

## **CFMS Position Paper on Responding to Medical Student Suicide**

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### **BACKGROUND**

Medical professionals are often subject to heavy schedules, stressful encounters involving life-or-death decisions, and high expectations on behalf of the population they are treating. The Canadian Medical Association National Physician Health Survey in 2017 found that of the 3000 Canadian residents and physicians who responded, 30% reported burnout, 34% experienced symptoms of depression, and 8% had had suicidal ideations within the past 12 months (1). In addition, the prevalence of suicide disproportionately affects physicians, with rates among male and female physicians being 40% and 130% higher than in the general population, respectively (2). Such statistics are very worrisome for both practicing physicians and for medical students.

Burnout is known to have a strong dose-response relationship with suicidal ideation. Many stressors affecting medical students may contribute to such burnout, including high academic demands, harassment or discrimination, insufficient social support, exposure to patients' suffering and death, financial concerns, workload, decreased sleep, and suboptimal learning environments (3,4,5). It has been hypothesized that medical students' well-being deteriorate during medical school. Upon entering medical school, students typically demonstrate fewer symptoms of both depression and burnout compared to college graduates of the same age that are not studying medicine (3). To illustrate, a study by Brazeau et al. shows that 26.2% and 27.3% of incoming medical students demonstrate symptoms of depression and burnout, respectively, compared to 42.4% and 37.3% of age-matched college graduates pursuing careers in other fields (3). However, once medical school begins, the mental health profiles of medical students compared to those of their age-matched peers pursuing other careers are worse, exhibiting more emotional exhaustion, depersonalization, and overall burnout. As such, the drivers of burnout are thought to be rooted in the medical learning environment (4,6).

Studies by Dyrbye et al. and Rotenstein et al. have shown that, by the time of graduation, 1 in 10 medical students experience suicidal ideation, approximately one-third experience depressive symptoms, and one-half experience burnout (6,7). In addition, a survey sent out to the 17 Canadian medical schools (response rate of

94%) reported that there were six Canadian medical student suicides between 2006 and 2016; five of the six deaths occurred during senior years of study (third year, fourth year, after graduation before residency) (8). It is important to note that not all suicide attempts result in death. In fact, the prevalence of self-reported suicide attempts across 37 studies of medical students ranges from 0% to 6.4% (9).

Even with the introduction of pass-fail grading systems, wellness programs, and team-learning sessions implemented to address mental illness, the stigma associated with mental illness still remains especially difficult to overcome. This fear of stigmatization by both peers and the medical establishment has been identified as one of the barriers for medical students seeking care. As a result, medical students in distress rarely reach out. In addition, concerns over professional ramifications including negative impacts on residency applications, academic records, insurability, and medical licenses all prevent medical students from seeking help when they need it the most (10,11).

The Canadian Medical Association recognizes physician health as an important concern within the medical profession and has released a policy in 2017 that provides recommendations at all levels of the healthcare system to help promote physician health (12). Some of these recommendations include, but are not limited to, the integration of the maintenance of personal well-being as part of the CanMEDS Professional Role, the optimization of healthy and supportive learning environments, providing physicians and students with accessible mental health services, and the integration of wellness programs and formal wellness curricula at the undergraduate and postgraduate levels. Physician health has a direct impact on the quality of patient care, and these recommendations highlight the importance of addressing this issue as early as undergraduate medical training (12).

## **PRINCIPLES**

The CFMS endorses the following principles in support of an action plan that addresses both the prevention of and the response to medical student suicide.

1. Medical student suicide is of serious concern to CFMS members, medical faculties, and others, including family and friends of medical learners, and society as a whole, given the system-wide impact of the loss of medical trainees.
2. Collaboration between CFMS, medical student societies, medical faculties, provincial medical associations, regulatory bodies, and the Canadian Medical Association is important to reduce the stigma associated with mental illness, to encourage students to seek help, and to support them when they do.
3. A coordinated postvention (support-based interventions that occur following a suicide) plan based on communication, education, and counselling should be established in medical faculties.

## **CONCERNS**

Concern 1: Suicide risk increases as medical training progresses.

Documented suicides among Canadian medical students primarily occur later in education (third year, fourth year, after graduation before residency) (8). In addition, the risk of burnout increases in upper years of training compared to more junior years of training (13).

Concern 2: Many students at risk do not seek the help they need.

Despite experiencing distress and/or burnout, medical students may not seek the help they need due to fears of privacy breaches, stigma of mental illnesses, and potential consequences on career trajectories. In fact, more than two-thirds of medical students don't seek help despite going through emotional distress (15). This trend persists among Canadian physicians from a localized cohort: 18% reported being depressed, 25% of them considered seeking help, but only 2% of them actually did (18). As well, there is a fear that when one appears unwell, it may poorly reflect upon their medical competence and suggest that the need for help is a reflection of their inability to cope (14).

Concern 3: Not all Canadian medical schools have suicide response policies.

It is critical to have a plan in the event of a student suicide. However, a recent study reported that only ten (63%) of Canadian medical undergraduate programs have policies or guidelines on the steps to take following a medical student suicide. (8)

## **RECOMMENDATIONS**

The CFMS supports the following recommendations to Undergraduate Medical Education (UGME) across Canada:

1. Strengthen prevention and education efforts surrounding mental health
  - 1.1. Integrate teaching about mental health and mental illness in the medical curricula, including but not limited to self-awareness, self-care, resiliency, and suicidality, especially in the first and second years of medical school, to provide opportunities to reduce stigma surrounding these topics and for students to reflect on their own mental health and develop ways of coping.
  - 1.2. Promote accessible mental health resources both on-campus and off-campus and make this information readily available to students.
2. Promote early identification of students at risk
  - 2.1. Train peers to have a role in early identification of at-risk students by making training available to students (eg. Sentinel training or Applied Suicide Intervention Skills Training (ASIST)) to learn how to recognize both signs of distress and risk of suicide, and to refer peers to appropriate resources within their university/community.

- 2.2. Train clerkship site directors to have a role in early identification of at-risk students; student feedback is given routinely throughout clerkship rotations and these mandatory meetings can also act as checkpoints for staff to identify students at risk of suicide and refer them to appropriate resources.
3. Provide timely support
  - 3.1. Offer timely support throughout medical school and especially in clerkship when suicide risk often increases. Options of timely support not only include counselling during the day, but also evenings to accommodate for the schedule of clerks.
  - 3.2. Offer accessible forms of support for students on visiting electives (eg. online/telephone). Web-based cognitive behavioural therapy (CBT) can also be considered (16).
4. Establish a suicide response protocol at each Canadian medical school
  - 4.1. Collaborating with students and faculty partners, faculty should establish a plan in the event of a student suicide in their population. In the event of a student death, in keeping with respect for the student and their family, sensitive communication between the school and student body is needed to provide support in a timely manner.
  - 4.2. Possible resources that can provide guidance in protocol development include: [After a Suicide: A Toolkit for Residency/Fellowship Programs](#) (19) and [After a suicide: A toolkit for schools](#) (20)

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