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What's missing from medical education?

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Editor-in-chief
David Peters
infoprofpeters@gmail.com

Editorial Board
Professor David Peters
Dr William House
Dr Antonia Wrigley
Dr Thuli Whitehouse
Bruce Cryer

Production editor
Edwina Rowling
edwina.rowling@gmail.com

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EDITORIAL

What's missing from medical education?

David Peters, Hugo Jobst and Louise Younie

With student burnout at an all-time high and many trainees leaving the NHS for easier work abroad, can medical schools find better ways to equip graduates for the rigours of clinical life? 'What's missing?' is one way of asking what's to be done, but as we shall see other less obvious, vexing questions circle around it. All around our universities we see how societal breakdown, austerity, and mental health challenges weigh on healthcare. Our profession is having to deal with information overload, ever-increasing complexity and litigation. Our educators too are overwhelmed and working flat out.

This issue of JHH gives us the student perspective on how 'the system' turns them into practitioners. Your three o-editors must declare their interests in this. David is a retired GP academic researching NHS burnout and resilience. Louise is a recognised innovator in medical education and creative enquiry. Hugo, a final year medic in Glasgow, organises the Humanising Medicine Forum.

> *'As a final year medic, I can see student dissatisfaction growing and its insidious consequences manifesting in individuals and at the systemic level. There are so many people with good ideas out there, and the feeling that medical school misses the mark is felt by many. Now is the time to come together for cultural, systemic change in medical education. The articles in this issue give students a voice to say what they feel is missing from their learning experience.'* Hugo Jobst

We share a disquiet about the wellbeing of our colleagues and alarm at the healthcare professions' direction of travel. We worry together about the industrialisation of medicine and education and what happens when their nourishing humanising currents dry up. Over decades, since the General Medical Council's comprehensive recommendation, medical schools have reformed their course content, reformed ways of teaching and reformed assessments. Medical schools strive to provide what's needed for the professional journey ahead in an uncertain world, and much of what they offer (though by no means all) is necessary. But clearly it isn't sufficient: student burnout is common, and many junior doctors have felt unprepared for the demands of their foundation year (Gale *et al*, 2022). In recent times as many as half of our would-be trainees leave the NHS at the end of foundation year 2, many of them to train outside the UK (https://blogs.bmj.com/bmj/ 2020/02/06/why-are-so-many-doctors-quitting-the-nhs). Perhaps this is an indicator of the pressures on our junior doctors in a struggling NHS, but is there more that medical schools can do?

Business as usual isn't working and in a medical system so evidently in trouble we need to ask what medical schools might do to adapt and mitigate. Too many young clinicians are in distress, though it's a moot point whether this calls for better education, access to psychological support, or better working conditions. Probably all three, the balance depending on how we conceive the purpose of medicine. However, there are and ever have been 'key tensions inherent in the professional socialisation of doctors – between "objectifying" and "humanising" currents' (Cribb & Bignold, 1999). These longstanding disagreements are about why, where and how the practice of medicine can strike a balance between 'objectifying' cure and 'humanising' care. Without this new consensus medical education will stagger on in its current unsatisfactory trajectory.

In the BHMA's survey of medical students and foundation doctors (still under way), just over half of the responders so far feel the curriculum is adequate, yet very few say that medical schools look after them or take their views into account. This disparity between content and process suggests it isn't simply knowledge that's missing. Technical fact-based aspects, even if overloaded, may be good enough, but feeling listened to or supported are emotion-laden issues. The perceived lack might have to do with the swelling medical school intakes, or students' increasing workloads and the heavy systemic demands on their educators. Yet we suspect there's more to it than this: the hidden curriculum and the traditional doctor persona – emotionally detached and stoical – encourages a macho non-engagement with the challenges, especially the emotional labour of our work. Even where extensive student support is available, our students and doctors have tended to hold back from asking for help.

The 2022 BHMA's annual Kilsby Essay Prize asked healthcare students to tell us what's missing. In this issue we present the winners and some runners up in the form of essays and artistic responses. Relatedness seems to us to be an emerging theme: students and medical teachers have contributed articles on ways to escape the limitations of the lecture room and the encroachment of online teaching and virtual consultations that can put an unhealthy distance between student and teacher. Several articles raise concerns about these power dynamics whether in the clinic or by the hospital bed, and particularly if online consultations were to depersonalise the patient and submerge the humanity of the doctor.

Our profession should take these concerns seriously at a time when many doctors fail to flourish, and when they burn out their unhappiness impacts on patients and on the leadership and morale of the workforce. Can medical schools become altogether less anxious and competitive places, teach a more future-proof curriculum, where educators expand their imagination and students learn more effectively? If ever they are to flourish together in a long and satisfying patient-facing daily life they will need time for personal development, and to be psychologically and socially, as well as technically, well-informed. We are told in this issue of JHH that space will have to be made beyond the confines of the teaching hospital space for creative engagement in the community, for authentic reflection, and healthful recreation.

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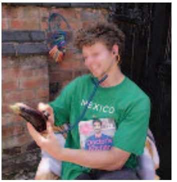
Creating space and providing tools for personal development



Hugo Jobst

Final year medical student, University of Glasgow

I am a final year medical student at the University of Glasgow and founder of the Humanising Healthcare Forum (HHF). After almost six years as a med student, I have come to the belief that medical school can be counter-productive to whole-person development, and that this has far-reaching impacts on the individual and the health system. I think that medical school could produce clinically competent doctors without the negative consequences that frequently affect students if institutions work to evolve medical curriculae. Outside of medicine, I love to explore the Scottish Highlands, read, think about things, share ideas and make bread.

Giskin Day

Principal teaching fellow, Imperial College Faculty of Medicine

I originally trained in South Africa, not as a doctor but as a botanist. I joined Imperial College London to develop humanities teaching and was made a national teaching fellow in 2016. Alongside my PhD studies at King's College London I am course director for the intercalated BSc in medical sciences with humanities, philosophy & law at Imperial College School of Medicine.

with David Peters

University of Westminster, Editor JHH

Summary

Non-biomedical content and medical humanities, though they are given a place in the curriculum, are overshadowed by the hard facts of anatomy, pathophysiology and medical therapies. Because of the sheer volume of this information, a waning of any genuine interest, and the absolute imperative to score highly in knowledge tests, medical students apply a subliminal filter to whatever content they are given. 'What do I need to know for the exam?' limits the scope of learning to the (long) bullet-point list of intended learning outcomes (ILOs). All the rest becomes noise.

> *'It is of course true that all great physicians have been those who are not only well versed in the hard-core physiopathology of their time, but are equally at ease, mostly through their own insight and accumulated wisdom, with the human heart in conflict.'*
>
> Antonio Domasio, Descartes' error (1994)

Exams and student attention

Exam-motivated learning shapes our medical education, but its effects are insidious. It creates a soulless culture of studying that can breed disillusionment with the institution, disinterest in wider learning, and fickle, grade-dependent self-esteem. It is common for it to drive students into the ground in the run-up to exams. Then they may develop maladaptive coping habits such as alcohol consumption, smoking and the use of study drugs. In a recent independent survey only 16% of medical students were sure that getting through medical school had not compromised their mental or physical health (Jobst). Some fall by the wayside and for those who get through finals, burnout is a rite of passage many will face as junior doctors: in April 2022, 62% said they were currently suffering from depression, anxiety, stress, burnout, emotional distress, or another mental health condition, relating to or made worse by their work or study (Hallett, 2022) and with worrying knock-on effects for patient care (Hodgkinson *et al*, 2022). However, in our meritocratic medical profession this should come as no surprise: career progression, points, prizes, research opportunities and jobs demand

top grades. In an education system driven by the objective metrics of fees in and graduates out, the way institutions measure the value of their students will sway how students value themselves. Knowledge becomes the dominating asset for success and student self-worth gets pegged to the exam grade.

In the UK, some students begin medical school when they are only 17 years old, even before they have reached legal adulthood, let alone emotional and intellectual maturity. Uprooted from family and with much personal (and brain) development still in process, they face new stressors: exams, human dissection, encountering disease and suffering, witnessing surgery and patients dying. It seems to us that medical schools' duty of care requires that time be made for students' full individuality to emerge, and for care to be available if they find this arduous professional journey hard to cope with. We see such a pastoral re-orientation as essential if doctors are to flourish, and be at their most effective, and for medicine as a whole to become more human-centred. Without this attention to personal development, medical schools risk becoming a production line turning out demoralised doctors eager in their early 20s to leave the NHS for easier working conditions (Wilson *et al*, 2021).

What if the curriculum were to embrace this change?

Whether students would actually engage with a personal development stream will depend on getting it through the attention filter so effectively contrived by the exam system. Exams, fear of failure and the professional pecking order can motivate intense study. They also breed medicine's typical competitive and individualistic atmosphere, not one that is collegial and cooperative. And all too easily this mood extinguishes students' innate desire to learn.

How might we overhaul the exam system to assess student competence and quality without the unwanted side-effects; give the marginalised 'fluffy (ie non-bio-medical) stuff' and creativity due attention and, crucially, facilitate our young students' personal development more holistically? Fear of failure won't motivate them to engage with the 'emotional labour' of medicine, nor help them acquire so-called 'soft skills'. Here, the character and enthusiasm of the educator matters. Where the human dimension and the relational aspects of clinical work are concerned, we need passionate, caring educators to inspire wonder, curiosity, enjoyment, humour and humanity. Fortunately, even though our fact-focused system constrains how and what is learnt, some medical teachers can do this.

Some medical schools are already paying more attention to values and character, personal development, life aspirations and students' quality of experience. This is important because society needs doctors who are willing to engage with, not turn away from, the realities of suffering and its impacts. Wider still, medical schools should be preparing students to face the many present-day obstacles to good healthcare. Some of them will be the profession's future leaders; they have to understand the whole field in context. Though deluged by ever more new facts and discoveries, surely with the benefit of information technology our education can lose its addiction to biomedical facts rote-learning and attend more to producing emotionally literate, mindful, critical thinkers.

Can creative coursework be embedded in the curriculum?

Among several examples of successful approaches, Imperial College London offers an intercalated BSc in medical sciences with humanities, philosophy & law (HPL). Its aim is to recognise creativity as a core task for good doctoring. Students have opportunities to work with artists to develop skills in life drawing, sculpture, creative writing, musical interpretation and photography, and to reflect on how these competencies are relevant to clinical practice. Students experience first-hand the impact on wellbeing of creative practice, and workshops are complemented with discussions on narrative attentiveness, ways of looking and seeing, and legal and ethical considerations of modes of representation. Every week, students on the HPL BSc may plan and lead class discussion on a film or book – a valuable and more importantly enjoyable way to take ownership of part of the curriculum and experience autonomy so often sadly lacking in medical education. Ideally, opportunities like this would be available to all students, rather than only those that have opted for an intercalated course.

Another showpiece of creative education is the creative arts student selected component which Dr Louise Younie has been running for 15 years, first at the University of Bristol and now at Barts and The London. This course is a rare opportunity for medical students to keep their creative side alive through experiencing arts-based health practices. They do not need to have well-developed creative talents, just a willingness to engage with and explore the creative process. The course is facilitated by patient artists, arts for health consultants, arts therapists and clinicians. Students witness patient creative expression, hear about different creative enquiry processes, engage in the processes and share and discuss what emerges through this work. Together they explore themes such as human flourishing, understanding ourselves, understanding the other, the third space in between, epistemic injustice, reflexivity, narrative humility and more. Students learn from the patient stories and creative expressions, from their own explorations as well as hearing from each other and the facilitators. Through running small group learning environments with self-selecting students where vulnerable leadership is coupled with creative enquiry, it became evident that students were flourishing, sharing, building solidarity and exploring challenging parts of their lived experience as medical students (Younie, 2016, and see www.advance-he.ac.uk/knowledge-hub/creative-enquiry-and-space-flourish-medical-education).

At the University of Glasgow the Humanising Healthcare Forum holds a fortnightly discussion group for medical students. The sessions are a student-led bottom-up approach to stimulating creative thinking through discourse on subjects not usually covered in the standard curriculum such as sociology, spirituality and mental health. The meetings have no formal structure, nor learning outcomes or faculty staff. Given this freedom, students have explored challenging topics in greater depth, and felt more able than they would in a standard course group format to bring in their own highly relevant personal experiences.

Reframing content

We cannot expect all students to be future leaders and system-changers, but at the very least they should leave medical school able to think critically, with a solid grasp of medicine's predicament, a sense of their own values and the inner freedom to express them in their working life. As our health system struggles to adapt to the gathering crisis this will mean recalibrating the tone and content of the medical curriculum. It would be unhelpful for universities to pretend that healthcare is doing well, that we can expect 'business as usual' to continue. Instead, they should dedicate more time, care and attention to educate and prepare students for a complex but turbulent future. Openly acknowledging the problems of our current system is surely necessary if we are to redesign for better outcomes, and it would naturally lead to the restructuring of medical curricula. Yet most traditional medical education remains staunchly didactic: 'learn this because this is how it is and you need to know it because I'm telling you that's how it is (and I'll test you on it too!)'. Instead, while encompassing the biomedical essentials, medical education must come to be seen as a crafted invitation to draw out and encourage the creativity and innovation sitting latent in its students.

Tools for individuation

There is a case to be made for equipping students with some tools for individuation: developing an understanding of the self is a key concept in developmental psychology. It's a process that deserves protected time, especially when most students enter medical school in the sensitive years of late adolescence and their early 20s. But in a crowded curriculum, institutions are unlikely to make this a priority unless they realise its value and begin to care more for its students' inner life. Practices such as meditation, authentic reflective writing and creative enquiry, for example, could help students figure out just what kind of doctor they really want to be, and steer them towards sustainable ways of coping with the demands of professional life.

'Reflection' is a recognised essential component of medical education. Unfortunately, it is now widely derided as a tick-box task for the end-of-block sign-off. This kind of reflection is counterproductive to authentic introspection and personal development because it usually focuses on the biomedical aspects of a clinical case and not student experience. But time and motivation for ungraded authentic reflection, responsive to individual needs would make a simple, powerful and affordable contribution to students' development. It could be based on group learning journeys, group discussion, painting, music, written and spoken words or any form of creative inquiry, and it wouldn't even need to be facilitated or marked by a doctor. One way of doing this would be to assign students – just as they are assigned a clinical skills group – to an ongoing reflection group at the beginning of medical school. Members would be expected to meet regularly (fortnightly or monthly) and to bring experiences to reflect on together. If the faculty needed assurance, they could ask senior students at times to monitor and facilitate groups. This would create bonds between the year groups making the student body as a whole more cohesive and facilitate the sharing of accrued and evolving student wisdom. In the process of maturing as people and professionals we cannot avoid intense encounters and difficult experiences. Given the right tools and a culture where genuine reflection and expression were the norm, rather than gloss them over in the heat of a busy semester, they would become opportunities for growth and learning.

Conclusion

Medical schools have a responsibility to think about how they facilitate or might unwittingly be constraining students' personal development. This will mean reviewing and evolving their existing institutional values. After reflecting on the missing curriculum, we suggest one significant contribution would be ungraded, free-form learning sessions covering a range of topics that embolden students to work creatively and critically. Though this would not suddenly transform medical culture, the style of learning we envisage – by stimulating reflection, creativity, personal growth, innovation and progressive thinking – could help revitalise medical education. In the long term, it is impossible to know what effect that may have on the life of a student and the world they engage with, but we believe it would encourage self-care, reduce burnout and ultimately lead to the emergence of a more sustainable, effective and humane health system in the future.

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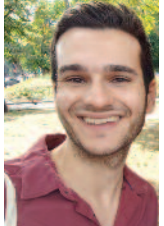
Medical education should be helping us develop as whole people



Jonathan De Oliveira
Final year graduate medical student, St George's, University of London

I am co-president of my university's psychiatry society. I have a keen interest in holistic approaches to improving mental health and looking after the mental health of students. The inspiration for this essay came both from my own challenging experiences on placement, and from hearing other students telling countless similar stories. I believe a lot more can be done to support students' wellbeing, and I hope my essay helps to fuel fresh thinking about this important issue.

Summary

This year's BHMA student prize invited health-care students to write about what is missing from their education. There were 50 wonderful essays and creative submissions. The winner of the essay prize was Jonathan de Oliveira and the winner of the creative enquiry prize was Karla Maria Hamlet. These are published here with some runners up elsewhere in the journal. We thank everyone who submitted their work.

> *'There's no such thing as a doctor.'*
> Caroline Elton

This quote is intended to emphasise that nobody is ever just a 'doctor', or healthcare professional, in isolation. The meaning and quality of the experiences an individual derives from their role in healthcare are intimately inter-connected with, and inseparable from, the other elements of their life and psychology. The most pressing omission from clinical education, therefore, is its neglect of the holistic psychological aspects relevant to clinical work. General Medical Council (GMC) curriculum guidelines fail to include a substantial component aimed at nurturing students' psychological growth and resilience (GMC, 2022; GMC, 2018). As educationalist Ken Robinson emphasises, everyone exists in 'two worlds – the world within you… and the world around you', and 'the core purpose of education is to enable students to understand both worlds' (Robinson, 2022). However, the curriculum I have experienced centres almost entirely around how to play the external role of doctor: on key facts, clinical skills and reasoning. This essay will first illustrate why the relative neglect to address students' inner psychology is detrimental. Then, it will propose an original three-step framework, which could be incorporated into curriculum guidelines, to address the imbalance. The essay will focus primarily on my own field of medicine, but much is probably relevant to other healthcare professions.

There are three key reasons why a curriculum's failure to sufficiently address students' internal psychology is problematic.

