Mens sana in corpore sano: student well-being and the development of resilience

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As time goes by, increasingly one finds oneself reminiscing with like-minded doctors of a similar age. Somewhat fondly, we remember 100-hour weeks, one in two on-call rotations and shifts in the Emergency Department with nothing more to hand than the Guide to Practical Procedures, including helpful line-drawn diagrams should you have to drain a pericardial effusion with a lumbar puncture needle connected to a single ECG lead. Which you did have to do. ‘That’, we tell ourselves ‘was how to become resilient’, as we potter off to fill in another on-line assessment for a trainee who has never seen a pericardial effusion drained, never mind done it in the middle of the night with nothing more than a pocket handbook to help. Developing resilience? Well, maybe. Patient safety? Almost certainly compromised.

One important change in medical education over the last 50 years, reflected in the pages of this journal, has been the recognition that fatigue, stress and other mental health problems are a major cause of concern in medical education, with significant effects on the professional performance of students and doctors alike and on the safety of their patients. Where once these pages were dominated by curriculum reform, pedagogical methodologies and assessment techniques, increasingly as a community we are concerned with effective clinical supervision, team-working and professionalism, all of which have an impact on future patient care. In this issue, Dyrbye and Shanafelt provide a timely review of the literature on burnout, showing that students and doctors suffering from burnout are more likely to have poor professional behaviour, ranging from cheating and plagiarism in exams to falsifying clinical examination findings, delivering substan-
standard care and failure to manage their own health.

Fatigue, stress and other mental health problems are a major cause of concern in medical education

Stress, burnout and other mental health problems are increasingly recognised in universities and some data suggest that medical students may be more affected than their peers. Across all disciplines, university entrants now seem less well-equipped to deal with the challenges they face or make the most of the opportunities for personal growth and development offered alongside academic studies, meaning that additional transitional support programmes have been recommended. Secondary-school education has become focused on achievement in public examinations. The requirements for university entrance demand that students not only have high academic qualifications but also demonstrate excellence in a range of extracurricular activities. Parents, families and schools invest huge amounts of time, effort and money into helping students meet these requirements, but the cost may be over-protection and increased stress and anxiety levels from an early age. Extracurricular activities possibly generate further stress as a result of the perceived need for perfection in all areas of endeavour. Thus on entry to higher education, students appear to find the transition more difficult than their forebears. Rather than ‘flying the nest’ and developing themselves as independent adults, they are more likely to be in constant touch with parents through text and social media, and they may struggle with different learning styles, while dealing with the uncertainty of a changing knowledge base and increasing financial pressures, resulting in anxiety and stress.

Students and doctors suffering from burnout are more likely to have poor professional behaviour

Students seek regular institutional support and approval, which, paradoxically, may be encouraged by increased monitoring and the development of learning contracts. This infantilisation of the student population is receiving attention in both the educational literature and the media. General media reports suggest that students are turning to stress-reduction methods usually associated with primary-school education (try typing ‘student stress petting zoo’ into the search engine of your choice).

Learning to be a doctor is inevitably stressful, as is the practice of medicine. Medical school entrants are hugely talented young people; intelligent, altruistic and skilful – how can we help them develop as adult, life-long learners able to cope with the challenges ahead? Two interlinked solutions may be valuable: the enhancement of well-being and the development of resilience.

The concept of well-being centres on self-care and personal integrity, enabling individuals to cope with life’s stresses and make a positive contribution to their community. Stressful events for medical students originate in the curriculum and in external events, including family disruption, illness and bereavement. Institutional pastoral and welfare support, ranging from peer mentoring systems through formal student counselling to the provision of easily accessible physical and mental health services, is vital to promote well-being. Students should be encouraged to develop healthy lifestyles, good interpersonal relationships, social support networks and recreational activities.

Student well-being can be enhanced by good educational practice, including well-constructed curricula, effective teaching and learning methods and appropriate assessment procedures, delivered by faculty staff who are responsive, engaged and offer ongoing personal contact. We investigated mental health and stressful factors in undergraduate medical education that might have an adverse effect on future patient care in a longitudinal cohort study, including the prevalence and persistence of depression, changes in empathy, attitudes towards cadaveric dissection and palliative care and the implications of personal bereavement. The prevalence of depression in medical students was similar to comparable groups although there was a small increase in depression in male students during the latter part of the course. Women demonstrated greater empathy throughout and we observed a small reduction in affective, but not cognitive, empathy in men. Negative attitudes towards dissection were greater in women and in students with higher levels of anxiety (particularly anxiety regarding death) or a recent bereavement. Attitudes to palliative care were positive, declining in the early years of the course but restored following greater clinical experience. A subsequent study revealed the importance of anxiety about death as a predictor of ongoing psychological distress and concerns about future clinical capability to deliver palliative care. At matriculation,
23% of our students had experienced a recent close personal loss and between 13% and 22.5% were bereaved in each year of the course. Taken together, these studies and others emphasise the need for effective teaching skills and pastoral care. A supportive learning environment allows risk factors to be identified early and appropriate measures to be put in place. Importantly, the educational programme should be a meaningful experience for students in which the significance of each module for future patient care is acknowledged. With time, students should be given responsibility for aspects of clinical practice and learn to work within multiprofessional teams, both of which lend authenticity and meaning to their studies, factors known to enhance well-being.

Emotional resilience is a more complex construct although the factors required for well-being assist its development. Resilience has been defined in many ways, but in essence it reflects an ability to cope with, learn from and thrive in the face of adversity. Resilience is dynamic and, crucially, can be developed over time. Programmes that assist students to become reflective learners, using simulation from an early stage and regular small-group discussion of clinical, ethical and professional problems are invaluable. Students are adept at identifying good clinical role models; they should be encouraged to evaluate characteristics demonstrated by positive role models and aim to emulate them. However, this approach is not without its risks: our student feedback indicates that negative experiences of clinical practice may outweigh this apparently theoretical exercise, making group sessions where students are encouraged to report concerns appear superficial and naïve. Skilled facilitation is essential, with staff prepared not only to address individual students’ needs, but also to investigate reports of poor practice amongst clinical colleagues. This requires engagement by faculty staff at a high level and for institutional procedures to be in place within a culture of openness that supports both students and staff. If students feel confident that their views will be heard and if clinicians accept that students’ views are of value, then both groups will benefit—and become more resilient in the process.

The available evidence suggests that the maintenance of well-being and the development of resilience are important for the prevention of mental health problems associated with poor patient care. Whilst a return to those ‘good old days’ cannot be recommended, the professional and emotional support provided by traditional clinical teams, particularly out-of-hours, should not be underestimated. As medical educators, we need to accept that young people entering medical education today are indeed different from their forebears and our challenge for the future is to ensure that they develop and flourish as well-balanced, independent adults able to practice medicine successfully in a rapidly changing world. Mens sana in corpore sano (a healthy mind in a healthy body), immortalised by the Roman poet Juvenal as the most desirable attribute in life, remains as important today and tomorrow as it was 2000 years ago.

As medical educators, our challenge is to ensure that students develop and flourish as well-balanced, independent adults able to practice medicine successfully in a rapidly changing world.

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