

Mental Health for Medical Students

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Canadian Federation
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Executive Summary

Medicine has always been demanding both during training and in practice. The volume of knowledge and skills to be acquired in a complex professional setting, while the emotional demands of working with ill people can prove a significant burden and source of distress for many medical students. While the experience of mental illness during medical training will be a core focus of the CFMS/FEMC recommendations in this position paper, addressing mental health stigma is equally important. Important professional bodies, like the Canadian Medical Association, are starting to publicly address endorsement of stigma towards mental illness embedded in medical professional culture in Canada. Further, medical faculties are becoming increasingly conscious of the role of the “hidden curriculum” as a catalyst for stress in medical learning. Aside from being the source of important professional learning, the hidden curriculum has also historically encompassed behaviours that reinforce stigma.

This position paper is underpinned by two assumptions. First, academic success, professional progress and personal development require good mental and physical health. Second, medical training and practice are inevitably demanding undertakings that bring trainees under significant stress, which can be normal, but also distress. We examine four important principles from previous editions of this position paper, and put forward seven principles upon which CFMS/FEMC advocacy around the mental health of medical students will be based.

1. Healthy learners become healthy physicians who create healthy systems and improve population health.
2. All medical students, like all Canadians, should have equitable access to quality, appropriate health services, including mental health services, for which there are multiple entry points, high visibility and ensured confidentiality.
3. Understanding the nature and scope of the burden of mental illness experienced by undergraduate medical students through quality research is essential.
4. All medical students should feel safe, and be adequately accommodated, to pursue mental health services, within and outside of their educational institution, without fear of professional or personal repercussions.
5. Peer support has a specific role within a comprehensive mental health program for medical learners.
6. All medical institutions should collaborate on the prioritization of physician health.
7. Reducing stigma around mental illness within medical professional culture is both possible and necessary.

Next, we offer and discuss recommendations for how to further address growing concerns around the mental health of medical students:

1. Develop formal and informal mental health and wellness support initiatives at each medical school in Canada
2. Develop mental health awareness initiatives at both the university and national level.

3. Institutional partners in physician health, including the Ministry of Health and Long Term Care, Canadian Medical Association, the provincial medical associations and the Faculties of Medicine across Canada, should support research exploring mental health in medical learners and evaluating mental health and wellness initiatives.
4. Establish accessible and realizable standards for accommodation of medical students with mental illnesses in each university's policies for each phase of undergraduate medical training.

The CFMS/FEMC first became engaged with medical students' mental health after the suicides of a number of fellow learners in the mid-1990s. Mental health of medical learners remains as relevant to the work of the CFMS/FEMC today as twenty years ago, and we applaud significant shifts in the landscape of official policies, at all three levels of government and within the medical faculties themselves. 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, institutional policy and peer-to-peer supports.

Background

The CFMS/FEMC first became engaged with medical students' mental health after the suicides of a number of fellow students in the mid-1990s. Medical training is a uniquely stressful undertaking and the mental health burden imposed through the training process, especially on learners already vulnerable to mental illness, is an important matter for research and policy.

Currently in Canada, 12.5 per 100 000 persons per year between the ages of 20-24 commit suicide (1). 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 (2). Among medical students, a 2006 systematic review of depression, anxiety and burnout among US 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" (3). 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 (6). System constraints to the delivery of timely, appropriate care to patients also interfere with students' learning and function within that very system, and health system reform continues to be an area of action for physician mental health (4).

While the experience of mental illness during medical training will be a core focus of the CFMS/FEMC recommendations, addressing mental health stigma is equally important. Stigma is a social process characterized by exclusion, rejection, blame or devaluation resulting from an adverse social judgement about a person or group (5). 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 (6).

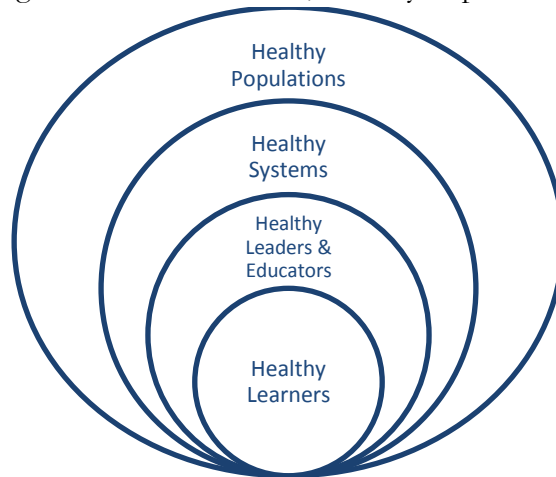
Medicine has always been demanding both during training and in practice. The volume of knowledge and skills to be acquired in a complex professional setting, while the emotional demands of working with ill people can prove a significant burden and source of distress for many medical students. For many trainees, the transition into medical education comes at the age where mental illness often presents. 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 during undergraduate medical education.