First, it can result in a more inefficient learning experience. According to educational philosopher John Dewey, if educators do not consider students' internal worlds while teaching external facts, it makes 'the process of teaching and learning accidental' (Dewey, 1938). A healthcare student's inner psychology and mental state are left to chance if educational institutions fail to integrate adequate support and preparation into the curriculum. However, a student's mental state can profoundly affect their ability to learn effectively from placement experiences. For example, stress can impair memory retrieval, make it more difficult to update memories with new information, and promote rigid, habit-based forms of learning over learning how to be cognitively flexible and problem-solve (Voegel & Schwabe, 2016). Indeed, as a student I have at

times felt so psychologically underprepared for situations encountered on placement that the resulting feelings of discomfort and fear have made assimilating relevant new learning points unnecessarily challenging. These situations have included encounters with new forms of human vulnerability and objectification, medical failures, and patients' frustrations. As Elton illustrates, such encounters are not uncommon. Better psychological preparation and support would allow students to learn more through these experiences.

Second, the lack of a substantial psychological curriculum component represents a missed opportunity to promote better resilience and mental health among healthcare professionals, and thus improve patient outcomes. A 2018 survey of UK doctors found that 31.5% had high burnout scores, and 30.7% had low compassion satisfaction, meaning they were deriving minimal pleasure from helping patients (McKinley *et al*, 2020). Less capacity to show compassion is bad for patients. As one systematic review has demonstrated, less compassionate doctors make more medical errors, are less resilient and achieve worse patient satisfaction and patient outcomes, due to worse medication adherence, lower patient self-efficacy and a dampened placebo effect (Trzeciak & Mazzarelli, 2019). In my experience, more burned out and less compassionate doctors also make poorer role models. This is significant: encounters with role models are perceived by students as highly impactful and are crucial in promoting the development of students' compassion towards patients (Murinson *et al*, 2010; Pohontsch *et al*, 2018). Psychological training can reduce both burnout and compassion fatigue. Mindfulness training delivered to physicians has been shown to reduce stress and burnout and increase empathy (Krasner, 2009; Fortney *et al*, 2013; van Wietmarschen *et al*, 2018). Psychological training from an early stage could therefore greatly support healthcare workers' resilience.

Third, the lack of a substantial curriculum component focusing on students' psychological development means students are less likely to make effective, self-aware career decisions, potentially reducing their career sustainability. Occupational psychologist Caroline Elton writes of 'countless stories of mistaken career choices that doctors have recounted' to her. This led to a great deal of unnecessary suffering, as doctors continued working in specialties to which they were poorly suited, due to underexplored priorities and past experiences (Elton, 2019). I have encountered similar cases on placement, including one psychiatrist who had switched specialties after years of training in hospital medicine, having realised that the work-life balance would never suit him. As Elton stresses, more student discussion and reflection around specialty choice could enhance career decision-making and sustainability.

To combat the issues outlined above, this essay proposes a novel three-step framework – prepare, support, process (PSP) – to be incorporated into GMC curriculum guidelines. This would embed institutional support for students to enhance their self-awareness and harmoniously integrate their clinical experiences into their personal psychology and narratives.

Prepare

Initially, the curriculum should prepare students for the psychological challenges of healthcare work, particularly in earlier years. Three forms of preparation are recommended. First, students should receive regular expert sessions about the mental health risks of working in healthcare, and how to utilise healthy lifestyle habits such as sleep, exercise, meditation and journaling to nurture resilience (BSLM, 2022). Second, students should be prepared for experiencing situations in which they may feel uncomfortable or scared. This could involve regular discussion groups, each session centring around a different psychological challenge. Elton's book provides pertinent examples, including transference and counter-transference, clinicians' fears of inappropriate feelings or thoughts towards patients, and encounters with particularly distressing life events. The pre-warning and sense of solidarity offered by such a group would have significantly improved my sense of wellbeing and the efficiency of my learning on placement. Third, all students could be given regular careers workshops, where specialties' advantages and disadvantages are honestly discussed, and students reflect on how these might interact with their past experiences and personal narratives.

Support

The medical curriculum should also include an explicit emphasis on sessions which support students' psychological growth and wellbeing while on placement. These could include timetabled workshops where teaching and clinical staff sit with medical students, and a neutral facilitator, to discuss potential student difficulties and how all parties can encourage greater mutual awareness and support. Juniors and consultants could also be encouraged to discuss some of the personal challenges and joys they have experienced in medical school and more recently. The net effect of the above would be to foster a more compassionate, open and communicative culture in healthcare education, helping clinicians to be more positive role models and creating more psychologically protective spaces in which students can grow and develop. These are certainly the effects I feel whenever I experience an all-too-uncommon discussion with a clinician about vulnerabilities.

Process

Finally, the curriculum should nurture students' ability to productively process past challenging experiences, to improve resilience and maximise the extraction of learning points. This could include offering regular Balint group sessions for all students. I have never attended one, but a

fellow medical student emphasised to me the tremendous therapeutic value he derived from its unique format, where participants each bring a clinical situation which made them feel uncomfortable, and the group discusses it non-judgementally. Moreover, research suggests that Balint groups can improve students' empathy and intellectual interest (Monk *et al*, 2017). The curriculum could also include regular workshops where students learn and practice reflection with facilitators trained in reflective practice. Research indicates that reflective skills can be taught and improved with practice, and that through reflection 'students may become more self-aware, which could increase self-care and decrease stress', among other benefits (Uygur *et al*, 2019). During my studies, my direct exposure to teaching and meaningful feedback from staff trained in reflective practice has been minimal. Educational institutions must do more to nurture students' abilities to effectively process their experiences.

In conclusion, our clinical education is missing an emphasis on nurturing students' internal psychological resilience and growth, as they integrate their new roles in healthcare systems with the rest of their personality, preferences, and past experiences. This deficit makes the learning process less efficient, deprives doctors of psychological tools which could significantly boost their resilience and help prevent burnout, and results in less effective career decision-making. The net effect is a significant missed opportunity to curtail unnecessary suffering, and promote empathy, compassion and thriving, among healthcare professionals. This essay has proposed the incorporation of a simple three-step framework – prepare, support, process – into GMC curriculum guidelines, to address this deficit and create a more holistic educational experience for students, during which they learn not just about their external role, but also how to attend to their inner world and the relationship between the two. In the words of acclaimed spiritual teacher Eckhart Tolle, 'If you get the inside right, the outside will fall into place' (Tolle, 2001).

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Finding our voice

Karla Maria Hamlet

Second year nursing student, Canterbury Christ Church University

The opportunity to exercise care and compassion while providing a gentle hand in the process of healing, as well as in those vulnerable times of transition from this life to the next, propels me into my chosen career as a healthcare professional. The vocation of nursing is an honour to fulfil and the innate sense to help and empower others – a gift. Likewise, justice, inclusivity, self-development, creativity, research, and advocacy continue to ignite a zeal within me. As a student, I am preparing my way; creating fertile ground for new initiatives and competences to flourish. Dancing with challenges that bear gifts for self-expansion; honing personal qualities as a future nurse and future compassionate leader. All, to be of service to those in need.

Give me my voice

If I am without my voice, how do I
challenge fault and advocate for my patients?
If I am without my voice, how do I
flatten hierarchy and empower my colleagues?
If I am without my voice, how do I
debate solutions and extend praise?
If I am without my voice, how do I
speak with the family of a dying patient?
If I am without my voice, how do I
lead, and, how do I learn?
If I am without my voice, how do I
bring resolution to conflict?
If I am without my voice, how do I
raise my self-esteem and develop my competence?
If I am without my voice, how will you
know my limitations?
If I am without my voice now, tell me, how am I
to ever truly be effective in the future?

University may develop my intellect and deepen my empathy, but neither of these can have a significant impact on my aptitude if my voice remains silent and my assertiveness is still sleeping. The scope of my knowledge and the compassion of my heart yearn for a conduit to be expressed through. I am a whole being of mind, body and soul, and my voice is my power to create the change I wish to see in this world, and, in the world of healthcare. My voice, my assertiveness, will be the role model for the next generation of student nurses! My voice, my assertiveness, will enable other voices, and cut through the silence of fear and oppression. For the colleague and the supervisor who are too scared to bring forth their valid concerns, train my voice and it will help amplify theirs. I don't need a soap box to stand upon, I just need my voice box to be valued. So, train my assertiveness, exercise my vocal cords, and prepare me well for the professional life ahead.

My creative submission expresses my heartfelt passion for enabling the voices and the assertiveness of my fellow students and registered nurses alike. To support my advocacy, Ayhan and Seki Öz (2021) state that self-confidence, problem-solving and decision-making abilities, as well as academic and professional achievement, may all be positively impacted by assertiveness. It is my belief that with robust training in assertiveness through examples such as workshops, roleplay and virtual simulation, students may develop greater levels of self-awareness and self-esteem, enabling their ability to speak up with confidence and diplomacy.

Furthermore, to support my idea McCabe and Timmins (2002) highlight the importance for nurses to receive sufficient preparation throughout their under-graduate studies. Thus, teaching assertiveness skills is of utmost relevance to nurse educators. They further remark that certain nursing schools throughout the United Kingdom have assertiveness training within their curricula. However, assertiveness education does not follow a prescribed structure, nor have regular class times or protected hours. For myself as a first-year student nurse, having not experienced any type of training in assertiveness so far at university, understanding that assertiveness training nationwide is sporadic, and at best left to the discretion of the tutor, is disheartening and only exacerbates the issue of what is ultimately a sincere lack of advocacy on the part of academic faculties, towards all student nurses.

The importance of our student and future nurse voice is further highlighted by our commitments to the Nursing and Midwifery Council (NMC) Code (2018). Cl. 3.4 states: 'Act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care.' Cl. 9.3: 'Deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times.' Finally, cl. 20.8: 'Act as a role model of professional behaviour for students

and newly qualified nurses, midwives and nursing associates to aspire to.' Without well-developed verbal and assertive communication skills, how are these clauses to be truly fulfilled?

Through the medium of graphite pencils and oil pastels, I feel my creative submission (below) conveys my intended message well. My art expresses the need for greater focus of assertive development for nursing students. The headless grey figure representing the student nurse, female in gender to reflect myself, but inclusive of all genders as the womb brings forth life. She encapsulates lack of identity through her hidden head and face. Only when she has established her voice will her face appear, and her identity be complete. From her heart she grows, and her right hand becomes her intellect. Nonetheless, she lacks colour because she has not yet become whole in her development. She is naked to represent the transformational journey of self-progression and improvement, through the stripping away of old habits and rebuilding herself anew.

Similarly, the blended colours and faint pod like shapes within the surrounding oils represent the emergence of self, maturity, and success from the humble state of beginnings. The hue and flow of colours, representing the materialisation of possibilities once the nurse becomes assertive and develops her voice. The larynx stands larger and higher than the figure, heart, and brain, to indicate the significance of its development. The shades of yellow and orange encircle the larynx, to signify the organ as a torch of light (inspired by the torch of the statue of liberty and by Florence Nightingale, 'the lady with the lamp); a tool which may lead and guide others through its warmth, its light, its power, and brightness.

Creative inquiry student competition winner

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Effective learning can create time for a more complete medical education

Samuel Soete
Final year medical student, University of Edinburgh

I'm a lifelong learner wondering how we align ourselves with our ancestral past while leveraging the unique opportunities modernity presents us with. Tackling the root causes of disease is what matters to me. As a final year medical student I am acutely familiar with the nature of medical school curricula and thought it important to give a point of view on how they could be improved.

Summary

Imagine a medical school where students learned to use effective study tools from the very beginning, alongside practical guidance on how to make them part of their daily lives. The consequences would be profound: students would feel more confident about acquiring the knowledge they need in exams and on the wards; exam grades would probably improve, and greater engagement on placements would make them more inviting and less likely to be skipped. With better long-term retention of information, the junior doctor's flow of work could improve too. This article introduces learning science and its many benefits.

Introduction

Getting into and then surviving medical school demands over half a decade of studying. Medics are notorious for the amount of time they spend in the library, but this unrivalled dedication to studying is often a compensation for ineffective learning techniques. However, sooner or later these bad study habits have negative consequences for the student, not just in their grades, but for their quality of life and personal development as well.

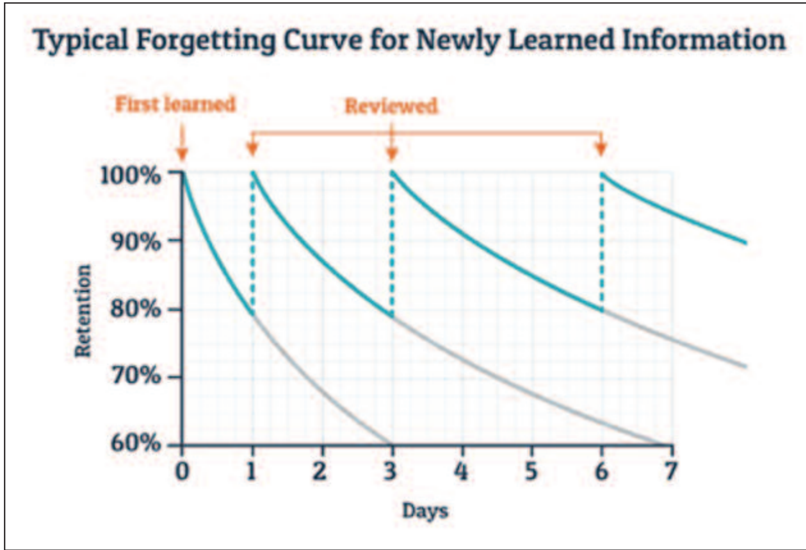
Rather than discussing 'what' is missing from the curriculum, this article focuses on 'how' to learn the most relevant content in a sustainable and effective way. Although it may seem banal in the shadow of the more obvious challenges in health and medicine, the benefits of effective learning are far-reaching: giving students the tools early on in their studies can have a ripple effect on all aspects of their lives while at university, and ultimately, having these skills will enhance their ability to take care of patients and sustain a career in medicine.

The basics of 'learning science'

Much of a medical student's remit, especially in the early years, is rote memorisation of biomedical facts. Therefore it is crucial to introduce the concept of learning science – a field that engages with the underlying psychological and mechanical aspects of learning. Here, certain fundamental principles yielded from learning science are worth mentioning.

The forgetting curve

A central discovery of learning science is that humans forget information at a repeatable rate. The 'forgetting curve' model (page 12) depicts an exponential decay pattern observed in the process of remembering, forgetting and relearning.



Source: www.educationcorner.com/the-forgetting-curve.html

Spaced repetition

'Spaced repetition' leverages the forgetting curve by implementing review sessions of learning material at specific times – just as it is about to be forgotten. Over time, as content is established in our long-term memory, reviews are scheduled at increasing intervals so that the time between repetitions gradually becomes longer.

'Active recall'

'Active recall' involves retrieval of information from one's memory in response to a stimulus. Although this is a relatively uncomfortable technique compared with passive learning ike such as reading or listening, the increased effort involved in retrieving information leads to improved retention.

Learning science and medical education

Though decades have passed since their discovery, and despite their obvious relevance to medicine, there has been minimal crossover between the field of learning science and medical education. Learning science has not been integrated into the curriculum, where in general students get minimal guidance or training to 'learn how to learn'. Having observed six years of medical school, I can say with some certainty that ineffective study techniques are widespread and consequently so are the problems they invite.

Before I understood the learning science concepts I would spend endless hours transcribing lecture slides. By the end of the semester, I could present a beautifully curated, colour-coded series of notes. But without my notes in front of me, their information was impossible to recall. In the exam hall where it really counted I was lost without the mental crutch that had always been there at my desk or in the library.

I made the wrong assumption that 'hours spent studying' equated with 'things learned'. Transcribing is a passive activity. In the run up to exams, with gritty determination, coffee and camaraderie, we can do it from morning 'til night. However, though we can easily measure (hours) this metric doesn't correlate at all well with the desired outcome (retrievable memory of medical information).

Anki – a flashcard tools for efficient learning

Only by regular testing of recall with questions can we more accurately measure learning. Anki is an open-source flashcard programme that combines the two key principles of learning science; spaced repetition and active recall. It allows for infinite customisation to tailor settings to one's learning style, however most of the time its benefit can be felt in full just by using the app's most basic functions.

The flashcard employs a scheduling algorithm to sidestep any individual bias towards studying information already well-lodged in memory. This process also exposes any gaps in knowledge point blank, so time isn't wasted re-reading things already known. Then, what needs remembering is identified and will be presented again until it is learnt. The key to using spaced repetition l earning successfully is daily completion of flashcards, even several months away from the exams.

Tools like Anki are slowly permeating into communities of medical students. But Anki can be confusing and misuse can lead to bad habits (such as creating poor quality cards, or failing to complete scheduled reviews), or frustration and recourse to weak study strategies such as re-reading or highlighting. Without expert guidance or careful research, students may meet costly pitfalls on their journey to sustainable effective learning.

Building habits to facilitate flourishing in medical school

As students move from high school or college to university, their environment changes. Without a teacher or parent to tell them what to do and when to do it, students who don't know how to build healthy habits and personal accountability are thrown into the deep end where their ability to tread academic water will ultimately depend on their capacity for learning alone.

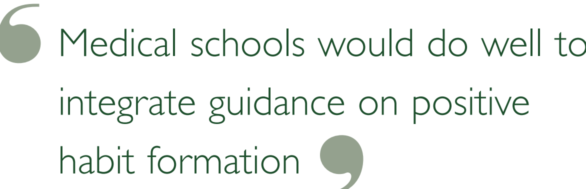
In my experience, habits do not restrict freedom, they create it. A routine of active recall studying empowers can enable us to make steady daily progress. Rather than getting sucked into a toxic culture of cramming in the run up to the anxiety and stress-producing nightmare of exams, I was able to approach them as an opportunity to exhibit the knowledge I accrued over the semester. That

shift allowed me to look up from my books and engage with life fully, grow in my love for reading, take up strength training and hill walking, and still find time for nurturing my friendships.

