

Beyond resiliency: shifting the narrative of medical student wellness

Au-delà de la résilience : changer le récit du bien-être des étudiants en médecine

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Introduction

The markedly high risk of burnout, mental illness, and suicide is well documented in physicians and physician-trainees. A study of nearly 7000 American physicians revealed a burnout rate of over 50%, with similar numbers reported in Canadian studies.¹⁻³ Further, physicians carry twice the risk of suicide compared to the general population.⁴ Unfortunately, these findings are not exclusive to practicing physicians and can be observed early in medical training. A large cohort of students surveyed before starting medical school showed less burnout, fewer depressive symptoms, and higher quality of life compared to peers.⁵ Yet, medical students have demonstrated significantly higher rates of burnout and mental illness compared to their peers.^{6,7} This dichotomy suggests that experiences and exposures in early medical training play a significant role in altering the well-being of trainees.

Meaningful strategies to target this crisis must then include efforts to improve physician-trainee well-being. Indeed, medical schools have been addressing this primarily by adopting resiliency education into their curricula.⁸ Although this is a forward step, the current narrative, where resiliency is staged as the primary solution for burnout and poor well-being, is insufficient given the reality of training environments. Here, we outline trainees' perspectives on the reality and limitations of the resiliency narrative within medical training.

The origins of resiliency

The concept of resiliency originally emerged from the field of psychology, identifying protective characteristics of those living in high-risk situations.⁹ Though a gold standard for its measurement remains elusive, a synthesis of over 270 articles has come to define resiliency as a dynamic response that changes throughout life based on environmental factors, and is best described as “the process of negotiating, managing, and adapting to significant sources of stress or trauma,” or simply, the capacity of one to bounce back in the face of adversity.¹⁰ Various disciplines including military,¹¹ police,¹² and public health executives¹³ have utilized resiliency training in attempts to facilitate employee well-being.

In medical education, Dunn et al.¹⁴ introduced the “coping reserve” model of medical student well-being, where positive or negative inputs replenish or deplete an internal coping reserve, resulting in either overcoming adversity (resilience) or burnout. They proposed that medical schools could foster resiliency by increasing positive inputs for their students. Over a decade later, resiliency has become nearly ubiquitous in discussions of medical student well-being. However, its interpretation and intended use have become somewhat distorted. Dunn et al. described positive inputs to students' coping reserve as role-modeling healthy attitudes, addressing self-doubt, and working collaboratively with students toward academic success.¹⁴ However, the narrative behind today's medical

school resiliency training is often presented more superficially: eat healthily, sleep well, stay active, and try journaling or mindfulness.⁸ Where resiliency once described protective personality traits when facing unavoidable adversity, it now implies an expectation that developing more resiliency will give students the ability to thrive in ever-increasingly challenging environments. As learners, we are observing an over-dependence on the resiliency narrative, which has limited the examination of the role of the learning environment in trainee well-being, for lack of a more effective solution to our declining mental health.

Limitations of the resiliency narrative

Who is responsible for trainee well-being?

The basic health maintenance messages that typically comprise medical school resiliency training are well-intentioned, though not always well-received. Among increasing publications by resident physicians voicing frustration towards the resiliency narrative, Meeks et al. eloquently describes the incongruence between this messaging and the realities of the clinical environment: “wellness programs implemented in environments that do not support self-care may unintentionally cause [learner] distress.”¹⁵ There may be several reasons for this. Aside from the lack of time to pursue resiliency techniques, embedded in this narrative is a hidden message that the onus of a learner’s well-being is entirely their own. Burnout, mental illness, or psychological distress, even in the face of unhealthy clinical environments, is then one’s personal failure to maintain it. It is easy, then, to understand the stigma towards seeking mental health help in the medical profession.

Do resiliency interventions address the sources of learner distress?