Medical faculties are becoming increasingly conscious of the role of the "hidden curriculum" as a catalyst for stress in medical learning. The hidden curriculum is "the process by which a learner's

knowledge and skills become situated in the context of daily work” (7). It involves intentional imparting of information from the teacher to learner, however, as described by Gofton and Regehr (8), “in addition to the knowledge and skills we intend to convey, we also transmit to the learner a vast array of behaviors, beliefs, and attitudes we never intended to share, nor even recognized we were imparting.” The hidden curriculum is an essential process by which medical instincts, essential ‘ways of being’ and wisdom are cultivated in students. Additionally, the hidden curriculum has historically encompassed behaviours that reinforce stigma, such as ridiculing patients with mental illness, and are tantamount to bullying. In *What Doctors Feel: How Emotions Affect the Practice of Medicine*, Dr. Danielle Ofri writes “Given that we do not accept the idea of the good-enough doctor...every doctor feels that he or she falls short to some degree...Medical students are particularly prone to this overwhelming experience of shame. Being naïve and inadequately skilled when all those around you are busy saving lives is potentially shameful, and unique to the field of medicine...Despite wearing the white coats of the profession, they felt like outsiders in this world, similar to the feelings of many patients.”

This position paper is underpinned by two assumptions. First, academic success, professional progress and personal development require good mental and physical health. Healthy medical students in health learning environments with healthy teachers and mentors working in healthy systems for healthy populations is the shared ideal (Figure 1). There are, of course, a number of other essential determinants of population health explored in other CFMS/FEMC papers.

Figure 1: Health Learners, Healthy Populations



Second, medical training and practice are inevitably demanding undertakings that bring trainees under significant stress, which can be normal, but also distress. The CanMEDS Physician Competency Framework 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.

Multiple Entry Points	<ul style="list-style-type: none"> ensuring that students can access a range of services tailored to an array of challenges and coping styles
Visibility	<ul style="list-style-type: none"> ensuring awareness and adequate penetration of knowledge around mental health services into diverse student communities
Accessibility	<ul style="list-style-type: none"> ensuring equitable access to inclusive, evidence-based services, in spite of increasingly distributed medical education and scheduling restraints faced by students
Confidentiality	<ul style="list-style-type: none"> ensuring that students are safe to experience appropriate care as they need, informally or formally, while their health information and therapeutic experience remains private within the circle of care

Additionally, mental health services can operate along a continuum, including proactive, anticipatory and reactive approaches. In public health vernacular, the continuum spans health promoting environments to tertiary prevention. Proactive approaches ensure that students are aware of entry points to care before they need it and make it less difficult to ask for help. 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 (6). These approaches assume that stress, while integral to the process of medical education, can be debilitating at times while entirely benign at others. Further, it assumes that all students, regardless of their previous diagnoses, can experience stress in harmful ways and that this harm can be mitigated with appropriate, timely services. That is, stress does not need to become distress. 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.

Principles

- 1. Healthy learners become healthy physicians who create healthy systems and improve population health.**
- 2. All medical students, like all Canadians, should have equitable access to quality, appropriate health services, including mental health services, for which there are multiple entry points, high visibility and ensured confidentiality.**
- 3. Understanding the nature and scope of the burden of mental illness experienced by undergraduate medical students through quality research is essential.**
- 4. All medical students should feel safe, and be adequately accommodated, to pursue mental health services, within and outside of their educational institution, without fear of professional or personal repercussions.**

5. **Peer support has a specific role within a comprehensive mental health program for medical learners.**
6. **All medical institutions should collaborate on the prioritization of physician health.**
7. **Reducing stigma around mental illness within medical professional culture is both possible and necessary.**

Recommendations

1. **Develop formal and informal mental health and wellness support initiatives at each medical school in Canada**

Medical student-specific initiatives, as well as those available for the general student body, are important because they represent multiple entry points for care. Formal programs, as typified by the physician health programs (PHP) available in most provinces, can be practitioner-delivered and peer-to-peer. Programs can be delivered online or in person, in groups and in private. Informal programs, though impossible to plan, can be anticipated and supported. The array of formal mental health services should be catalogued at 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.