Medical schools would do well to integrate guidance on positive habit formation for a sustainable study routine, and for equipping students with tools for effective learning and helping fellow students discover the same freedom.

The wider implications of effective learning

Imagine a medical school where students learned to use effective study tools from the very beginning, alongside practical guidance on how to make them part of their daily lives. The consequences would be profound: students would feel more confident about acquiring the knowledge they need in exams and on the wards; exam grades would probably improve, and greater engagement on placements would make them more inviting and less likely to be skipped. With better long-term retention of information, the junior doctor's flow of work could improve too. But, more importantly, it would also free up time and mental capacity for hard-pressed stressed medics to 'stop and smell the roses'. I think we can foresee what this radical shift in the mindset might lead to. Medical schools' primary goal would no longer revolve around remembering an ever-growing mountain of facts and figures, and there would be time and space for medical students to nurture other aspects of their humanity – parts of their lives blurred out in their unrelenting soulless exam-chasing hamster-wheel rat race through high school and medical school.



Having mastered the study of medical science, attention would be available for the art of medicine. Engaging more fully with the world the medical student, now eligible to become a whole person, would discover uniquely what it meant for them to be a good doctor. Free from the anxiety, stress and crippling low self-esteem engendered by tackling a mammoth learning chore with inadequate tools, they would have time for hobbies and curiosity, reading, exercise, making social bonds and to be active in the community.

Unclarity about medicine's timeless values, an absence of personal meaning and the dearth of genuine fulfilment and joy of work is setting up medical students for burnout 10 years down the line. Record numbers of NHS workers are quitting the healthcare sector. By providing the tools to learn the nuts and bolts of medicine more efficiently, medical schools could unlock time for humanising medical education. This would shake the dogged traditional culture of medical education out of its preoccupation with accumulating hard facts. It would prepare medical schools to support students' journeys to becoming doctors attuned to the rapidly changing health needs of contemporary society. As Mahatma Gandhi said, 'There is more to life than increasing its speed.'

Conclusion

How can we create more space for students to flourish? If medical schools want to produce better doctors, they have a responsibility to streamline the examinable curriculum. As students embark on one of the most demanding of all degrees, medical schools should provide them with learning tools in line with modern learning science. Now, more than ever before, in preparing for four decades of life in medicine, students and doctors will need to be resilient and fulfilled, creative and compassionate. To make the learning of biomedical essentials as efficient as possible we may have to ask not only what is 'missing', but also look into what could be cut away. 'Perfection is achieved, not when there is nothing more to add, but when there is nothing left to take away.'

Special thanks to Calum McCutcheon for his help with this article.

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View from the frontline

Maryam Malik

Second year medical student, UCL

I enjoy exploring different ways to be creative to allow ourselves to express the emotions and feelings that we often hide. To make way for academia, I found myself practicing art very rarely despite it being a stress-relieving mechanism. I believe that being a doctor should not take over our passions and goals and that the medical curriculum should make time for us to dive into interests beyond science so we can provide care with the best mindset.

Deciduous trees shed their leaves in order to survive the harsh winter coming their way. Their branches are bare leaving them exposed to every gust of wind, and their roots are trapped beneath the frozen ground.

I am doing the bare minimum to survive in medical school. And that is enough. I see other students battling these intense workloads with resilience. But me? I want to flourish. I want to be able to go further and take on extra opportunities, without losing myself in the process.

You would expect such a large tree to have a very extensive root network, but mine does not. I find that I have not spent time on exploring my own roots and values – what makes me? In our medical school curriculum, there is nothing about learning who we are and how we deal with things that affect us emotionally. We have no deep roots to keep us in place, only lectures and seminars.

It takes time before trees gradually grow their leaves again and are ready for the next stage of their life. I need to be able to find my own values and strengths to hold me firm throughout medical school before I venture into the hospitals to care for patients without knowing how to care for myself.

Student stress: what one university is doing to support student wellness

Bruce Cryer
Executive Director, Integrative Health Institute at Salem University

Summary

Student stress theory (Barnhart, 2019) posits that stress in a learner's life will directly affect their health decisions and health behaviors, and alter health perspectives in relation to academic performance. Current literature points to the negative impact of stressors on adult learners and their health and multi-dimensional wellness behaviors, as well as overall academic performance. This stress has been amplified by the impacts of the Covid-19 pandemic and its social consequences on learning, as well as on healthcare access and equity (Barnhart, 2019; Pascoe *et al*, 2019; Schwartz *et al*, 2021).

Covid-19 drastically increased individuals' levels of stress, and has affected multi-dimensional aspects of wellness and mental health. Lockdowns, stay-at-home orders, and remote learning shifts, for example, had negative effects on learner achievement and learner health behaviors (Son *et al*, 2020). Yet not all students were equally affected: black, Latino and Asian students, for example, reported higher rates of worry about continuing their education compared with white students, (Copeland, *et al*, 2021). Copeland also notes that in institutions with fewer Covid-19 related health impacts, students' self-reported wellness (including mental wellness) and academic performance were less badly affected.

In view of these research findings academic institutions should prepare for any long-term consequences of Covid-19 and for the impacts of future epidemics on learner's abilities, wellness, and academic performance. Salem University, founded in 1888 in Salem, West Virginia, is making efforts to lead such mitigation efforts and to provide guidelines and a framework for educators, institutions, and organizations promoting student outcomes and positive wellness behaviors. The university's healthy & safety committee is taking account of emerging research and recommendations from the Centers for Disease Control and Prevention, local health departments, and the National Collegiate Athletic Association. Policies for students, faculty/staff, and community are being monitored and revised as needed.

Salem focuses on four distinct areas to improve learners' multi-dimensional wellness.

Student engagement

Salem University Student Life (a department at Salem University that is committed to transformational, student-centered learning and development that enhances students' relationships and experiences during college and beyond) uses a multi-dimensional wellness wheel to plan student activities for all students. The student life department engages students in events that include:

- **Emotional wellness** – stress and anxiety workshops
- **Physical wellness** – intramural basketball, kickball, dodgeball, bowling, roller-skating and homerun derby

- **Environmental wellness** – recylemania, camping, and hiking trips
- **Social wellness** – movie nights, athletic tailgates, educational roadtrips, video game tournaments, and games nights
- **Intellectual and educational wellness** – workshops, history alive speakers, and student organization fair
- **Spiritual wellness** – student religious organization meetings, mindfulness, meditation, and other related events, many sponsored by the Integrative Health Institute at Salem University
- **Occupational wellness** – resumé/cover letter writing workshops, mock interviews, internship opportunities, and job fairs

Mental health

Salem University Student Life sponsors a program through Empathia called Life Matters. Students and their families have access to mental health counseling that deals with:

- stress and depression
- balancing school and personal needs
- family and relationship concerns
- alcohol and drug dependency
- conflicts at school or work.

Beyond just mental health concerns, Life Matters offers financial and legal consultation as well. Life Matters is available free to all students (including domestic, international, and online students) as well as their family members, 24/7, 365 days per year.

Food service

Salem University Student Life sponsors Aladdin Campus Dining (the Salem University food service partner) has developed a BeWell program that started in response to Covid-19 at Salem University. The program emphasizes a philosophy of 'Stay fit. Stay focused. Choose well.'The BeWell eating approach combines the latest in nutrition science and culinary trends to create attractive, nutritious menu choices. BeWell promotions, wellness education programs, and partnerships encourage students to choose the best options for a balanced and healthy diet for life.

Integrative Health Institute (IHI) @ Salem University

Salem University's Integrative Health Institute (IHI) was established to provide a range of graduate programs, graduate certificates, health coaching and lifelong learning programs based around integrative and holistic health principles and practices. As part of integrating these innovative studies for the Salem community, selected IHI programs are offered free to all Salem students, faculty and staff via online training. Since the campus student body is primarily student athletes, programs are offered specifically to benefit the needs of student athletes around mental health, test anxiety, sports and academic performance, and overall well-being.

Salem University is aware of the research that indicates how stress in academics affects wellness in learners. Consequently Salem has initiated programs, resources, and processes to address student wellness issues and encourage healthy, positive wellness behaviors among learners, community members and educators.

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Scratching the surface of the hidden curriculum: the BMJ Student podcast Sharp Scratch

Anna Harvey Bluemel

Doctor and junior academic

I am a foundation year 2 doctor in the north of England, a former BMJ editorial scholar and current member of the Sharp Scratch panel team. My clinical interests are in obstetrics and gynaecology and I hope to start my specialty training in the field in 2023.

Charlotte Rose

BMJ editorial scholar

As BMJ editorial scholar I look after all of the content that BMJ Student will produce this academic year. As part of this, I host the student podcast Sharp Scratch. I have also just finished my fifth year of medical school at the University of Oxford. I will return in July to complete my final year. I have a keen interest in medical journalism and medical student wellbeing.

With: Nikki Nabavi, Laura Nunez-Mulder, Pat Lok, Chidera Ota, Declan Murphy, Olukayode Oki, Andrew MacFarlane, Isobel Walker, Lily Copping, Anisha Banerjee, Natasha Binnie, Ryhan Hussain, Maz Sadler, Stanimir I Stoilov, Sarah Inéwari Fabyan, Judith Ugwuja, Patrick Flanagan, Ramneet Gill

However you conceptualise the unspoken assumptions and expectations that shape the medical community – its 'etiquette' its 'culture', we know that a huge – often unconscious – part of medical education functions as a 'hidden curriculum'. Somehow, the hidden curriculum tells us how to adapt and fit into professional culture, shaping our professional identity (Hafferty, 1998; Lempp & Seale, 2004). But how are students to understand these undercurrents? If we could talk about them and assess them critically, might we be more free to develop our own authentic professional identities? And, importantly, do we really need all these 'unwritten rules' in medicine? Brought into the open, debated, unpacked and discussed, might any that are toxic or outdated be dispensed with?

Why Sharp Scratch?

Sharp Scratch is a student-led podcast that explores 'all the things you need to be a good doctor, but that might not be covered at medical school'. It is aimed at medical students and new doctors and is named for the common phrase, 'you'll just feel a sharp scratch': a phrase medical students and junior doctors are often taught to use to 'warn' patients that an upcoming blood draw or other minor procedure is going to hurt.

Medical students and junior doctors inevitably encounter unfamiliar and often very challenging situations, human encounters that peers outside of medicine don't come across and might not fully understand. Yet in medical school there are often few opportunities to discuss these experiences. Sharp Scratch episodes offer students the space to think about these encounters. Some episodes, for instance, address potentially awkward situations such as how best to raise concerns about a colleague, or the way doctors use gallows humour. Episodes with a palliative care doctor have discussed coping with death and, in an episode with an obstetrician, the panel discussed the experience of witnessing births. In one episode that tackled the 'hidden curriculum' head-on, we set up a conversation with an expert guest who was able to give us an academic perspective on our personal experiences. In other episodes – for example ones about racism and queerness in medicine – we have discussed how medicine's structures and culture will need to change to better serve an increasingly diverse community of students and junior doctors.

Having started as four medical students and new doctors, the Sharp Scratch team has expanded to 19 panel members, who represent a wide range of medical student identities. The panel is led by a medical student-appointed

BMJ editorial scholar, who works full time for the BMJ in a year out of medical school. Editors and producers from the BMJ run the technical aspects of the show, providing support with brainstorming topic areas and promoting the podcasts after they are released.

Our aim with Sharp Scratch is for listeners to feel like they are sitting at a table with peers and with near-peers, sharing experiences and learning from people 'in the same boat' and others slightly further on. A key part of developing a professional identity involves slowly moving from the edges of the medical community of practice into the centre (Cruess & Cruess, 2020). Sharp Scratch aims to give all medical students and new doctors insight into some of the seldom discussed (or often unnoticed and unspoken) steps we take on this journey. We hope especially that the podcast is of value to those who may be under-represented in medicine, especially those from widening participation/widening access backgrounds. While we have a UK focus, we try to choose themes and topics relevant to medical students and new doctors worldwide.

A podcast, rather than a series of academic articles, gives contributors space to bounce ideas off one another and be naturally reflective about their experiences. This allows for panellists to shape and sometimes change their views throughout the course of an episode, unconstrained by word counts and references. Through podcasting, listeners are able to develop para-social relationships with panel members as they relate to them and their experiences. We believe this can give listeners permission to reflect on their own, similar though unique, personal experiences and perhaps encourage them to also share (Giles, 2002).

Episodes

Each fortnight, the editorial scholar selects an episode topic informed by their own experiences and areas of interest, and through brainstorming sessions with panel members. The editorial scholar then acts as host, setting out loose discussion points, directing the conversation and sharing their own experiences. Our invited guest – usually a topic expert or educationalist – isn't expected to provide the answers or overshadow student experiences. At their best they share their own insights into the topic and signpost evidence or useful resources that will help students reflect. In our most effective episodes the guests and panel end up learning from one another and as the formal barriers break down we can access the tacit knowledge and assumptions that make up the hidden curriculum.

Some episodes have focused on elusive or emotional aspects of being a medical student and becoming a doctor. In a summer 2022 episode we discussed compassion and why medical schools, despite being staffed by compassionate individuals, sometimes feel as though they lack compassion (Compassionate medical schools, Sharp Scratch on Apple Podcasts). Using such delicate topics as a springboard, we took a dive into deeper themes: do we feel we belong at our medical schools, and how has our medical school experience been shaped by the support we have (or have not) received along the way? Our expert guest, a faculty member at a medical school, helped us unpack all this, offering us a fresh perspective that helped us contextualise our experiences as students. In a 2020 episode our expert guest psychiatrist discussed shame with us. We touched on the way it is used as a teaching tool in medicine, sharing times when we have felt shame and even talking about the ways healthcare professionals sometimes project shame in their interactions with patients (*Fighting shame by talking about it, Sharp Scratch on Apple Podcasts*). Having viewed shame through the lens of our own experiences, we came away with practical strategies for minimising shame and stigma in our own patient interactions.

Reception

Initially promoted in the UK, the podcast is now increasingly accessed around the world, with regular listeners from as far afield as Australia, Saudi Arabia and Bangladesh. Listener numbers on each episode have range between 2,000 and 5,000 listens per episode. Comments from listeners highlight how much they enjoy the informal nature of the podcast, as well as the 'great guests with open and candid discussions'. Listeners also appreciate hearing from near-peers who are slightly ahead of them for insider knowledge on how to approach certain topics, such as night shifts: one listener said the episode addressed a bunch of the common anxieties about them [night shifts] in a relaxed and candid way, including with a junior doctor who had just done one! The impact the podcast can have on the wellbeing of those who listen, as well as those who are involved, is also clear, with listeners commenting, '[it's] good to hear fears we have as medical students openly discussed' and 'I love that someone speaks what is on all of our minds'.

The podcast was presented at the Health Education England Learner Wellbeing Conference 2020 to raise awareness among educators, who might then recommend the podcast to their students. This talk had an excellent reception from educationalists and has been added to the recommended resource lists at several UK universities.

Being part of Sharp Scratch

What makes Sharp Scratch so special is our panel of medical students and junior doctors. Those on the panel have valued the opportunity to participate in an innovative project that allows them to explore forming professional identities and values in a non-judgemental platform. For graduate entry medic Stanimir Stoilov, who studies at the University of Warwick, this carried through to his experience as a panel member having previously been a listener:

'As I was preparing to apply for medical school, I came across Sharp Scratch and so many of my anxieties were eased as I listened to a great bunch of current medical students, junior doctors and expert guests talk about their experiences navigating a medical degree and offering advice to those (like me) who were about to embark on this journey. What really amazed me was the diversity of experience and insight the Sharp Scratch panellists offered giving each episode a distinct flavour…I have since joined a small but mighty community of enthusiastic medical students with a vast range of interests and experience from whom there is always something to learn.'

Another key element of being part of the Sharp Scratch team is meeting medics studying across the UK, and internationally, and being exposed to a diversity of views. Judith Ugwuja, panel member and fourth year medical student at the Medical University of Silesia, said: 'Meeting medics from all over the country with different backgrounds, interests and experiences was extremely inspiring and there hasn't been a single meeting where I've left without learning something new about medicine and feeling excited about the journey ahead', sentiments echoed by University of Buckingham fourth year Sarah Fabyan, who reflected on her own experiences of listening to the podcast before joining the team: 'As a listener it was interesting hearing from diverse students from around the country at differing stages of their medical career and seeing what themes were common and what varied.'

The panel also have fun, as summarised by London foundation year 1 Lily Copping. 'I joined Sharp Scratch with absolutely no idea what I was doing but equipped with enthusiasm and the sheer desperate desire to expand my world during lockdown. I never could have predicted how much fun I would have and how much I would learn, however saccharine that sounds. This podcast has given me the opportunity to meet truly incredible people (both guests and fellow panellists), engage in unique conversations, and dip my toe in the strange world of broadcasting and media. I'll be forever thankful to have joined this team.'

What's next for Sharp Scratch?

In the 2022/23 academic year, Sharp Scratch aims to focus on the fact that there is not one 'type' of medical student. We are keen to stress that every medical student is different and brings their own experiences into university and the workplace. Future episodes on what it's like to be a medical student with a phobia, or how your regional accent might change when you leave for university, speaks to these issues as we discuss topics with doctors, sociologists, psychologists, linguists, and more!

It's a challenging time to be a medical student or a new doctor. The pandemic, the changing political scene, the possibility of industrial action – these are just some of the things our panel, and our audience, may be thinking about. We want to continue to amplify all the great bits about being a doctor, while also providing space for students to air their fears and worries about the changing climate of the NHS, and of the world. Sharp Scratch aims to cover these topics in an accessible and engaging way, potentially allowing students to think in a different way about the biggest issues affecting their studies and their lives.

