified by the physician health programs (PHP) available in most provinces, can be practitioner or peer-to-peer delivered, online or in person, in groups or in private. Formal programs include traditional counselling programs targeted at mental health, but also programs that target common stressors like financial and time management (14). Informal support services include those where students can get help outside the context of the institution. Well-known programs, such as the ASIST (Applied Suicide Intervention Skills Training) program, could be offered to all medical students so that when a medical student considering suicide reaches out to a peer, that peer has some fluency in suicide prevention and can support formal help-seeking (17). Peer-to-peer support options in the context of medical education are underexplored in research. In the *CMA Mental Health Strategy*, the discussion of peers is limited to the role that medical peers play in reinforcing mental health stigma, but it's also quite possible that fellow students represent an additional entry point into the formal system for students that would otherwise not engage in help-seeking behaviours (18). Medical students need therapeutic relationships to address and manage primary care needs, both of which can be neglected given time constraints and perceived stigma.

It must be emphasized that full-fledged physicians are also not immune from work-related stressors and personal distress. Extensive research has indeed shown that unwell physicians negatively affect health care delivery by impeding recruitment of physicians, workplace productivity, patient care quality and patient safety (19), among

others. In fact, the Canadian Medical Association (CMA) reports that several factors may negatively impact physician health, including the unprecedented expansion of medical knowledge, political and economic uncertainty of work location, organization and remuneration as well as the growing expectations of an increasingly informed patient population (20). Recently, the 2015 CanMEDS Physician Competency framework includes the concept of "responsibility to self, including personal care, in order to serve others" as well as the competency "to demonstrate a commitment to physician health and well-being to foster optimal patient care" (21). In fact, CanMEDS articulates that the professional role of a physician is an important link between personal and population health, and demands that physicians:

- Balance personal and professional priorities to ensure personal health and a sustainable medical practice.
- Strive to heighten personal and professional awareness and insight.
- Recognize other professionals in need and respond appropriately.

To encourage the implementation of a culture of health and wellness within the medical student body is to empower the physicians of tomorrow in dealing with these complex issues and ultimately improving health care delivery. Therefore, the CFMS/FEMC endorses the following principles and recommendations:

Principles

1. Emotional, mental, physical, nutritional, spiritual and financial health are core elements of medical students' wellbeing.
2. Health and wellbeing are required for academic achievement, professional development and delivery of optimal patient care.
3. Systemic stressors are inherent to medical training and have the potential to influence students' health.
4. Collaboration among medical institutions on the prioritization of physician and learner health is necessary.
5. Understanding the nature and scope of the burden of mental illness experienced by undergraduate medical students through quality research is essential in creating evidence-based policy.
6. Equitable access to quality and appropriate health services, including mental health services, for which there are multiple entry points, high visibility and ensured confidentiality is crucial for all medical students.
7. All medical institutions must prioritize safe learning environments and implement strategies to minimize harassment and emotional abuse towards medical students.
8. All medical students should feel safe, and be adequately accommodated, to pursue physical health, mental health and wellness services, within and outside of their educational institution, without fear of professional or personal repercussions.
9. Reducing stigma around mental illness within medical professional culture is possible and necessary.
10. Access to quality, timely and comprehensive career planning services and academic advising is warranted for medical students of all levels at all medical faculties in Canada.
11. Peer support has a specific role within a comprehensive wellness and mental health program for medical learners.

Recommendations

1. Canadian medical faculties, institutional partners in physician health and medical student-led organizations should develop formal and informal wellness and mental health support and awareness initiatives.

Institutional partners include, among others, the Ministry of Health and Long Term Care, the Canadian Medical Association, the Association of Faculties of Medicine of Canada and the provincial medical associations. As of 2015, all medical faculties in Canada have a wellness-oriented student-led committee, which can facilitate implementation of mental health and wellness activities tailored to students' schedules and needs.