Formal programs include traditional counselling programs targeted at mental health, but also programs that target common stressors like financial and time management (6). The CFMS/FEMC endorses programs like Ottawa's Code 99, which is a collaborative project of the Academy of Medicine Ottawa (AMO) as well as the Faculty Wellness Program in the Faculty of Medicine at the University of Ottawa. Code 99 encourages and facilitates physicians, residents and medical students with the task of obtaining their own family physician (9). Medical students need therapeutic relationships to address and manage mental health and primary care needs, both of which can be neglected given time constraints and perceived stigma.

Peer-to-peer support options in the context of medical education are underexplored in the 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. The Queen's University Mental Health Commission recommended that "increase the profile of all health promotion programs, including peer-provided initiatives" (10). Well-designed peer programming would be expected to foster networking and mutual support among students to create a platform for help-seeking, as well as for positive learning experiences.

The experience of mental illness 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. If the ability existed for students to engage the formal systems earlier without disclosing their personal health information, it may hasten the transition from pre-contemplative to motivated to seek change.

Informal support services include those where students can get help outside the context of the institution. A student discussing their situation with a friend is an example of informal peer support. 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. In their study of crisis calls to national hotlines, Gould et al found that “Callers were significantly more likely to feel less depressed, less suicidal, less overwhelmed, and more hopeful by the end of calls handled by ASIST-trained counselors” (11).

2. Develop mental health awareness initiatives at both the university and national level.

Mental health awareness should have two goals. First, it should help students identify sources of help. Second, it should help students change and stop stigmatizing behaviours that reinforce negative stereotypes about mental health in medical professional culture. The CFMS/FEMC supports the advancement of local and national awareness initiatives that leverage social media, regular in-class schedules of pre-clerkship and clerkship students, and other non-traditional mechanisms. Essential messages for these initiatives include:

- Every medical student should have a family physician.
- Medical students should be safe to explore experiences of stress within their professional community without fear of repercussion or mischaracterization.
- Mental illness is a common, and growing, source of morbidity in the population, and physicians are at particular risk.
- Every medical student should purchase disability insurance.
- Every medical student will be appropriately and reasonably accommodated by their MD program to seek care and support for mental illness.
- People with mental illness do not necessarily experience continuous impairment, and this impairment may be limited to certain domains. Further, when people with mental illness are experiencing impairment due to that illness, they should be treated by official school policies and by the community of learners and teachers with sensitivity and respect.
- There are healthy ways to cope with stress, including mindfulness, discussion and maintaining support systems.
- Medical educators and peers must work to ensure that their behaviours, beliefs and attitudes do not implicitly or explicitly cause undue stress on learners nor reinforce stigma around mental illness.

3. Support research exploring mental health in medical learners and evaluating mental health and wellness initiatives. This could include partnerships with the Ministry of Health and Long Term Care, the Canadian Medical Association, the provincial medical associations and the Faculties of Medicine across Canada.

The overall goal of this research should be to elucidate best practices and key relationships between medical education and mental health. While medical professional bodies engage themselves in improving the health of populations and that of physicians, there are a number of unanswered questions about how mental illness emerges during medical training and beyond. Understanding how learning processes and contexts in medical education work will lead directly to the design of primary, secondary and tertiary prevention programs for mental health. Key relationships of interest include:

- Depression, anxiety, burnout and the process of undergraduate medical training.
- Demographic variables, personality characteristics, stressful life events and medical student distress.
- The role of burnout in patient care and professionalism.
- Current opportunities for shared reflection, stress management training or self-care strategies and reduction of student distress.

4. **Establish accessible and realizable standards for accommodation of medical students with mental illnesses in each university's policies for each phase of undergraduate medical training.**

The CFMS/FEMC encourages expansion and standardization of opportunities for accommodation of medical students with mental illnesses. Standards for accommodation should be uniform across the learning institutions. Further, explicit permission embedded in policy that allows students to take reasonable time out of their pre-clerkship and clerkship schedules and, if necessary, to reasonably adapt those schedules to support mental wellness. These permissions make it simpler and more straightforward for students to make it to appointments during regular office hours without fear of repercussion, stigmatization or undue questioning by supervisors. Further, as the definition of mental health services expands into non-traditional, peer-to-peer and informal settings, it will be easier to access services outside of scheduled learning activities.

Appropriate standards of accommodation allow students to access services early on in the course of their illness, so as to prevent more intractable and more consequential morbidity outcomes that may require long term absences from learning. In rare cases where long term absences are required, standards should be made for care plans during absence, and for re-entry to full-time learning.

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