With the arrival of a new editorial scholar each summer, there comes a new perspective and a whole new set of ideas, allowing the podcast to grow and develop in new and interesting ways. The continued aim of Sharp Scratch is to keep tackling current events in a timely manner and provide a space for medical students to think more broadly about key issues that aren't often discussed. We want to encourage medical students to think about their own personal and professional identities, and the overlap or conflicts that might occur there. Sharp Scratch intends to be the universal 'year above' to uncover some of the hidden knowledge that makes medicine so unique as a profession, but that can also be difficult to understand without explicit conversation. So, next time you hear yourself using the phrase 'sharp scratch' take a moment to reflect on the gap between what's said, and what happens in reality. This is the gap that our podcast aims to fill.

You can listen to Sharp Scratch wherever you get your podcasts, and remember to check out BMJ Student on social media:

Twitter: https://twitter.com/BMJStudent
Instagram: www.instagram.com/bmj_student/
Facebook: www.facebook.com/BMJStudent/

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Overprescribing: reimagining medical education with social prescribing champions

Hamaad Khan
First year medical student, Anglia Ruskin University

I studied neuroscience at King's College London for my undergraduate degree, went on to complete my MSc in global health and development at University College London and am now starting my medical degree as a graduate student. I am keenly interested in developing global health systems with a vision of health promotion and disease prevention. My research looks at international models of social prescribing implementation and I am interested in championing this learning to affect wider systemic change in the future health workforce. I work as Development Support for the Global Social Prescribing Alliance with the National Academy for Social Prescribing.

'*Remember, you are meeting your first patient*.' There was a sudden stillness – a silence pulled taut over our initial excitement of being in the dissecting room. All of us students now stood solemnly over the cadaver. Over the next few weeks, we would begin to see the body as matter and mechanism. We would pinch, pull and peel at various membranes to uncloak and uncover deeper anatomy; our clinical gaze focused more on limbs than life, unaware that in exploring bodies of the dead, we were bearing witness to stories of their life.

Medicine is not simply a matter of biology – a molecular tweaking, tampering and tinkering of the body machine. The way we fall ill or recover is as much about the environment, society and politics as it is about disease. Yet as a medical student I can tell you more about the pathogenesis of diseases, how dementia settles in or cancer grows out, than I can about how health can be promoted and protected. I know more about why a patient might see me as a doctor than I do about the ways I can help prevent their disease and ill-health from occurring in the first place. What we prize and value in biomedical principles within medical education, we lose in our acknowledgment of the wider environmental context and sociopolitical determinants that shape patients' health. The prevailing practice of medicine can then all too often become clinical, empirical and impersonal, too far removed from personal patient experiences. In exploring the overprescribing health crisis, this essay will argue that medical education must teach beyond the biomedical model of health. It must find a more holistic language that captures the reality of why we fall ill; only then can we hope to build a sustainable future for our health service. We know much of our health is made beyond the membrane of our biology. Health is promoted and destroyed in our houses, in communities, in our social lifestyles, in poverty and beyond. It's time to rethink the delivery of meaningful healthcare. It's time to create a cultural shift in the future health workforce. It's time for medical education to go beyond pills.

Doctors are overprescribing. Medical education needs to change

In 1949 the British National Formulary contained around 250 drugs. Today it lists more than 18,000 (Mir *et al*, 2021). The miraculous promise of modern medicine is that there seems to be a 'pill for every ill'. The peril is overprescribing these drugs and patients suffering from side effects. Over the past 20 years, there has been a four-fold increase in prescriptions for diabetes treatments, sevenfold increase for antihypertensives, and twenty-fold increase for statins (Hawe, 2009; NHS Digital, 2017). The National Overprescribing Review similarly reports that the number of medicines prescribed in England alone has doubled from 10 to 20 drugs per head in 10 years (DHSC, 2021). It's unsurprising therefore to find that around 10–20% of in-patient hospital admissions are now due to adverse drug reactions (DHSC, 2021). In other words, the very drugs that were designed to revive, restore, and renew good health are now causing ill-health due to their clinical overuse. The review further estimates that at least 10% of medications prescribed in primary care are

considered unnecessary, wasting £2 billion every year. At a time when the NHS is underfunded and overworked – with reports of a current shortage of 12,000 hospital doctors and nearly 10% vacancy across all jobs in the NHS (Health and Social Care Committee, 2022; NHS Digital, 2022) – overprescribing is creating more patients, more ill-health and increasing spending on drugs.

The problem, in part, is that medical students are taught to view health as a biomedical construct, where health is defined only by the functioning of bodily systems and their molecular makeup. The biomedical model of health initially arose from the conclusion that all illnesses are a result of cellular abnormalities (Porter, 1999), and therefore health is achieved through rectifying these aberrant cells. Though this is relevant for many disease-based illnesses, the model loses its explanatory power for most mental health illnesses, the well-evidenced impact of psychosocial factors on overall health and wellbeing (Wills *et al*, 1997) and new research on the relationship between mental and bodily states, such as psycho-neuro-immunology (Danese & Lewis, 2017). The World Health Organization recognised these limitations from the outset in 1948, and gave a more comprehensive definition of health as 'a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity' (WHO, 1948). In comparison, the biomedical model offers too narrow a conception of what health and illness is.

Consequently, the dominant use of the biomedical model in medical education creates a cultural tendency for future clinicians to reduce medical conditions – many of which are affected by complex biopsychosocial interactions – into simple diagnoses. The patient experience is minimised and isolated to biological symptoms, and the inevitable outcome is to favour biomedical interventions, that are not without their harms. If the problem is only seen as biomedical, then the solutions considered by clinicians will only be biomedical, leading to the over-prescribing of drugs.

In 1977, Engel challenged the biomedical model and introduced the biopsychosocial model of health and illness to capture the oft-ignored social, psychological and behavioural dimensions of illness (Engel, 1977). The benefit of this holistic model of health is that it creates a wider paradigm for evidence-based medical interventions to be considered, beyond 'plasters and pills'. If diseases can be accurately conceptualised by their underlying biopsychosocial context, then their remedies can take the form of non-pharmacological interventions, working at the root causes. It's reimagining what effective and meaningful healthcare delivery can be. As Gavin Francis aptly wrote 'drugs can be the least of healing, and the idea that therapies must be something that you swallow or inject – that they should be pills or syrups or infusions – is manifestly untrue' (Francis, 2022).

Therefore, what's currently missing in clinical education is the fundamental appreciation that though illness is a medical problem, it demands more than a medical solution. The former chief pharmaceutical officer, Dr Keith Ridge, acknowledged this when he suggested solutions to tackle the overprescribing crisis, and recommended social prescribing as 'a constructive alternative to drugs for many patients' (DHSC, 2021).

What social prescribing taught me about cures and remedies

Social prescribing involves a patient referral to local, non-clinical services designed to support social, emotional and practical needs. Referrals involve a link worker, who takes the time to co-design a social intervention with the patient, addressing their specific concerns. Globally, social prescribing has grown in its profile, prevalence and practice across the world and within different health system contexts (Morse *et al*, 2021). Despite differences in practice or terminology, the principle remains the same: addressing underlying social determinants of health to improve overall wellbeing. Effects of social interventions have been positively evidenced on improving mental health outcomes (Kimberlee, 2013) and reducing primary care and emergency service use (Polley *et al*, 2019; Bashir & Dayson, 2014).

Two years ago, as a neuroscience undergrad, I volunteered at a weekly social prescribing drama workshop for early-stage dementia patients. I saw dementia beyond its neurofibrillary tangles and amyloid plaques and found vibrancy in many who persisted through their disease.

There was David, a 77-year-old retired priest. Every week he showed up in brightly coloured and elaborately patterned tracksuits. At first I thought his eccentric dress sense was a mark of him being mentally aloof. I considered his clothes as an expression of a confused perspective, dislocated from co-ordination and order, turning almost kaleidoscopic – a fragmented mind refracting the order of light into a psychedelic vibrancy. However, his partner Rachel explained that his sartorial flair was always present, even before his diagnosis:'He simply became more vibrant and daring once he joined the workshops'.

I saw that despite his physical illness progressing, David and so many others found mental reprieve in these workshops. I saw how the benefits of traditional pills can

be too singular and individualised as diseases diffuse across relationships, affecting whole families. But social prescribing offered something that no pill can – connection, validation, acceptance; and more widely, reconciliation and communalisation with others. The patients, and their families, were better for it. And that is as great a remedy as any other.

Yet a study in 2019 found that 93% of UK medical students had not heard of social prescribing (Santoni *et al*, 2019). It is vital to fill this educational gap so that the future health workforce can move beyond overprescribing culture, and where necessary – and most beneficial – seek alternative, evidence-based therapies with lower risks to patient health and the health system overall.

Social prescribing champions: addressing gaps in medical education with the future health workforce

Current medical education informs future clinical practice. The National Social Prescribing Student Champions Scheme was set up by medical students in 2016 to raise awareness of social prescribing across universities and among all healthcare students to instil holistic clinical practice in the future health workers. Since 2016, more than 350 champions have engaged with more than 20,000 medical students, allied healthcare professionals, young doctors and trainees, spreading the word about social prescribing and helping to ensure that it is part of the curriculum at universities across the UK. These champions represent their local academic institutions to co-ordinate peer-to-peer teaching sessions and knowledge sharing with publications and presentations . The current cohort of 70 new social prescribing champions represent 20 out of 44 medical schools across the UK.

> *'To me, social prescribing is the renaissance of community. Its mental and physical health benefits are unmistakable, but the life it gives to a world-wide network of interlinked, local communities is a power that cannot be overestimated. As we step away from over-prescription and focus on personalised care, social prescribing is the tool we'll use to contend with the social determinants of health.'*
> David Phillipps, Speech and language therapist

> *'We need to shift away from asking questions related to our own specialities and ask about a patient's overall health. This makes social prescribing so important; it creates an environment in which patient's feel listened to and valued, and ultimately will motivate them to have a lead in the decisions related to their healthcare.'*
> Eden Nabiyou, MSc orthoptics

> *'Healthcare should focus on what we, as professionals, can do for patients rather than what we can do to them. The only way to ensure this is delivered is to include well-rounded health education focussing on the change from paternalistic medicine to models of shared decision making, acknowledging individual needs. This is what social prescribing does best.'*
> Tamzin Ogiliev, fourth year medical student

> *'If two-thirds of medicines-related hospital admissions are considered preventable, why do we still view pharmacological therapy as the best way to fix medical problems? Learning how to keep patients healthy should be just as important as learning how to treat them when they are ill. Social prescribing teaches us to find out what really matters to the patient, allowing us to support and empower them to take control of their own health.'*
> Aliya Siddiqui, third year medical student

Reorganising healthcare beyond pills: a hope for the future

Currently the medical profession is swollen with feelings of despair and dissatisfaction. Waiting lists are growing longer, and the will of doctors is growing shorter. The health service, dulled by the pressures of the pandemic, current workforce crisis and political design, is at a breaking point. At this time, the opportunity arises for us to reimagine a better, more sustainable health system. A system designed not just to respond to crises, but developed with a vision of health that is focused on prevention and recovery – a true National Health Service.

In truth, the overprescribing crisis is a crisis of education. Tackling overprescribing with better medical education presents the opportunity to reorganise healthcare; where the future health workforce is able to look beyond the pills and treat holistically. The paradox of modern medicine is that we are living in an age with more medicines, more therapies and yet also more illness.

Envisioning health in its complete biopsychosocial form will ensure that when anyone falls ill, their experience will not be reduced only to its biological symptoms. Their healing will be whole, and their care comprehensive, consistent, and compassionate.

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Re-imagining Medical Education - Survey

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Should medical schools be doing more to foster student wellbeing and flourishing?

How can course content better prepare us for the foreseeable health challenges?

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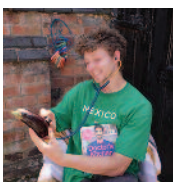
Medics in the community: developing the tools for effective social prescribing



Hugo Jobst
FInal year medical student, University of Glasgow

I am the founder of the Humanising Healthcare Forum and am working to involve the community more in medical education, especially those recovering from addiction and drug addiction. I have a special interest in the science of learning and see it as a key to unlocking time for more holistic medical education. Other than work, I am passionate about the Scottish Highlands, long adventures, riding bicycles, thinking and sharing ideas.

Andrea Williamson
Professor of general practice and inclusion health, Glasgow Undergraduate Medical School

I teach and train about the social determinants of health, inclusion health practice and trauma informed care. I lead on research about 'missingness' in healthcare and am involved in wider research to improve care for people experiencing severe disadvantage. I am a founding member of the steering group of GPs at the Deep End, deputy chair of the Health RCGP Inequalities Standing Group a member of the NIHR Health Services and Delivery Research Prioritisation Committee UK, a medical officer in Glasgow Alcohol and Drug Recovery Services and a GP in Glasgow.

Summary

The first time a patient tells a doctor (usually a GP) about their symptom is often long after the onset of the disease process. Most illnesses begin at home in the community so, if doctors are to tackle health problems in context and guide patients more effectively back to health, medical training will need to pay more attention to the psychological and socio-cultural determinants of health and illness. We describe two ways in which faculty and students at the University of Glasgow Medical School have sought to do this.

Experiential faculty teaching

Professor Andrea Williamson started small, first initiating a five-week block of learning for a small number of year two medical students. We focused on the social determinants of health and ways of tackling health inequalities – topics already covered to some extent in our curriculum – but aimed to move beyond academic learning. There were some traditional lectures by experts on related topics importantly, but we also involved 'experts by experience' – people at the sharp end of societal inequity. The project facilitated brief shadowing experiences in the NHS and voluntary sector. Among them were deep end GPs (www.gla.ac.uk/schools/healthwellbeing/research/general-practice/deepend/), the navigator programme in A&E departments (www.mav.scot/navigator/) and a food pantry(www.scottishpantrynetwork.org.uk/). Thirty students now do this module every year and it is frequently described as their standout experience at medical school. Importantly, it inspires many students to get more involved in equity-related activities and it influences their future careers.

The enduring connections we have made through this small module have also enabled us to extend elements of this teaching. We now have a slot that involves experts by experience of homelessness for the whole year group in the year 3 GP week. Experts by experience have also been

invited into into postgraduate training for GPs in the West of Scotland.

Humanising healthcare

Students at the University of Glasgow set up the humanising healthcare forum (HHF) in 2020. The group explores gaps in the curriculum which they believe may serve to perpetuate some of the problems facing the NHS. It was suggested that one such gap is the disconnect between medical school and the community. The HHF then set out to develop a health-tailored volunteering system for medical student involvement in the community, using a framework for 'service learning' (Stewart & Wubbena, 2014).

Over several months the HHF met with organisation leads in various parts of the city to discuss how medical students could get involved in a mutually beneficial way. Reflecting on this part of the process, Hugo Jobst says: 'I witnessed the so-called Glasgow effect (Cowley *et al*, 2016) in real time: cycling just 15 minutes from the wealthy west end of Glasgow to the impoverished western banks of the Clyde for a meeting with the charity DRC Generations. The shift in architecture, industry, health and atmosphere made me realise how sheltered and detached we are from the realities of daily life in a socio-economically deprived community in our opaque university hospital bubbles.'

The purpose of the project was to involve students in the community in non-clinical roles. We believe there are benefits to both students and community in this arrangement. First, students can make genuine human connections with people from the more socio-economically deprived areas of their city. Instead of looking up at future doctors from a hospital bed – naked save for a loosely tied gown and often experiencing uncertainty, fear and pain from disease – members of the community are now at eye level with future doctors. As the power dynamic shifts to equilibrium two humans can interact, learn from and help each other. If such interactions help us develop more natural fluent and authentic communication it ought to safeguard against the objective, structured, clinical examination-driven dehumanisation of 'communication training' and the recognised deterioration in patient perceptions of student communication skills (Graf *et al*, 2020). Also, students experience at first-hand the power of community effort: how people coming together can address a felt need and make a positive impact in their area.

This seems like an effective way to sensitise students to the 21st century's many social problems but also how people in their community are galvanised in response to them. Inevitably, students will think for themselves about social threats to health, and how they might contribute through their work. Lastly, connecting and working with people in the community can give students a greater sense of purpose and satisfaction during medical school: something to make the grind of learning medical facts feel more worthwhile. Student feedback from recent HHF educational sessions about addiction and recovery that involve the community seems to confirm this:

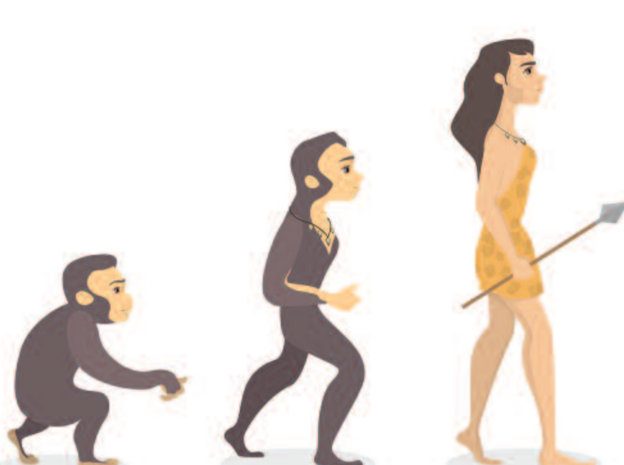
> *'Such a fantastic session – finally hearing things from the perspective of a person.'*

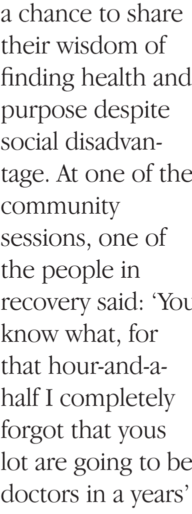
> *'Getting real answers from real people. Not a guess that doctors have made. Humanising patients, especially when some with so much stigma.'*

> *'Listening to experiences of people who recovered first-hand puts everything that we've seen on slides into perspective. It's hard to empathise with words on slides but listening to these wonderful people share their personal experiences speaks volumes.'*

The HHF worked with the North West Glasgow Recovery Communities and the Scottish Recovery Consortium to set up a 'medics night', where people in recovery from problem drug use can share their insights and stories with medical students. With drug deaths in Scotland now the highest per capita in Europe (www.gov.scot/publications/suspected-drug-deaths-scotland-july-september-2021), the need for connections that enable experiential learning and stimulate thinking about service improvement is indisputable.