Undergraduate medical programs should ensure that medical students be informed and aware of all mental health

and wellness support initiatives available at their institution very early on in their training. The array of wellness support initiatives and formal mental health services should be catalogued by each institution, so students are given great agency in choosing how to engage. Catalogues should be widely available and describe the level of confidentiality or anonymity provided by each service. Medical faculties should send periodic reminders to their students regarding available services, especially during clerkship where students spend most of their time off campus.

Mental health and wellness awareness initiatives brought forward by undergraduate medical programs, provincial, national and student-led medical organizations should have three goals. First, they should equip students with a diverse set of strategies to foster personal wellbeing. Second, they should enable students to easily identify potential sources of help, within and outside their faculty. Third, they should help students reflect on and strive to change stigmatizing behaviours that reinforce negative stereotypes about mental health and personal wellness in medical professional culture. The CFMS/FEMC supports the advancement of local and national awareness initiatives that leverage regular in-class schedules of pre-clerkship and clerkship students, social media and other non-traditional mechanisms.

Essential messages for these wellness and mental health support and awareness initiatives include, but are not restricted to, the following:

- Every medical student will be appropriately and reasonably accommodated by their faculty to seek care and support for mental illness or other health-related issue.
- There are healthy ways to cope with the stress of medical studies, including mindfulness, maintaining support systems and striving for the maintenance of healthy habits.
- Medical students should feel safe to discuss any health-related or wellness issue, including mental health, within their professional community without fear of repercussion or mischaracterization.
- Behaviours, beliefs and attitudes of medical educators and peers should not implicitly or explicitly cause undue stress on learners nor reinforce stigma around mental illness and other health-related issues.
- Mental illness is a common and growing source of morbidity in the population, and physicians are at particular risk.
- Every medical student should have a family physician.
- Every medical student should be adequately informed about disability insurance.

2. Canadian medical faculties should promote safe learning environments for all medical students.

The CFMS/FEMC recognizes the importance of providing safe learning environments for all medical students in Canada. As such, faculties should strive to minimize student harassment and emotional abuse in all settings, including, but not limited to, the classroom and the clinical environment. Many faculties have implemented formal Codes of Conduct and official and transparent methods to report learner abuse. Such initiatives should be implemented nation-wide, be easily accessible and actively promoted. Canadian medical faculties should be transparent in addressing student issues relating to the safety of their learning environments. Furthermore, accrediting bodies should regulate and monitor the safety of learning environments at all Canadian medical faculties.

Essential components of safe learning environments include, but are not restricted to, the following:

- Clear understanding for learners about how to anonymously disclose issues of harassment, learner mistreatment, discrimination and occupational hazards in the workplace.
- Active and ongoing solicitation of student feedback on the safety of their learning environments.
- Active recording and monitoring of student complaints and subsequent institution of corrective measures with targeted faculty members, when appropriate. Corrective measures should include faculty development activities to train educators regarding pedagogical and interpersonal skills.

3. Canadian medical faculties should develop and promote accessible, realizable and standardized accommodation policies for medical students in each phase of undergraduate medical training.

The CFMS/FEMC encourages clear definition and expansion of accommodations for medical learners by undergraduate medical programs. Policies surrounding accommodations should include how to acquire permission to take time out of a student's learning schedule and importantly, how to adapt reintegration processes to support the learner's health. Standardized accommodations should be offered to students who are experiencing issues pertaining to mental health, physical health and difficult personal life events. Students should be counselled on all possible options of accommodation and their repercussions on their training so that their decision is fully informed.

The experience of mental illness, other illnesses or personal and familial emergencies can be very serious for the career of a medical student because of potential impairment but also because of stigma. For this reason, help seeking may take place far later into the course of the disease than is beneficial for the student and for the community. Undergraduate medical programs should ensure that students have the ability to engage with the formal systems earlier without disclosing their personal health information. For confidentiality purposes, special consideration should be given to ensure that students engage in therapeutic relationships with professionals whom they have not worked with in the past and are not expected to work with in the future.

