

A commentary on “Medical student wellness in Canada: time for a national curriculum framework”

Un commentaire de « Le bien-être des étudiants en médecine au Canada : il est temps de définir un cadre pédagogique national »

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It is with great interest that I read Bourcier et al.’s¹ perspectives on the need for a unified wellness framework in Canadian medical education. They drew attention to various individual and environmental sources of student distress and how institutional approaches to wellness are widely inconsistent. They also highlighted the importance of an evidence-based framework that supports students’ basic psychological needs for wellness, based on some of my own work within the area of self-determination theory (SDT).² I write this article to applaud these efforts made by the Canadian Federation of Medical Students (CFMS), but also out of a deep concern for the way that “wellness” continues to be approached in medical education. Truth be told, I believe that individual-based interventions should not have to exist, and my fear is that attempts to regulate medical student wellness will ultimately undermine it if we are not extremely careful.

As Bourcier et al.¹ mentioned, student distress is a growing problem in medicine, and Canadian organizations, accreditation bodies, and medical associations have responded—albeit inconsistently—by integrating “wellness” into their standards and policies (hence the proposed need for a standardized approach). The CFMS wellness curriculum framework³ aims to guide this movement for Canadian medical programs, with a focus on the individual and what makes a medical student unwell. Like most “wellness” interventions in medicine, this framework categorizes wellness into “competency” and “skill” domains. I would argue that this kind of approach

represents a necessary defense against a medical system that is failing its learners—that aims for healing but harms in the process—but one that perpetuates the message being sent to learners that *they* are the problem, when the *system* is the real issue.⁴ If we want to truly support student wellness, we need to move away from such discordant (and potentially harmful) strategies, and as swiftly as possible. Additionally, I think we need to carefully listen to what SDT and other empirically supported frameworks tell us about human motivation and wellness, and how controlling social contexts and policies can undermine them.²

Let us start by recognizing that well-being is not a simple construct: it is a richly complex phenomenon with a myriad of facets and biopsychosocial determinants.⁵ Though it is typical in medicine to want to simplify and create an algorithmic management plan for something undifferentiated, doing this with student wellness is problematic for a variety of reasons. Yes, there are individual-level (e.g., mindfulness and coping) and domain-level (e.g., physical, social, financial) factors we can teach when it comes to self-care and wellness in medical education, and Bourcier et al.’s¹ suggestion to target these is reasonable. However, while standardizing approaches to “wellness” may make it more measurable and targetable for programs, my experience—both as a resident and as a researcher with expertise in motivational psychology and wellness—tells me that treating wellness as a competency, and trying to externally regulate it, is likely to create more harm than good. The reason for this comes down to a

simple law which applies to any educational policy or research endeavour—Goodhart’s law.

According to Goodhart’s law, any measure that becomes a target ceases to be a good measure.⁶ This is because when we set a specific goal, people will tend to optimize for that goal, regardless of the consequences. Professor and Associate Dean for Evaluation and Educational Research at the George Washington University School of Medicine, Artino et al.,⁶ emphasizes the seriousness of this problem in medical education. He and colleagues point out that if the outcomes we seek (e.g., higher student well-being) become our metrics and standards, the approach (and any results or conclusions that derive from it) becomes fundamentally flawed—unified or not. Even with anonymous surveys, ethical approval, and surrogate measures of learner wellness (e.g., their perceptions of the learning environment), it is easy to see the moral dilemma this creates—in the pressures this will put on programs to press for accountability, and the undue influence it will have on medical learners, as a result. This explains why policing “wellness” is likely to undermine it, along with any autonomous motivation students may have to engage in such activities.

There must be a better way to support learner well-being (from within), without programs forcing “wellness” on students (from without). More flexible scheduling, pass-fail grading, and transparency around mistreatment or the hidden curriculum are all valid considerations,¹ and bringing any form of assessment into “wellness” interventions is indeed discouraged.⁷ However, we need to think bigger. As was rightfully pointed out,¹ we must address the culture and learning environment in medicine. I would add to this by stressing the importance of also very carefully considering how organizational efforts to regulate “wellness” (i.e., in policies, curricula, and institutional norms) will impact the self-determination of medical learners in Canada. Intervening may help programs claim more responsibility for student wellness, but at what cost? The fact is that we still lack quality evidence to support such approaches, and wellness “interventions” run the real risk of exacerbating distress for medical students,⁸ by adding to what already constrains their autonomy (e.g., demanding curricular structures, high-stakes assessments, overburden of mandatory surveys, rigid accommodations standards, and a toxic culture of perfectionism, etc.).

In closing, this commentary is not to dismiss the value of the CFMS wellness curriculum framework, as I believe its

guidelines are among the best available. I simply wish to highlight that individual-based approaches to “wellness” are largely treating the symptoms (and not the root causes) of medical student distress, and that trying to help learners to better cope with workplace stressors is laudable, but even the most resilient of doctors are still displaying high rates of burnout.⁹ It is based on these realities that I propose a few key considerations. First, let us adopt the CFMS wellness curriculum framework, but continue to discuss what “wellness” really is and question how best to (and not to) address it in medical education. Second, let us recognize that “wellness” interventions may be helpful, but that they can also cause psychological harm to students, depending on how autonomy-supportive they are. Lastly, let us agree that fixing the learning environment needs to be our main priority, moving forward. As I have said before,² when a plant does not bloom, you fix the surroundings in which it grows—not the plant.

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