During these sessions, we saw how the community can benefit too. At a very basic level, they have an extra pair of hands to help out with their events. They also have a chance to share their wisdom of finding health and purpose despite social disadvantage. At one of the community sessions, one of the people in recovery said: 'You know what, for that hour-and-a-half I completely forgot that yous lot are going to be doctors in a years'





time!' Surely a hopeful message about facilitating better doctor-patient relationship for the future.

These sessions have been recognised as an important model to learn from by the universities of Glasgow and Dundee. Glasgow is trialling them as an institutionally run event with its community oriented medical experience track (COMET) students (www.gla.ac.uk/schools/medicine/mus/communityorientatedmedicalexperience-trackcomet/), and Dundee has created space for them in the addictions psychiatry teaching curriculum this year. Unanimously positive feedback shows unequivocally that students enjoy and benefit from connecting with the community in this way.

The case for a spot in the standard curriculum

Two of the main challenges facing healthcare are an increasing burden of multimorbid chronic diseases and an ageing population whose biopsychosocial needs are not being met in modern society. The solutions to these problems may not simply be a matter of better pharmaceuticals, more technology and more doctors. Many communities, realising this, have organised to bring the responsibility for health into their own hands (Crisp, 2020). A philosophical shift in attitudes towards health and healing is taking place in these community organisations. If doctors of the future are to work with these organisations so their patients achieve better outcomes, their relationship with community health organisations should start developing while they are at medical school.

Andrea's student selected component takes 30 students a year, which is 10% of the total year group. The remaining 90% will not be so powerfully exposed to the social determinants of health nor be given the opportunity to work with the community. The HHFs initiative has been extra-curricular in Glasgow and uptake relative to the size of the medical school is still poor. We believe that opportunities to experience, understand and connect with the community should not be an optional added extra, but instead a mandatory core component of medical education.

Although the roots of social inequality are deep and tortuous, it is not right to ignore their part in disease processes and treat all symptoms (which may just be the tip of the iceberg) with medical therapies alone. Working from incomplete assumptions about health and disease has let medical prescribing spiral out of control into wasteful, often harmful and costly polypharmacy (www.nia.nih.gov/news/dangers-polypharmacy-and-case-deprescribing-older-adults).

Giving medics the tools for effective social prescribing (which is widely discussed as being an increasingly relevant aspect of healthcare) requires that they know what kind of social intervention would benefit their patients, that they have an idea of the organisations and resources available and know how to connect their patients with them. This could be achieved through a community-based social prescribing/health creation module that integrated medics into community organisations via 'service learning' along with expert-led group discussion about the socio-cultural determinants to health – effectively, an amalgamation of the two approaches described in this article embedded into the standard curriculum.

Conclusion

We expect that students would enjoy and benefit from a module in community health, with space for group reflection to harness experiences into practical learning that will become a part of their therapeutic tool kit. If taken seriously we may find our way out of the toxic culture of polypharmacy and get closer to addressing the social roots of diseases. Depression stemming from loneliness, social isolation or lack of purpose in later life may be approached by forming connections through community companionship programmes. Patients with heart disease and diabetes may be linked into community organisations that involve growing healthy foods, or spending time being physical active in nature with other people. Biological metrics and quality of life are bound to improve. If normalised, it make more sense to start funding community health organisations and health-creating city infrastructure with the same commitment and vigour as we do hospital-based healthcare.

Most doctors are aware of the insufficiency of pharmacology alone, yet there is a palpable feeling of despair that there is nothing they can do to modify the more complicated social and human factors contributing to disease. This is depressing and frustrating for medical professionals, and obviously unhelpful for patients who may get stuck on long-term medication whilst the roots of their symptoms are left untouched. But we argue that if medical education were to find its way out of the classroom and into the community more often, future doctors could be empowered with the tools, connections and insights into disease necessary to shift from the failing mechanistic paradigm of health to a truly holistic biopsychosocial approach with quality and humanity at its heart. Not all human woes would be set aright, but at least we would be barking up the right tree. Medicine may then begin to re-gain greater meaning for students and restore its relevance to the needs of contemporary society. Doctors want to help their patients, and students want to learn how. It's time we give them the right tools.

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So much goes missing when we work online

Andrew Zhou
University of Cambridge Medical School graduate 2022

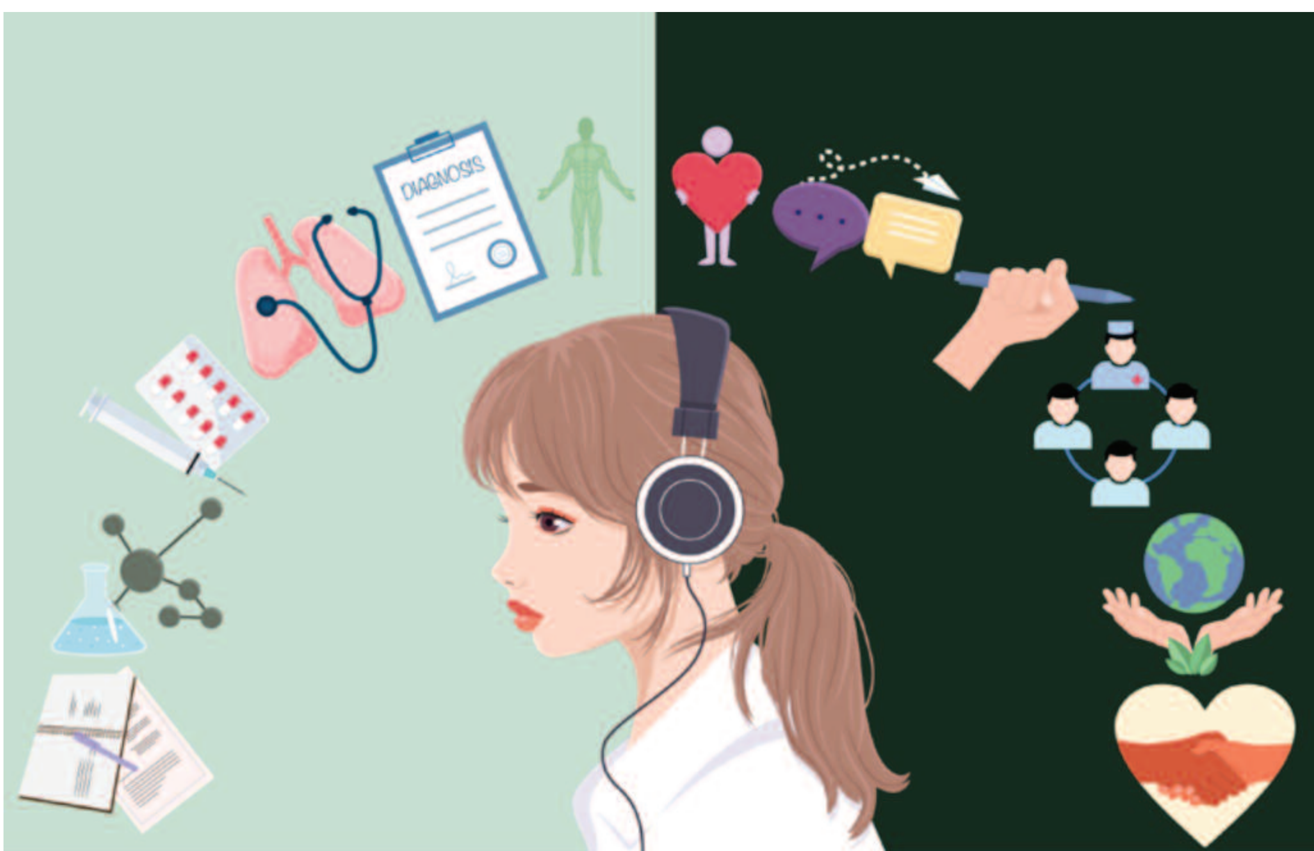
Holistic care is about treating the individual as a whole, incorporating aspects of the body, mind, and spirit. Over the past decade we have progressed toward a more holistic, patient-centred medical education. However this has regressed during the pandemic through depersonalising online teaching, which heavily focuses on diagnosing and treating the condition. The pandemic has put unprecedented pressures on medical students who have had to adapt their learning under difficult circumstances. Many have missed out on the opportunities to experience holistic care in their clinical education as Covid-19 disrupted clinical services. At the peak of the pandemic, medical students were able to develop clinical knowledge but missed out on fundamental communication skills and interactions with patients, and the opportunity to transfer their knowledge to actual patient care.

Throughout the pandemic, the constant streams of online, didactic lectures and assignments made many students focus on the outcome rather than the process itself. Online teaching lacks patient presence. Even if we interact with patients online, it can be awkward and unnatural, and connection issues can also be very disruptive. Undoubtedly, this can cause one to forget the true purpose of being a doctor and thus forget the critical aspects of what is required to become a good doctor. Needless to say, I fell into this negative spiral and failed to recognise the process for many months during the pandemic. My experiences during the pandemic made me fall out with medicine. I found it difficult to appreciate the human aspects and non-technical skills, (such as communication skills, kindness and situational awareness) through this pandemic didactic teaching, which I thoroughly enjoyed at the start of my clinical training before the pandemic started. However, the reintegration of in-person learning through shadowing my supervisor on my elective placement made me realise that medicine is about enjoying the process and rarely about the outcome, which applies to all aspects of care. In an ideal world, we would all like to have good outcomes. However, many factors are out of our control, and therefore all we can do is try our best through kindness and hard work. While technical skills are pertinent to a clinician, we must not neglect our mission and purpose as doctors which is to provide high quality care which includes not just treating the condition but taking a holistic approach to patient care.

Those who underwent clinical training during the pandemic missed out on crucial bedside training, which ultimately helps medical students provide a better picture of patient care by creating a better opportunity for patient engagement and building relationships. This was an ongoing problem even before the pandemic struck. However, the pandemic has highlighted how easy it is to return to our old habits, and this problem is continuously underappreciated in the current medical education system (Gupta *et al*, 2021; Forrest *et al*, 2006). I am pleased to see a positive change in the medical education system, moving to incorporate aspects of diversity, equality and inclusion (DEI), sustainability, and communication into the curriculum (www.medschools.ac.uk/news/medical-schools-come-together-to-support-inclusion-and-diversity-in-undergraduate-training). However, the current medical education system focuses very little on these overlooked aspects and is still under-addressed in the medical education programme. By creating the illustration on page 28, I hope to highlight essential aspects of holistic care that are often overlooked and raise further awareness of this problem in medical education systems.

This illustration depicts the disparity between what current medical education focuses on and what is missing from the current system, especially during the pandemic and even before the pandemic. Here I present a medical student studying in the hope of graduating one day. With reference to the illustration, I have highlighted the current focuses of medical school on the left and depicted through the lighter background. These aspects include research, biochemistry, diagnosis and treatment, physiology, and anatomy.

On the right, I have highlighted the neglected aspects, depicted using a darker background. These aspects include kindness, communication skills, work ethic, patient-centric care, sustainability (including career



sustainability for doctors), and DEI. Communication and patient-centric care are often neglected in current clinical practice (Tyler *et al*, 2022; NIHR, 2019; Engle *et al*, 2021). A recent large-scale UK cross-sectional study reported that only 50% of a patient cohort agreed that they were always treated with dignity or respect, 56% of participants felt they did not receive enough information and did not feel listened to, and 44% did not feel involved in the decision-making process regarding their care (Tyler *et al*, 2022). More importantly, only 18% got all the answers to the questions they had about their care. This study highlights how neglecting essential non-technical skills in medical education and forgetting the essential tenets of medicine can translate to future doctors failing their patients. This study further reported that these poor markers of patient care led to more unsafe behaviours from patients, such as self-medication without medical advice. Evidently, this could have been reduced or avoided if doctors showed more kindness and moved towards more patient-centric care and listening to their patients. Although all the neglected aspects are essential, I would like to end by sharing a phrase from a senior doctor which resonated with me. 'Kindness and hard work can take you a long way, and everything else will fall into place'. This phrase succinctly emphasises the key take-home message from this article, as employing the correct mindset will allow an individual to appreciate the other holistic aspects of medicine that are commonly overlooked such as DEI and career sustainability to avoid burnout, resulting in better patient care.

I hope that this illustration can raise awareness of this ongoing problem, and we can promote the other aspects of holistic care which are commonly forgotten.

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The missing link: human interconnection in online learning

Anamika Pereira Pai
Third year medical student, Barts and The London, QMUL

I am a student from Singapore living in London. I came here in the midst of the pandemic and have had all three years of my education impacted by lockdowns and the transition an online system of learning. The introduction of new technological methods in teaching and healthcare is something that I feel strongly about and I have endeavoured to communicate and explore those feelings in the form of art.

During the Covid-19 pandemic, the ways we interact with our environment and those around us changed: perhaps irrecoverably so. With the move to online education, some have argued that a certain human element has been lost. My picture Cognitive Disconnect aims to represent my own feelings about these uncomfortable transitions, and the sense of isolation and loneliness when learning only happens through the computer screen.

University has traditionally been a place to bond with like-minded people through connections with classmates and mentors. This crucial aspect of interconnectedness is amplified for medical students because, even in the early years of medical education, we also interact with members of healthcare teams and patients. By working closely in tandem with others we mirror the multidisciplinary aspect of clinical healthcare.

This is why the transition to online learning can be so jarring: intimate case-based small group discussions suddenly became impersonal zoom mosaics of onscreen icons dispassionately reading out their notes. A great deal of subtlety and collaboration is lost in these situations: intangible cues and expressions are missed, overall it feels not just disconnected but actively disconnecting. My art piece (below) depicts this isolation and loneliness. The central figure is sitting with other people seemingly in the middle of a lively discussion, but actually looking into the camera rather than interacting with their surroundings. Furthermore the other people at the table have hidden faces with no discernible features. These figures make gestures, as if interacting with one another, but cannot truly connect: perhaps online interactions by their very nature are disingenuous. The lighting is top down, isolating and separating the central figure from the rest, here again eliciting feelings of isolation. Ironically, the whole piece has been produced in the digital format on which its subject, online education, depends.

All these pictorial elements try to illustrate the tension and contrast between the inherently collaborative nature of medical education and the potentially robotic, stiff interface of novel technologies introduced into education during the pandemic. No doubt they will persist long after the pandemic is over. All the more important then for medical education to strive to preserve the subtle elements of human connection that make learning and working with others so special, especially when we can only do so through a zoom lens.

Compassion – walking the walk, who does the talk?

Louise Younie

Clinical reader in medical education, Barts and The London, QMUL

Ever since qualifying as a GP I have been seeking ways to develop understanding of ourselves and our practices as students and clinicians. Creative enquiry, that is reflective engagement with our lived experiences through the arts, has been central to this journey. I have discovered that the languages of the arts can invite voice and expression of that which is difficult to put into words. Such work can enrich exploration of the human dimension which is so central to compassionate practice. www.creativeenquiry.qmul.ac.uk @LouiseYounie

Summary

In this article I explore the depersonalisation in the medical student lived experience (hidden curriculum, ranking, biomedical distanced approach) followed by ways in which we might begin to explore compassionate practice authentically with our future doctors and healthcare professionals (leadership, voice, agency, humanity). I offer one example of an approach to learning about compassion from Barts and The London, QMUL and some student responses and quotes.

I stand with Wheatley (2017) in a metanarrative describing this age as a time of global, political and ecological instability. Her response is to call for local leadership, for humanity and compassion in her book *Who do we choose to be?* As future clinicians and leaders, if we can even be present and offer compassion to one patient, one junior, one colleague, we are making a difference and grounding hope and humanity where we find ourselves.

> *'I cannot emphasise enough how meaningful it was to me when caregivers revealed something about themselves that made a personal connection to my plight … The rule books, I'm sure, frown on such intimate engagement between caregiver and patient. But maybe it's time to rewrite them.'*
> Kenneth Schwartz (founder Schwartz Centre & Schwartz rounds)

Compassion comes from the Latin root *pati* which is 'to suffer' and the prefix com meaning 'with'. So, to be compassionate is to 'suffer with' the other. Schwartz's quote above describes the value of making a 'personal connection' in the face of suffering. Compassion has also been described as having 'a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it' (Gilbert and Choden, 2013).

Writing on compassionate leadership West (2021) quotes research identifying that compassion is highly desired by patients, leads to better healthcare outcomes and improves the wellbeing of healthcare professionals. In addition, self-compassion is linked to flourishing (Satici *et al*, 2013) and can enable better dealing with uncertainty (Poluch *et al*, 2022). In short, compassion is evidence based (Trzekiak and Mazzarelli, 2019). Yet in his book and TED talk Compassionomics (the science of compassion) Trzekiak, a US-based clinician, announces the crisis of compassion in society and in our healthcare systems today. In the UK this is illustrated, for example, in the Framingham or Ockenden reports where massive failures of compassion in our hospital systems were found.