Appropriate screening or easy access to accommodation services should allow learners early in the course of their illness or hardship to take appropriate measures in order to prevent more consequential morbidity outcomes that may require long-term absences from learning. In cases where long-term absences are required, standards should be made for care plans during the absence and importantly, for re-entry when appropriate. The standardization of accommodations across learning institutions could improve accessibility and familiarity of relevant accommodations. The CMFS/FEMC recommends that accrediting bodies monitor internal student accommodation policies and compare them with top policies instituted at other faculties.

The expansion and standardization of accommodation services should include, but should not be limited to:

- Accessibility of wellness services for learners at distributed medical education sites or on regional placements.
- The process to requesting absence or accommodation due to religious holidays without discrimination or barriers to advancement.
- Access to proper representation or mediators when a learner is unable or unfit to represent himself or herself.

4. Canadian medical faculties should offer comprehensive and timely career planning services and academic advising for to all medical students.

The field of medical specialties is vast and students should have adequate resources to help them before, during and after the CaRMs application process. Accessing residency positions is an increasingly competitive endeavour and students must make judicious decisions geared towards their career goals throughout medical school. Career planning initiatives should be developed, catalogued and widely publicised at each medical faculty in Canada. Amidst a busy clerkship schedule, students should be accommodated by their faculty and hospital supervisors to meet with their career advisor. Services should be adapted to accommodate learners at distributed medical education sites. When face-to-face meetings are impossible, alternate methods of communication should be encouraged such as e-mail, phone and videoconference calls.

Additionally, the CMFS/FEMC recommends that accrediting bodies monitor the offer of career planning services and academic advising and compare them with top services available at other faculties.

5. Institutional partners in physician health should support research exploring wellness in medical learners and evaluating mental health and wellness initiatives.

Institutional partners include, among others, the Ministry of Health and Long Term Care, the Canadian Medical Association, the Association of Faculties of Medicine of Canada and the provincial medical associations. There are many goals to researching wellness and mental health in medical learners. Research should be conducted by provincial and national medical organizations as well as government bodies to determine stress factors and needs among medical trainees. Research should also define best practices for instituting wellness initiatives and address stigma around mental health in medical culture. As burnout and stress affects a large proportion of medical learners, there must be collaboration among all relevant bodies to understand and to prioritize physician and learner health. Undergraduate medical faculties, provincial and national medical organizations should strive to engage in effective knowledge translation so that core research can benefit in a tangible way Canadian students and future physicians. Research should include, but should not be limited to:

- The etiology behind depression, anxiety, addiction and burnout, and risk factors during medical training.
- How burnout and mental health affect patient care.
- How burnout and mental health affect professionalism.
- Current best practice wellness initiatives surrounding stress management, self-care strategies, time-management, shared reflection, and faculty support.
- Methods used to screen for unhealthy behaviours during medical training.
- Resiliency training and its effectiveness in increasing personal awareness and wellbeing.
- Recognition by peers or oneself of signs and symptoms of deteriorating mental health.

References

1. Dyrbye, LN, et al., Medical Student Distress: Causes, Consequences, and Proposed Solutions, Mayo Clin Proc, vol. 80, no. 12, pp. 1613-1622, 2005.

2. Liselotte N. Dyrbye, et al. 2011. Patterns of distress in US medical students, Med Teach. Vol. 33, No. 10 , Pages 834-839.

3. Warburton DER, Nicol CW, Bredin SSD. Health benefits of physical activity: the evidence [review]. CMAJ 2006 and 174(6):801-9.

4. Lobelo, F., Duperly, J., Frank, E. 2008. Physical activity habits of doctors and medical students influence their counselling practices. Br J Sports Med 2009 and 43:2 89-9.