Medical students face many unconventional challenges. They adapt to working much greater than traditional work hours, involving shifts longer than 24 hours with little to no restorative sleep.¹⁶ They are also challenged with developing their professional identity, choosing their specialization, and facing constant evaluation and pressure to pursue extra-curricular activities in the context of the residency matching process. They face high rates of workplace mistreatment,¹⁷ with 58% of recent graduates reporting experiencing workplace mistreatment at least once, as published by Association of Faculties of Medicine of Canada (AFMC)¹⁸ Historically, meeting these challenges

has been seen as a rite of passage for medical trainees, and that enduring these difficulties demonstrates the sacrifice and commitment necessary to overcome similar challenges during residency and throughout their careers. Though perhaps well intentioned on the idea of preparing students for the challenges of a medical career, treating medical training as a proving ground has likely contributed to the physician health crisis we face today. The resiliency narrative thus does not address the underlying strenuous environment in which medical students are expected to perform, nor does it change the physical and mental demands placed on residents and practicing physicians alike.

Is there still a role for resiliency training?

We do not dismiss the importance of identifying and reinforcing protective personality traits in a physician’s education. There does exist a body of evidence showing modest benefits of resiliency-based interventions on the well-being of medical students.¹⁹⁻²¹ However, the limitations of the resiliency narrative must be recognized. by students on the receiving end, it can often be seen as a facile blanket solution to their challenges.

A new narrative for learner wellness

We have described how, in the fight against physician burnout, mental illness, and suicide, resiliency to endure worsening working conditions is an insufficient solution. The troves of health care workers leaving the profession amidst the coronavirus pandemic and the ensuing state of understaffed and over-capacity health centres has demonstrated this well.^{22,23} Better alternatives exist in the literature: a recent meta-analysis compared 19 burnout interventions on 1550 physicians and found that organizational change improved burnout significantly more than physician-directed interventions, such as resiliency training.²⁴ Appropriately, calls have been made from physician and trainee representation, including the Canadian Medical Association, Canadian Federation of Medical Students, and American Medical Association, for stronger structural interventions to address physician and trainee burnout.²⁵⁻²⁷

What has stopped structural change so far?

Despite the evidence of the importance of structural changes to address physician and trainee health, they remain relatively elusive in comparison to resiliency-based and other physician-directed interventions, which are

often favored as simpler and less cost and time intensive to implement. Underlying this, the notion that physicians are responsible for their own well-being is pervasive still, and likely also contributes to a lack of structural change. Yet, the evidence is clear that there are achievable structural interventions that can be implemented to yield greater reductions in physician burnout, with examples such as quality improvement initiatives in workflow and communication, changes in shift scheduling for physicians, and fatigue management for on-call residents.²⁴ While these specific interventions fall outside the scope of this commentary, we do call on our medical training institutions to adopt a new systems focused narrative regarding the health and well-being of trainees.

A new narrative for medical learner well-being

The resiliency narrative was a step forward towards a positive cultural shift in medical education. It brought awareness to well-being in a culture where physicians historically sacrificed their own health both for patient care and to uphold the profession. To evolve the narrative further, equitable shared responsibility for learner well-being between trainees and the medical school must be both taught and demonstrated by medical training programs. In addition to reinforcing protective personal traits to promote success in overcoming adversity, schools should educate trainees on structural factors in the health care system and training environment that impact their well-being. Such education could include identification and epidemiology of poor physician health, the definition and recognition of burnout, and the impact of fatigue, sleep disturbances, emotional or moral distress, and other workplace factors on one's physiology, cognition, and quality of life. Recent calls to action and subsequent development of a wellness curriculum by the Canadian Federation of Medical Students is a promising example.²⁸⁻
²⁹ Ultimately, training programs can demonstrate their commitment to this collective responsibility by allocating more resources to the study and implementation of institutional interventions to improve the well-being of their trainees. This shift in narrative to one of shared responsibility for trainee well-being only will not only demonstrate support for learners but is also likely to shape healthier physicians and thus stronger medical leaders of the next generation.

Conclusion

The deterioration of mental health and well-being in physicians begins early in medical training, and medical schools have relied heavily on resiliency education to improve the health of their students. As learners on the receiving end, we offer our perspective on the unintentional consequences of this narrative and call upon training programs and health systems to commit to a narrative of shared responsibility for physician and physician-trainee health and well-being, both through education and system-wide interventions.

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