For medical undergraduates, the General Medical Council in its Outcomes for Graduates document, calls for compassion towards both the patient and self-compassion for the clinician (GMC, 2018). If compassion brings so much benefit and the GMC calls for it, what might we do in clinical education to enable development of future compassionate practitioners? This question is perhaps harder to answer in practice than at first it might seem. It is generally agreed in the literature, for example, that medical student compassion declines through

student years at medical school (Hojat *et al*, 2009). Research has also found that teaching compassion can have a negative impact on student perception, especially where it is perceived to be 'shoved down our throats' (Wear and Zarconi, 2008)

Challenges of educating for compassion

While we can teach the benefits of compassion and what compassion might look like, there is a lack of consensus on the most effective ways of enabling the development of compassionate practice (Sinclair, Kondejewski, Jaggi, Dennett *et al* 2021). Compassion is a dynamic, individualised and complex construct (Sinclair, Kondejewski, Jaggi, Dennett *et al* 2021) and in medical education may be diminished, for example, through the biomedical distanced approach, the hidden curriculum and the ranking and pressures in the system.

Biomedical approach

Medical students learn to objectively apply scientific knowledge for diagnosis or treatment. As students learn the 'medical gaze' (Good and Good, 1993) there is a risk of a growing disconnect within the self of the clinician as well as between the doctor and the patient selves in the consultation (Sweeney, 2005). The literature describes medical students losing their voice (Shapiro, 2009) and becoming unseen (O'Hagan, 2017). Medical enculturation can lead to disregard of personal ways of knowing and down-grade meaning-making as the 'soft stuff' (Peters *et al*, 2018).

Hidden curriculum

Disconnection from our humanity is further compounded by clinician invulnerability and the felt need to be macho, to shoulder alone or not even recognise the vicarious trauma and moral distress of being a clinician (Murray *et al*, 2018). This may in some way contribute to the high rates of suicide, burnout and liver disease in our profession (Gerada, 2008). Giving or receiving compassion is challenging when we are burnt out or when we lose touch with our own humanity or that of others. It is a human response that requires the human touch.

Ranking and pressure in the system

The UK-wide ranking system which measures and ranks medical student achievement through medical school probably sees our students who are struggling the most sent to the far-flung places where they have the least support (Elton, 2018). Another recent development is the nationwide situational judgement test examination which moved from an exam at the student's medical school to require booking and travel unless you book early for a local venue. One student described how he needed to sit and frequently refresh the web page to book while on placement and how the GP tutor supported refreshing of the page when the student was occupied with frontline patient engagement. Despite the educator compassionately supporting the student, the system, it seems, might not.

At a recent educational session on flourishing and the barriers to flourishing with junior doctors, their responses to 'what stood out' at the end of the session included images of the NHS being like a sinking ship and valuing at least the space to share and recognise they were not alone. Perhaps, one suggested, this would help prevent them from drowning. Students are probably feeling a similar pressure and pessimism regarding the NHS.

Daniel Morris, third year medical student

Leadership, voice, agency, humanity

It has been argued that for compassion to flourish it needs to be embedded into the infrastructure, vision and leadership of an organisation (Sinclair, Kondejewski, Jaggi, Roze Des Ordons *et al*, 2021) so, for example in medical education enabling 'compassionate pedagogy' or 'assessment'.

Development of compassion in medical education may also depend on student lived experience on the wards such as positive role modelling in the clinics (Wear & Zarconi, 2008) as well as patient teaching and engagement in student learning (Thangarasu *et al*, 2021). A patient artist facilitating a group of my first-year students recently responded to the question 'what advice would you give us as future doctors', with 'engage with the patients lived experience, I am not a walking diagnosis'.

Enabling patient voice, agency and humanity is a choice and can also be mirrored by enabling the same for students.

> Development of compassion in medical education may also depend on student lived experience on the wards

Approaches that we are exploring in the field of compassion in medical education at Barts and The London, QMUL, take a holistic approach drawing upon Sir William Osler's head, hand and heart of practice (philosophia, philotechnia and philanthropia) (Osler, 1919). Students are invited to read the literature on compassion (head) and reflect on the practice of compassion – their own and what they have seen in wards and clinics (hand). They also have the option of engaging in creative enquiry reflective processes (exploring lived experience through the arts (Brown and Younie, 2022) to allow for the emotional, ineffable dimensions of patient care, colleague interactions or connection with self (heart). Students work in small groups to create a presentation to give to their GP tutors, followed by exploration and dialogue. This aligns with a social constructionist pedagogical approach where students are making sense of practice and theory learning together with and from each other.

Recent student-led research into this course found that GP tutors were learning from the students not only about compassion but also the student perspective. This enabled development of compassionate pedagogical approaches 'to help create a safer environment for students while on placement'. GPs also described the student presentation as a refresher and reminder for compassion. Student participants in the research described both the freedom and challenge of creative enquiry and group working processes, as well as the value of bridging theory and practice and remembering the patient as person with feelings.

> *'I saw him shivering, which motivated me to cover him up with a blanket as a means of alleviating the suffering. I felt an extreme sense of joy & satisfaction when I did this small act driven by compassion.'*
> Ebrahim Al Enezi (third year medical student, 2021)

Enabling voice allows airing of concepts such as compassion fatigue from the student perspective.

Some students begin to ask questions about practice, their own wellbeing and self-compassion alongside compassion for others.

> *'Why is it that the compassion we feel for our patient's suffering is rarely if ever directed at ourselves?.... Self-compassion could very well be one of the tools we can use to protect ourselves and those that we provide care for. Our hope is that through such discussion, we are able to slowly but surely help breakdown the stigma and prejudice associated with mental health. To provide better care for those in need, we must first take care of ourselves.'*
> Aalaa Ibrahim Siraj (third year medical student, 2022)

Courage, candour and creativity

Flattening hierarchy and inviting voice and agency in this field of educating for compassion may require courage, candour and creativity for student, educator and clinician alike.

Courage is needed to bring other voices to the table. Meeting suffering and remaining present may require engagement with our own fragility and mortality. Finding ways to show up, as a person and not just a white coat, often requires going against the flow.

Candour – keeping it real – and honesty is necessary in our journey towards compassion – for recognising at times we don't feel compassion for others (we can reflect on internal and external factors contributing to this (Fernando *et al*, 2016). Also being open enough to accept compassion in our times of need from others or ourselves.

Creativity and improvisation are needed to find time and space to build connection, to read and respond to the patient sat in front of us as well as time to connect and listen to ourselves.

Conclusion

I believe that in order to enable compassion we need to move beyond informative approaches to education, towards transformative, that is working at the level of attitudes and beliefs, creating space for emergence of insight and new ways of seeing. We may need to reflect on how as medical schools we walk the walk as well as who is given the talking stick to talk.

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Coda

I started with Kenneth Schwartz's quote regarding his cancer experience. I will end with my own. No pretty words were used at diagnosis. It was out there in the room after one sentence from me and a quick scan: 'possible high grade breast cancer' – all within about five minutes of entering. But throughout that dark season, my cancer surgeon repeatedly and continually evidenced that he saw me, took into account my being a clinician alongside being a patient. He used imagination, improvisation, story-telling and kindness for which I will always be grateful.

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✓ Do you work in healthcare and feel that it's important to keep your life in balance?

✓ Will you allow yourself more inner peace, focus and kindness?

✓ Would you like to be inspired by **experienced and renowned meditation teachers** who also work in healthcare as professional, researchers or management?

✓ Do you desire more quiet moments of mindfulness, reflection and contemplation?

✓ Would you lie to receive tips on how to rain and integrate focus and compassion into your daily life and activities?

https://ccmm.care/meditations

Exploring the human dimension in medicine

Sivakami Sibi
Third year medical student, Barts and The London, QMUL

As part of a student selected component (SSC), led by Dr Younie, I was able to explore the importance of the human dimension in medicine through conversations with my peers, tutors, and patients. I learned about the lived experiences of those around me while sharing my own in a safe and nurturing environment. This experience highlighted the power of sharing stories through creative expression to foster meaningful conversations and I hope to carry the lessons I have learned with me throughout my medical career.

Introduction

I have created the painting opposite that portrays the importance of compassion in forming deeper connections with those around us, whether it is within a clinical setting or the outside world. I hope that this painting sparks meaningful conversations about the need for empathy and kindness in medical practice and education and each viewer can relate to its metaphor on some level.

Creating meaningful artwork

I visualised the powerful imagery of hands reaching out to connect which could symbolise the power of togetherness and human connections. To develop the symbolism of my piece further, I thought about adding details to the hands. I felt that by removing the skin of the left hand, it could be interpreted from a clinical perspective as the physical body through the visual imagery of tendons and arteries or could be symbolic of what is beneath our skin and represent the part of us deep within. This painting can also be seen as representing different people reaching out towards each other to form deeper connections or could be seen as both hands representing one person who is trying to connect the two sides of themselves – both the physical and mental.

The rose also has connotations of love and kindness. Therefore, the meaning of the left hand reaching out for love becomes clearer while the flourishing hand tapping the rose is symbolic of spreading love and empathy. The background reinforces this message through the use of colour. As mentioned in one of our group discussions, people often see warmth and kindness in warmer tones such as red and orange, so I have used these colours to show the spread of warmth almost battling against the darker colours on the left, which signifies the healing nature of flourishing through human connection.

I personally, interpret my piece as about myself and how I am trying to think more deeply about how I can connect my physical self with deeper meaning and creativity. The hand on the left is symbolic of how beneath my skin and deep within myself, there is a need for the physical form to connect with the spiritual, nurturing part of the soul.

Deeper meaning-making

This painting can also be symbolic of the doctor–patient relationship. The physical hand represents a patient reaching out to the flourishing hand which represents doctors in a consultation and depicts how patients reach out for empathy and kindness to connect with their doctors. This alludes to the importance of holistic care in medicine as physicians often focus on the physical symptoms of a patient while paying less attention to their mental wellbeing. This idea is emphasised by the World Health Organization (WHO) which defines holistic health as 'viewing man in his totality within a wide ecological spectrum, and … emphasizing the view that ill health or disease is brought about by an imbalance, or disequilibrium, of man in his total ecological system and not only by the causative agent and pathogenic evolution' (Stuckey & Nobel, 2010). This is an important issue in healthcare as physicians are often unable to connect with their patients when solely focusing on the physical presentation of their symptoms. A review conducted by Stuckey and Nobel suggests that a way to eradicate the idea of health as 'the absence of illness' but rather consider it as an 'active investigation into the fundamentals of whole-person' is by exploring the relationship of art on health (Stuckey & Nobel, 2010).

Integrating creativity into medicine has the potential to benefit patients and healthcare professionals in many ways. Art can help patients express their experiences that are too hard to put into words, allow them to escape from difficult experiences through focusing on an engaging activity or even simply help them find self-worth and

identity. A systemic literature review of the arts' impact on medical education analysed the qualitative content of 49 selective articles and concluded that 'the arts have unique qualities that can help create novel ways to engage learners. These novel ways of engagement can foster learners' ability to discover and create new meanings… The process can be enhanced when learners participate in the context of a group, and the group itself can undergo transformative change' (Haidet *et al*, 2016). This suggests that instilling creativity into the medical environment can be beneficial for patients, doctors, and medical students in forming deeper connections and learning from one another.

'A painting that portrays the importance of compassion…'

Relating my painting to flourishing in medical education

The concept of flourishing is an important aspect of my painting as I believe it is an essential part of medical education and compassionate practice. The idea that natural imagery can be used as a symbol of flourishing has been suggested by many others. An article on flourishing states that 'metaphorically, flourishing connects us with images of trees, flowers, gardens and with these the space to explore loss, growth, interconnectedness, and context, mirroring somewhat the complexity of lived experience… A tree needs space to stretch-out their branches and capture sunlight and students need space for meaning making and dialogue in a way that supports the finding of their own voices and personal growth' (Younie, 2020). I connected with this metaphor in particular, as by having the opportunity to connect with students and speakers and challenge my creative mind, I have thought more deeply about how I can create an art piece that has personal significance to me but also suggests a wider message about the powerful impact flourishing can have on medical education and in medical practice.

Conclusion

Ultimately, this painting is a visual reminder that I should be compassionate towards myself. In times of difficulty, I should reach out for help from others and that can allow me to develop as an individual. As a medical student, it reminds me of the need for compassion with patients, to see them not only by their disease but also from a human perspective and always offer my support and empathy. This idea has resonated with me after hearing the profound impact that empathy and kindness has had on patients throughout my medical journey. I hope that any individual, particularly doctors and medical students, that sees my painting will be able to feel the warmth I felt when painting it and I hope that they see the need for spreading love and compassion in healthcare or even in our daily lives and understand the power that art has in healing and forming deeper human connections.

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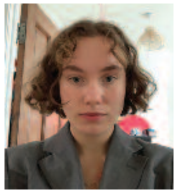
Challenges for learning about planetary health

Anna Moore

Barts Health Education Academy population health fellow and respiratory doctor, Barts Health Breathlessness Service

I'm a respiratory doctor and educationalist. I've spent the last four years working in medical education, particularly thinking about climate and health. I identified a gap in my knowledge about population and public health so completed an HEE Population Health Fellowship last year. The fellowship helped me to realise that our targeting of resources in secondary care is often at the expense of prevention of illness, and I could no longer see a place for myself working full-time as a consultant in hospital medicine. I resigned my training number and now do a very enjoyable combination of education for population health and sustainability with bi-monthly breathlessness clinics – my specialist clinical interest.



Rosa Caitlin Jones Hughes

Fourth year medical student, Barts and The London, QMUL

I have an interest in sexual health, preventative medicine and planetary health. I've been involved with Sustain@BL, the sustainability society at our medical school throughout my time at uni and I'm also a part of the music, drama and LGBT+ societies.

Summary

Teaching about health inequalities tends to be delivered in isolation unrelated to acute clinical care. The same applies to the climate crisis, yet despite these problems being so intimately connected, teaching about them is rarely integrated. Conversely, education about sustainable healthcare is too often approached without reference to the central part health or climate justice will inevitably play if sustainability is ever to improve. Foreseeable upheavals in climate, social and public health make rethinking these topics vitally important for doctors of the future.

Introduction

The latest *Lancet Countdown Report* describes the converging crises threatening the world's life-supporting systems. The world is on track for a catastrophic 2.7°C temperature rise, driven by fossil fuel dependence which directly harms human health through air pollution, among other mechanisms (Romanello *et al*, 2022). Healthcare systems globally contribute 4.4% of carbon emissions from fossil fuels and other pollutants (Karliner *et al*, 2019). In the NHS this figure is 4%, with 10,358 quality adjusted life years lost yearly through health impacts of air pollution emissions from NHS activities (NHS, 2020). Similarly, we are facing a crisis in health equity. The gap in life expectancy between the richest and poorest in society is actually widening (Munro *et al*, 2020), and stark ethnic and racial inequities in healthcare persist (NHS, 2022). Health professionals must lead action on climate change and health inequalities. This applies not only in healthcare settings, but also, as trusted professionals, in communication about the health impacts of these issues and the need for societal change (Brown & Booth, 2002; Gutrridge-Heritt, 2022; Holgate *et al*, 2016). Frustratingly, education on both these issues remains peripheral in many undergraduate medical curricula (Planetary Health Alliance, 2021; Landry, 2021)

Interdependent problems with shared challenges for medical education

The climate crisis is a health justice crisis. The legacies of colonialism and slavery mean that ethnically minoritised groups already experiencing healthcare inequalities are more vulnerable to the health effects of climate change and ecological breakdown (Tendayi Achiume, 2022). The term planetary health, which emerged from environmental and holistic health movements in the 1970-80s (Prescott & Logan, 2019), refers to the 'health of human civilisation and the state of the natural systems on which it depends' (Horton & Lo, 2015). Justice is a central feature of education for planetary health. Learners must not only gain knowledge and skills, but embody values in health equity (Shaw *et al*, 2021; Guzman *et al*, 2021), which in turn enables appreciation of the interdependence of the social and commercial determinants of health (SCDOH) (Marmot *et al*, 2020; Kickbusch *et al*, 2016), health, healthcare and the climate crisis (see Figure 1).