5. Puddester D, Flynn L, Cohen J. 2009. CanMEDS physician health guide: A practical handbook for physician health and well-being. Ottawa: The Royal College of Physicians and Surgeons of Canada.

6. Buske, L for the Canadian Medical Association. Results of the 2012 National Physician Survey of medical students and residents. Available http://nationalphysiciansurvey.ca/wp-content/uploads/2013/03/C3PR-Bulletin-StudentResidentDebt-201303-EN.pdf. (accessed 2015 March 08).

7. Statistics Canada, Centre for Education Statistics. Undergraduate tuition fees for full time Canadian students, by discipline, by province (Ontario). Available http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/educ50g-eng.htm. (accessed 2015 March 30).

8. American Medical Association Council on Medical Education. Report 3 (I-08): barriers to primary care as a medical career choice. http://www.ama-assn.org/resources/doc /council-on-med-ed/cmerpt3i-08.pdf. Chicago: AMA; 2008: 2. Accessed Aug 7, 2015.

9. Kessler RC, Amminger GP, Aguilar, Gaxiola S, Alonso J, Lee S, Ustun TB. Age of onset of mental disorders: A review of recent literature. Current opinion in psychiatry. 2007;20(4):359-364.

10. Statistics Canada. (January 2014). Suicides and suicide rate, by sex and age group. Retrieved from: http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/hlth66a-eng.htm.

11. Statistics Canada. (September 2013). Canadian Community Health Survey: Mental Health, 2012. Retrieved from: http://www.statcan.gc.ca/daily-quotidien/130918/dq130918a-eng.htm.

12. Liselotte N. Dyrbye, MD, Matthew R. Thomas, MD, and Tait D. Shanafelt, MD. 2006. Systematic review of depression, anxiety and other indicators of psychological distress among US and Canadian medical students. Acad Med. 2006 and 81:354–373.

13. Dyrbye LN, Thomas MR, Massie FS, Power DV, Eacker A, Harper W, et al. Burnout and Suicidal Ideation among U.S. Medical Students. Ann Intern Med. 2008 and 149:334-341.

14. Cohen JS, Leung Y, Fahey M, Hoyt L, Sinha R, Cailler L, Ramchandar K, Martin J, Patten S. 2008. The happy docs study: a Canadian Association of Internes and Residents well-being survey examining resident physician health and satisfaction within and outside of residency training in Canada. BMC Research Notes, 2008, 1:105.

15. Wallace JE. Mental health and stigma in the medical profession. Health (London). 2012 Jan;16(1):3-18.

16. Weiss MG, Ramakrishna J, Somma D. Health-related stigma: rethinking concepts and interventions. Psychol Health Med 2006 and 11(3):277-87.

17. Gould, Madelyn S., Cross W, Pisani AR, Munfakh JL, Kleinman M. 2013. Impact of Applied Suicide Intervention Skills Training on the National Suicide Prevention Lifeline. Suicide and Life-Threatening Behavior, 43-6 p 676- 691.

18. CMA Board Working Group on Mental Health, CMA Physician Mental Health Strategy Working Group, Moloughney B. 2010. Physician Health Matters: A mental health strategy for physicians in Canada. Canadian Medical Association.

19. Wallace, Jean E Je. Physician wellness: a missing quality indicator. The Lancet, 374(9702), Elsevier 2009-11-14, 0140-6736, p. 1714-1721.

20. Canadian Medical Association. 1998. Physician Health and Well-Being Policy. p. 1.

21. Snell L, Flynn L, Pauls M, Kearney R, Warren A, Sternszus R, Cruess R, Cruess S, Hatala R, Dupré M, Bukowskyj M, Edwards S, Cohen J, Chakravarti A, Nickell L, Wright J. Professional. In: Frank JR, Snell L, Sherbino J, editors. The Draft CanMEDS 2015 Physician Competency Framework – Series IV. Ottawa: The Royal College of Physicians and Surgeons of Canada; 2015 March.