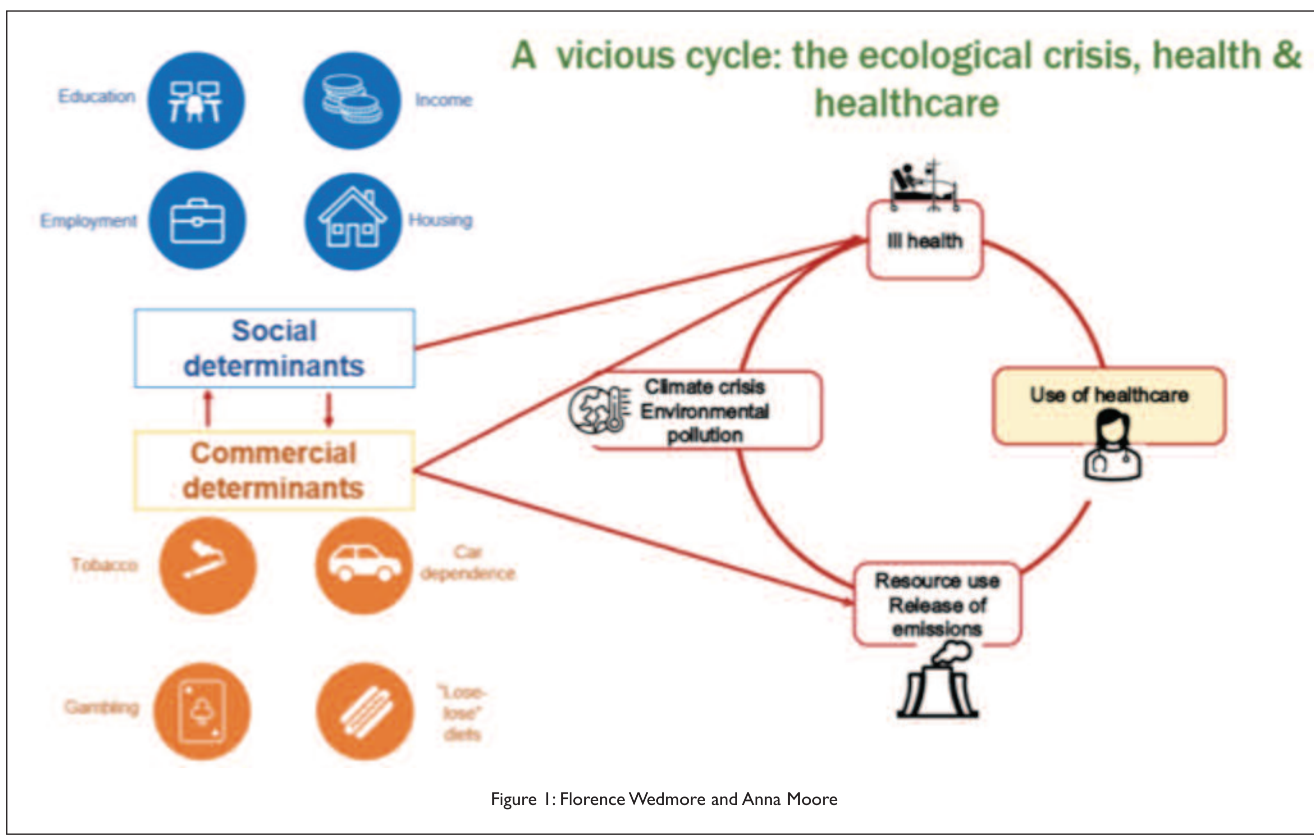


Figure 1: Florence Wedmore and Anna Moore

Health equity education at medical school is often considered a challenge (Lyon *et al*, 2016) and frequently delivered in isolation, separate from the acute clinical care context (Shar & Blythe, 2002; Landry, 2021). Further, integration of learning on the climate crisis is rare, despite these problems being so intimately connected. Conversely, education for sustainable healthcare is frequently approached without explicit reference to the central role of health justice in improving sustainability. Rethinking our approach to these topics, aiming for transformative learning, is vital.

In an educational context, climate change and health equity share several features which limit their effective integration into current curricula. First is complexity; neither fits easily into established medical education silos and both need students and faculty to think and work across multiple boundaries. A 'complex systems lens' (Rambihar, 2022) is needed, but is sadly not often found in medical education, where reductionism and the biomedical model of health and disease still dominate (Rocca & Anjum,2020).

A second, closely related issue, is assessment. Neither topic lends itself to single best answer questions, presenting a challenge to assessment at scale of students' grasp and understanding of the complexities of both crises. Compounding this, medical students in the UK are ranked by exam results from year one, extending to 'foundation job ranking'. Examination results are not only a matter of passing or failing; they determine where students end up living and working. Attention is understandably often focused on knowledge most frequently tested in these exams. For planetary health, assessment limits learning.

A third shared feature is lack of faculty knowledge, confidence, and buy-in. For climate and health this is understandable, considering the relative novelty of the subject. The same cannot be said for health equity, an ever present and deepening problem (Marmot *et al*, 2020). For our healthcare system, action on prevention and inclusion health often takes second place; which in turn affects

learning by limiting students' exposure to the modelling of eliciting and acting on health inequalities (Lewis *et al*, 2022). One proposed action for faculty development is for teachers and students to learn together, codesigning curriculum content (Tun *et al*, 2020) – a sensible, but radical, suggestion that would entail challenging long-established hierarchies in medical education and training (Vanstone & Grierson, 2022).

However, there are opportunities for transformational learning in current curricular structures – for example student selected components (SSCs). The next section takes the form of a conversation between the authors – Rosa (RJH: student) and Anna (AM: educator) reflecting on learning from participation in an SSC on sustainable healthcare.

Shared learning experiences in planetary health

AM: Rosa, you were among our first participants in the sustainable healthcare SSC. We framed the module using the 'vicious cycle' model (Figure 1), Principles of Sustainable Healthcare (https://sustainablehealthcare.org.uk) and social determinants of health. Recently I marked your third year SSC essay *What is Coping?*. You critique a paper (Brouwer & Menard, 2020) which refers to social determinants of health (SDoH) as 'difficult to modify', and apply health equity knowledge and values to your clinical communication skills-focused reflection.

RJH: My essay focused on a conversation about coping style, between myself and a terminally ill patient. He mentioned both personality traits – his pessimism and his wife's optimism – and external circumstances, including his strong support network, which helped him cope. I began to consider the importance of intrapersonal vs interpersonal factors in coping; it seemed both elements were significant. But although the literature confirmed this, all proposed interventions focused solely on intra-personal factors! Social determinants were unduly dismissed as 'difficult to modify'.

This reflects a wider reluctance to consider larger structures like housing, education and income as modifiable health determinants. Fast-paced and brief patient interactions on clinical placement mean socio-economic factors are often missed; In lectures too, SDoH are rarely acknowledged, unless being taught in isolated modules, like global health. And students often don't properly engage with these modules because they aren't incentivised grades-wise.

AM: You've touched on many issues: system pressures, modelling by clinicians and faculty, and the powerful effect of assessment. But you tackled these issues head-on in your essay – why?

RJH: I had several experiences as a second-year student that legitimised a pre-existing curiosity in health inequalities. One was the selective student component, which covered how sustainability is integral to healthcare, and interlinked with other health determinants. Another was critically appraising a quantitative study. This taught me to examine choices made by scientific authors, which may reflect personal biases, such as recommending only individual-focused interventions.

AM: I'm curious that you use 'legitimised' in relation to your interest in health inequalities. Why do you think you needed it legitimising?

RJH: There's this prevailing conception of medicine as apolitical. Talking about modifying social factors can be seen as unobjective, unscientific. But 'objectivity' is measured relative to the current status quo. It's crucial to examine the context of ours. What is the status quo, and how does that determine what's viewed as political, or radical?

AM: These are such important questions – and demonstrate critical thinking skills, which are vital for planetary health education. We need to appreciate that we take those 'norms' as incontrovertible truth – that in fact, we're trained to do it!

RJH: Yes – I think one particularly pervasive norm, both in healthcare and society, is individualism. It characterises many recent policies, for instance the introduction of calorie labelling on restaurant menus, ostensibly tackling the 'obesity epidemic'. This policy masquerades as public health, but lacks an evidence base, merely foisting blame onto individuals (Cantu-Jungles *et al*, 2017). It distracts from complex environmental and economic elements of obesity, such as 'food deserts'; areas where over a million people lack access to cheap fruits and vegetables, due to poverty, lack of transport and no large supermarkets nearby (Government Office for Science, 2007). Individualism also impedes climate discourse; 20 companies generate one third of all emissions (Taylor & Watts, 2019), but instead of holding these companies accountable, individuals are encouraged to minimise their carbon footprint, a concept popularised by oil giant BP (Kaufman, 2021). Individualism benefits corporate interests, whose priority isn't human or planetary health, but money. Tackling these systemic problems would improve health far more than telling people it's all in their hands – it is not.

I think individualism has enabled austerity to be publicly acceptable, and thus persistent. My essay on coping discussed how inequality in healthy life expectancy between the most and least deprived deciles has grown since austerity was introduced; life expectancy has actually dropped for the most deprived 10% (Munro *et al*, 2020). The Marmot Report gives overwhelming evidence that these harms arise from cuts to public services? Yet the government continues making cuts, landing millions more in food and fuel poverty, especially those living in poorly insulated homes.

AM: Those examples also link to planetary health; increased healthcare resource use means higher emissions, poorly insulated homes use more fuel, and manufacturing and transporting cheap, processed and packaged food is polluting, carbon intensive, and

harmful to health. We've spoken about how thinking critically – really asking what underlies the stories we're told – can sometimes feel subversive.

RJH: Yes – for me, addressing these complex issues is what makes medicine interesting and worthwhile to study. But it's an uncomfortable topic for some. We intuitively know that health inequalities contribute to the burden of illness, and that they're created by people, working in policy-making organisations and corporations. But these ideas can feel somewhat abstract, and the hierarchy of knowledge within medicine favours concrete numbers, creating a tendency to ignore complex issues for lack of specific examples that cannot be reduced to simple metrics. Teaching on SDoH is key to empower students to integrate it into clinical practice.

AM: I experienced this as both a learner and clinician; but it changed when I started my medical education masters. For the first time, I learned that there are names for different ways of thinking – eg positivism – those concrete numbers, vs critical theory – starting to question the structures that we learn and work in. And importantly we were encouraged to start thinking more critically about our own educational and clinical practice. Then, teaching on climate and health, particularly that session on SDoH, I really started to understand the effect of policy – and politics – on health and appreciate the downstream effects on our ecosystem. It's also changed my clinical practice.

RJH: It was pivotal for me too, in solidifying that intuitive knowledge. The view of medicine as divorced from politics feels like a historical relic; as medical students we've come of age through protracted austerity, which saw the NHS perpetually starved of funding and in crisis; through Covid-19, the Black Lives Matter movement, the current cost of living crisis and the resurgence of industrial action. I know some students were quite apolitical before lockdown, but now are aware that things like government policy play massively into everyone's health.

AM: That's interesting – so for you and some peers, this knowledge and understanding is now internalised?

RJH: Yes, but not yet for everyone, because as medical students we're still taught to conceptualise healthcare in a vacuum. This is so disempowering for students and doctors, because if your skillset is purely medical, and the thing making your patient sick can't be cured with a pill, for example unsuitable housing, you can't help them. Thus, phrases like 'difficult to modify' are ascribed to SDoH, despite the fact that we constantly modify them, through policy for example. In Marmot's words, housing policy is health policy.

AM: It's such an important missed educational opportunity. You're describing a need to engage with complexity in health systems to enable action. I also sometimes meet indifference from colleagues who don't share my approach, and it can feel quite lonely and frustrating.

RJH: Yes – there have been times when someone admitted with a respiratory illness is discharged to an unheated or damp home, and I've brought up the fact they'll probably be readmitted. The response is usually: what can we do about it?

AM: Yes, I hear that often too. I think it speaks to that lack of empowerment that lots of clinicians feel – as you say, we're taught that SDoH are non-modifiable from day one, so we just remove them from our clinical thinking.

RJH: It bleeds into non-healthcare issues too. When the rail strikes started, people were understandably upset because they couldn't get to clinical placements. But there was remarkably little curiosity about why RTU members were striking, the working conditions precipitating it – for future health professionals that's quite a lack of empathy!

AM: The media has such influence on our understanding though. It's very similar to messaging around activists 'causing havoc' on the roads – without any coverage of the underlying reasons for the protests. We're dealing with overwhelmingly compelling societal messages, combined with a disconnect between our thinking in a medical education context and socio-political awareness.

RJH: That's why the SSC was such a brilliant learning opportunity – it demonstrated that health systems are both affected by, and impact on, our environment's health and the climate crisis. These impacts are not felt equally; those in more deprived areas are worse affected, for example through pollution and lack of infrastructure. We also learned about health improvement, including a case study demonstrating how planning through an environmental health lens helped control a schistosomiasis outbreak in Senegal. It amazed me that action to improve the natural environment also improved human health, without formal healthcare use (Duff *et al*, 2020). I loved this module and have since integrated this knowledge into my studies. My essay on coping was one such opportunity; I included the Marmot report because this teaching illuminated connections between society, policy and health – connections I can't unsee now.

AM: We urgently need more clinicians to share this, to also be unable to 'unsee it!' There are some brilliant examples of explicit teaching on planetary health (https://phreportcard.org/success-stories/) but they are rarely well integrated into the curriculum. How can we do things differently?

RJH: First, let's stop ranking medical students to determine foundation jobs. This competition, rather than collaboration, is individualism manifesting in medical education. It encourages rote learning, limits critical thinking and pits us against each other. Second, we need education that actively counteracts overwhelmingly individualist narratives, by training us to think across organisational and disciplinary boundaries. What if, starting from our first-year lectures and problem-based learning sessions, students were encouraged to work together and with students from other disciplines, learning about housing, education, environmental and community-based interventions alongside purely 'medical' ones?

Finally, we must broaden the concept of 'management', beyond providing acute fixes for chronic problems. Clinical medicine should involve stepping back, examining the wider context behind how our patient got here, being creative in our conceptions of health and illness. Proper integration of planetary health into our learning at medical school would achieve all of this. The SSC is a great start, but more is urgently needed!

Conclusion

Our conversation explores multiple shared challenges for health equity and climate change education; the need to embrace complexity in health and healthcare, a lack of knowledge and buy-in from peers, faculty and clinicians, problems with assessment tools, and an underlying culture of individualism in both clinical practice and education. This discussion is emblematic of many we have had as both educator and learner and may resonate with readers, so we hope that these conversations will start to bring about change.

The climate and health justice crises are manifestations of planetary ill-health, which threaten the survival of our health systems, the stability of our society and even our survival as a species (Romanello *et al*, 2022). Health professionals must lead action and if this is to happen medical education will play a crucial role in enabling it. Current undergraduate medical curricula are structured in ways that limit effective integration of planetary health education into students' core learning, and therefore reform is needed urgently. Yet there are, however, opportunities in our current structures for transformational learning and educators must use them – there's no time to wait.

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Re-conceiving professionalism in a time of crisis

Vidya Nanthakumar
Climate activist and final year medical student, University of Glasgow

I grew up loving nature and so climate action felt like the most natural thing to do. When I started medical school, I realised how intertwined everything is, and learning about the health effects of the climate crisis made it feel even more urgent to take some form of action. I started thinking about how we got to this place of disconnection from nature and one another, and this led me down a long road of various interests, from spirituality, cognitive science, and the potential of psychedelics, to herbalism and other integrative healing methods. At the moment, I run an Interdisciplinary course on climate change at the University of Glasgow, as thinking beyond limited disciplines and taking on wisdom from other ways of knowing and being is necessary to find feasible solutions to the current crises.

One of the first lectures as first year medical students was about *professionalism* – we were told the things we 'should not do' because we were 'different to other students' and our behaviour would be held to a higher standard. We were told that not complying with these regulations would mean we could be 'referred to fitness to practise' – a vague threat, with vague consequences. Governed by fear, people are more likely to become politically apathetic – and this is something I have seen for myself as medical students progress through medical school.

In 2005, the Working Party of the Royal College of Physicians produced a report that sought to redefine the value of medical professionalism in a changing world. The report defined professionalism as 'a set of values, behaviours, and relationships that underpins the trust the public has in doctors'. Yet as the world has continued to change, 'professionalism' seems not to have adapted to the world we now live in: of global humanitarian crises, social justice issues, and systemic problems detrimental to the health of the population, paired with government negligence and refusal to follow scientific advice. At the heart of this lies the climate crisis, whose health consequences are indisputable (Lancet Countdown, 2020), not least of them for the Covid-19 pandemic itself – for habitat encroachment will increase the likelihood of new pandemic disease (Oakes *et al*, 2020), and air pollution aggravates the effects of Covid-19 (Ali & Islam, 2020).

Yet the social turmoil we have experienced as a result of Covid-19 is just a small taste of the destruction climate breakdown will cause. The UK government, whose response to managing the pandemic was so abysmal, having consistently ignored scientific advice, and ignored the public interest, is nonetheless expected to deal with the looming threat of climate breakdown. Governments make mistakes but, as Judith Butler (2020) describes it, the act of not acting, of 'letting die', is essentially a component of state violence.

In such dire situations, civil disobedience, a 'non-violent, conscientious yet political act contrary to law… with the aim of bringing about a change in the law or policies of the government' (Rawls, 1999) is surely justifiable. Now, with many doctors already engaging in acts of conscience despite the reputational risk (Williamson, 2020), the conflict between professional ethics and law is being re-examined, and some have concluded that 'ethical responsibilities usually exceed legal duties…[W]hen physicians believe a law violates ethical values or is unjust they should work to change the law' (Bennett *et al*, 2020). Richard Horton (2019), the editor of *The Lancet*, has stated that 'doctors and all health professionals have a responsibility, an obligation, to engage in non-violent social protest to address the climate emergency'. And they are – most notably, Doctors for Extinction Rebellion (2022) whose members, determined to increase public awareness of the climate crisis, have repeatedly risked arrest.

Why then is it that so few medical students are taking to the streets and protesting about these issues? The all-consuming demands of the medical curriculum partly account for it, but I suspect it's more to do with our professional self-image – arbitrarily defended as 'professionalism' and which plays such a large part in medical students' identity formation, that makes us reluctant rebels. A recent article in Medical Teacher (albeit one from Morocco where dissidence can have far-reaching consequences) asks whether 'dissident' medical students would make better doctors. It includes quotes suggesting that medical students are often seen as 'nerds… Only investing their time and energy on their very consuming studies…hardly interested in whatever else [is] happening outside their universities or hospitals, let alone politics or

macroeconomics…not really interested in unions or protests, not willing to risk a day for future gain.' (Fourtassi, 2019)

Yet this attitude is flawed, for surely social engagement should be a core element of medical education? One study pointed out that values of 'compassion, understanding, empathy, honesty… humanity…' and 'the less predictable: courage… a sense of justice' were what patients looked for in a 'good doctor' (Rizo, 2002). Even so, the system does very little to nurture these values and medical students' empathy has time and time again been shown to wane during their time at medical school. Whether due to burnout and stress or the curriculum's focus on objective diagnosis and treatment, rather than valuing empathy, there's a danger that our education reduces patients to a disease or an object.

When the explicit curriculum fails to tackle so important a set of issues, the hidden curriculum – the 'tacit ways in which knowledge and behaviour are constructed' (McLaren, 2015) – plays an even greater role. In the clinical environment we model our behaviour, attitudes, values and assumptions on those around us. This hidden curriculum, maintained by 'jaded, experienced practitioners, undermines the idealism, humanism, and empathy young clinicians bring with them to clinical medicine' (Chen, 2010). And so, clinicians learn to avoid the emotional repercussions of their work using detachment and cynicism to maintain this so-called objective 'professional' demeanour.

Of course, there are significant benefits to professionalism – a publicly funded service like the NHS could hardly survive without the trust created by professional behaviour and guidelines. To uphold that trust, medical students and doctors generally behave well: what constitutes 'unprofessional' behaviour is indisputable – drunk-driving, violence, sexual abuse, acts that could harm other people. What, then, if the caring professional's conscience conflicts with the law? When civil disobedience requires disobeying the law to ensure future public health, the lines get blurred.

The Overton Window is a model for understanding how ideas in society change over time and influence politics. Currently, civil disobedience for the climate crisis lies outside the window, but soon, when the climate effects are even more apparent and the threats more immediate, social values will shift and politicians will hopefully follow the votes. By then it will almost certainly be too late. What will patients think of their doctors then: doctors who were students when there was still time; who had been able to appraise scientific evidence and understand the extent of the consequences; who still did not 'take prompt action' realising as they must have, that 'patient safety, dignity, or comfort may be compromised' (General Medical Council, 2019)? The world will wonder why when they were younger, these doctors failed so abysmally to use their privileged position, scientific literacy, and communication skills to speak out about all that was so obviously at stake.

Medical students seem to understand professionalism – whether explicitly or implicitly – as the 'things they shouldn't do' (Brown *et al*, 2020). This will remain the case as long as we are taught about medicine as though it exists in a bubble, unaffected by social upheavals and the climate justice issues that plague our time. But until medical education catches up with 21st century thought and teaches us about how individual health and disease are interwoven into the larger body of society, relatively few medical students will risk social and political engagement.

If the curriculum, recognising the threat to planetary and public health, were to encourage future doctors to advocate and take action for their patients' wellbeing, then where ought the line to be drawn? What if following one's conscience conflicted with our profession's innate reluctance to risk social sanction? Dr Bernard Lown (1985) tells us (rightly, I believe) that 'physicians who shepherd

human life from birth to death have a moral imperative… to speak out for those yet unborn, for posterity has no lobby with politicians'.

Rosenbaum (as cited in Rizo 2002) suggests that being a doctor requires 'a lot of science, but also a little bit of magic, which is the end result of becoming a complete, integrated person'. If we are ever to be the doctors our patients hope for and deserve, the medical curriculum must make space for medical students to grow and dream, and to develop as professionals whose values make us truly deserving of respect, able to use well the huge privilege, responsibility, and authority the public awards us. Our duty as health professionals is inseparable from this social contract: our obligations to the public and planetary wellbeing have to include taking actions for the common good.

Catherine Thomasson (2014), writing about physicians' social responsibility, emphasises that advocacy requires an individual to believe he or she can affect change, is motivated to do so, and can 'envision what improvements are needed and how they can be instituted'. Therefore, 21st century 'professionalism' must take more seriously doctors' essential moral responsibility and permit us to follow what we believe to be right. We, doctors of the future, want to use science well but without becoming cold diagnosticians, out of touch with our own humanity. We are neither different nor superior to our patients. It is high time our education embraced these essential aspects of human life.

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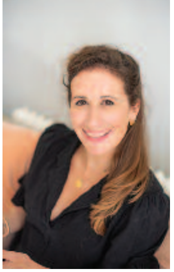
Yoga for medical student wellbeing



Ellie Grace
Yoga educator

I came to yoga over a decade ago at a time of tumultuous and traumatic grief. My passion is for guiding people into a practice that they have considered themselves excluded from, as well as training yoga teachers in trauma-informed practice and social change. I have been teaching the benefits of yoga to first and second year medical students at Queen Mary University, London since 2019. If our medical personnel were healthy and able to take care of themselves, I believe our need for expensive and sometimes damaging or ineffective pharmacological interventions would be reduced.

Summary

An experienced yoga practitioner and teacher developed a yoga module that has run successfully in a London medical school since 2019. Offered to first and second year students as a 'student selected' component, the course content aims to complement biomedical knowledge, and explore the neuroscience underpinning yoga and the evidence base for using yoga in medical settings. Students also experience breathwork, movement, meditation and relaxation practices and are encouraged to integrate them into their daily routines. 72% of students polled claimed they intend to continue practicing yoga. Programme evaluations have been overwhelmingly positive.

What is yoga for student wellbeing?

I developed yoga for student wellbeing after teaching a similar course to undergraduates of all disciplines during my Masters degree at LMU, California. The success of the course led to me, on returning to London, to propose an extended version in the medical department at Queen Mary University, London. It has been offered to first and second year students since 2019 as a student selected component. More than 500 students have taken part.

What does the course cover?

Yoga's rounded perspective of health and wellness, which takes into account the extrinsic and intrinsic factors affecting wellbeing, can complement what students have learned about the biomedical workings of the body. The neuroscience underpinning yoga helps students come to understand not just the personal importance of presence and embodiment, but also the empirical reasons for getting on the practice mat in the first place. The yogic tradition of self-study in relationship to self and others and personal responsibility provide a whole-person perspective to wellbeing.

The course emphasises yoga's philosophical, spiritual and ethical tenets. Over two weeks, students join six, three-hour modules. We explore yoga's origins, and the role Hatha yoga can play in managing stress and anxiety, in reducing burnout and supporting the healing of trauma. Students experience breathwork, movement, meditation and relaxation practices in the sessions and I suggest they try to integrate them into their daily routines. Each session is complemented by readings on the mind-body connection, neurophysiology including polyvagal theory, and the evidence base for using yoga in medical settings, plus group discussions on their readings.

We also look at the gut-brain axis, the unexpected impacts of gastrointestinal health and the potential impacts of nutritional self-care on mental health. Many students are surprised to discover this, and the evidence that relaxation, quiet time, time in nature and time spent in contemplation enable the body and brain to adapt and reset. In these and other ways, the tools of yoga offer techniques for preventing burnout – or worse.

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East–West perspectives

At the heart of the curriculum is an opportunity for students to examine some non-western models of health and healthcare including yoga's sister science, Ayurveda. Eastern models of medicine have long articulated the inter-dependence of bodily systems and the mind–body connection, aspects scientific modern medicine – and our culture in general – have until recently viewed as separated. Yogic philosophy and physiology is non-dual by nature and sees the self and our environment as dynamic, inter-relating facets that require self-understanding and self-discipline in order to live a life of balance and flow.

By learning how to ground and centre themselves, students come to recognise the importance of taking time for themselves before starting the tasks of the day, a simple way of 'coming home' or 'rooting' rather than running on autopilot. It's in referring to nature's need to root into the earth so that plants and trees can grow upwards, that they come to understand how to manage and contain their own energy in a way that is profoundly connecting and meaningful. Indeed, several students have expressed, in the submission of their creative work, this newfound connection to nature's rhythms and the interconnectedness of personal and planetary health.

The programme brings to life some of the ancient yogic concepts regarding energetics as a way of under-standing self and nature, not least the *gunas* (a system which seeks to explain how what we put into our bodies and how we care for ourselves ultimately affects our output and outcomes) and the *doshas* (Ayurveda's system for classifying mind and body types in such a way as to enhance life and our natural proclivities, as opposed to working against our inherent nature.) Ultimately, both concepts help awaken the students to their uniqueness and individuality in a medical education system that many report to be stressful, competitive and overwhelming.

Building on students' understanding of the enteric, sympathetic and parasympathetic branches of the autonomic nervous system, we examine how thoughts, emotions, hormones and behaviours are linked and the ways in which yoga and mindfulness can serve to identify and shift unhelpful personal patterns and so restore balance between arousal, effort and recovery. Throughout, students are invited to reflect on how these practices are affecting their cognitive, emotional and bio-perception of stressors, and to explore how they might be useful personally, or for family members and future patients with stress-related illnesses.

We close the course with restorative yoga practices designed to influence the parasympathetic nervous system and restore balance and stillness to overworked minds and bodies. We introduce soothing meditations on self-compassion and gratitude. For instance in yoga, contrary to the medical view of the heart as simply a biomechanical pump, the heart is considered an emotional centre and the seat of our capacity to forgive, extend compassion and make connection with self and others. This novel concept of connecting to the heart as an emotional organ is one that some of our students have found both useful and affecting.

At the end of the course, students are required to submit both a short written reflection on their experience of the course and their personal development. In addition either an academic essay on the evidence basis for yoga on a medical issue of their interest, or a longer personal reflection, or an exploration of a facet of yoga culture or history or a creative artefact exploring their response to the course in the form of creative writing or a visual piece of work. Students are marked on their attendance and engagement as well as their final written submissions.

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The adage 'I bend so that I do not break' is highly pertinent to those who study this course.

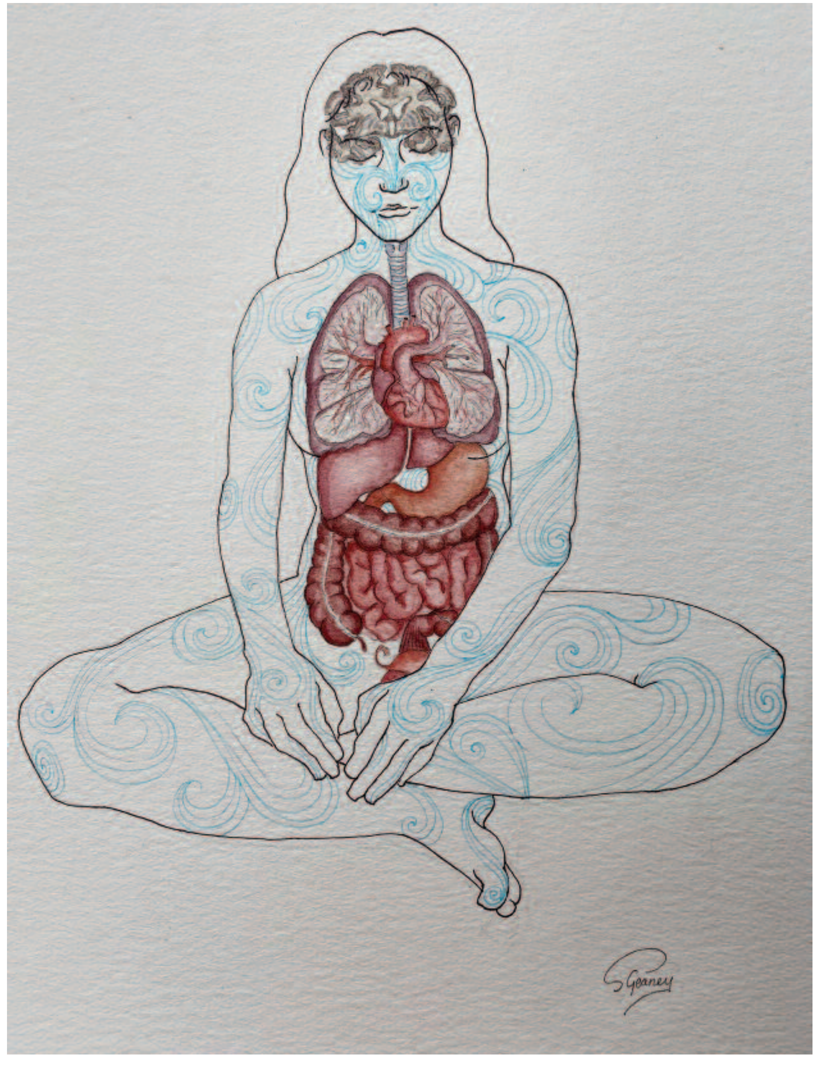
Why is it needed?

Many of my students are coming of age at a time when life lived largely online, exposure to social media, volatile geopolitics and uncertainty have defined their entry into adult life while creating unrealistic expectations about performance, productivity and success. Sleeplessness, skin conditions, gut ill-health, overthinking and stress are common complaints.

In the last couple of years, in pre- and post-course questionnaires aimed at tracking student expectations and outcomes, the majority of first- and second-year students have described medical school as either 'stressful', and/or 'overwhelming'. The Covid-19 pandemic has, for many, exacerbated feelings of loneliness, isolation and anxiety, and found the university experience largely been delivered online, to have added to their stress. 93% of students surveyed before the course stated that they wanted to change something about their mental health.

What's more, as the NHS is stretching far beyond its capacity, healthcare workers are subsequently at an ever-higher risk of burnout and poor mental health. Highly demanding work, often in under-resourced institutions, presents a huge burden of risk for those working in the system. If we don't teach those who are meant to care for us how to care for themselves, we will be creating a generation of health-care workers who regularly experience cynicism, detach-ment, burnout and dire rates of retention.

Compassion, resilience, self-awareness and self-regulation are skills that healthcare worker need if they are to be valued and effective in their work. This is why yoga for wellbeing core skills should be implemented before students become working professionals. My experience is that when people (medical students or otherwise) understand their own neurophysiology and how yoga benefits it, they are empowered to make it a lifelong practice. I've seen, again and again the fluidity, receptivity and acceptance that follows become key skills on their journey through professional life.



Watercolour and ink: Sophia Geaney, second year medical student

What do students gain personally from this course?

Over and over again, this programme receives glowing and overwhelmingly positive feedback from students, and particularly from those who previously wrote off the practice as 'not for me'.

At its core, the course provides a space for students to check in with themselves, identify what's going on and to select practices that either soothe or enliven them, depending on what's needed. Crucially, by being encouraged to share their personal insights as they go, we co-create an environment of mutual trust, compassion and openness between peers. The learning space is non-judgemental, accepting of life's ups and downs and made safe for them to express themselves authentically. This ability to be more open with themselves and one another can create a shift in how they see themselves and their peers and at the same time may provide a sense of empowerment and an appropriate awareness of their own strengths and limitations. Consequently many get to feel that they are not alone, as they previously thought, and that what they are going through is normal enough human experience. Some, who have been relentlessly hard on themselves may learn how to forgive and accept themselves. Rather than punishing and

berating themselves for missing the mark, students learn how to be compassionate and understanding.

During national lockdowns, when the course had to be delivered online with the option to practice yoga with their cameras off, many (to their surprise) reported that the privacy and intimacy of practice became a much-needed lifeline and time for healing. There were reports of rest in itself acting as an antidote to academic life and pressures; some noticed a rise in energy levels, improved clarity and focus and a renewed determination to persist and succeed. 72% of students polled claimed that they intend to continue practicing yoga.

Transformation of the body and mind: Janice Tan Sue Wei, third year medical student

How is this valuable and important for professional life?

If we expect our healthcare system to be robust, effective and compassionate, then we have a responsibility to provide tools to those who work in it to exhibit and live by those qualities. Through self-awareness and self-compassion, by knowing how to self-soothe and self-regulate, we are naturally better at caring for others. Emotional maturity, whose growth I believe these students expressed, leads to greater relatability with patients and colleagues.

What do students typically write about in their academic papers?

A lot of my students write of their personal struggles and are keen to find ways of helping themselves or those they love by

researching the evidence basis for yoga. Some examples of topics in student essays include: the therapeutic effects of remedial yoga on the management of irritable bowel syndrome; the benefits of yoga as a treatment for depression; yoga as a complementary treatment option for adults with ADHD; yoga's therapeutic effect on post-partum depression; yoga's benefits for athletes; the benefits of hatha yoga on patients with type 2 diabetes mellitus; the impact of breathwork on postural orthostatic tachycardia syndrome. Others have written on the similarities, for example, between hatha yoga and Islamic practices, and the value of yoga philosophy and culture in creating safe spaces for trans teenagers. Around 10–20% of students choose to submit creative artefacts depicting their experience of the practice.

What's the future for yoga in medical student education?

The larger question here, of course, is how would it impact the healthcare system if doctors had regular access to rest, healing and emotional expression and processing? My aim is to bring this level of whole-person education to medical schools throughout the UK and to make it core curriculum as opposed to student-selected. If our medical personnel were healthier and able to take better care of themselves, I think our need for expensive and often damaging or ineffective pharmacological intervention would be reduced.

Please get in touch if you'd like to start a conversation, I would love to chat with you!

Medical student burnout

Medical students are our future doctors. Numerous studies have found that many medical trainees experience burnout, a syndrome resulting from work-related stress characterised by emotional exhaustion, feelings of cynicism and detachment toward patients (depersonalisation), and a low sense of personal accomplishment. A 2014 study of medics in the USA found their training years to be the peak time for distress, burnout, depressive symptoms, and suicidal ideation. At every career stage, burnout is more prevalent among doctors than among their peers in the US population. Levels of student burnout are on the rise and if not addressed, maladaptive coping styles are likely to persist throughout professional life.

Dyrbye LN, West CP *et al* (2014) Burnout among US medical students, residents, and early career physicians relative to the general US population. *Academic Medicine*, 89(3) doi: 10.1097/ACM.0000000000000134

Increasingly, institutions are aware of the problem

Many medical schools are stepping up to combat student burnout and distress. A recent editorial makes some proposals that could help the next generation of doctors to look after themselves and their patients. The authors point out that medical schools have a moral and ethical obligation to ensure the wellbeing of their students in these stressful times. Students and trainees in health professions face similar pressures related to study or work environments. The pressures faced by clinicians are often 'life and death' situations involving high levels of stress and distress and, as the practice of medicine continuously evolves and changes, so too will the pressures. Because students enter medical school at a vulnerable stage in life they are more likely to develop mental health problems. The recent focus on the mental health and wellbeing of students has highlighted various worrying trends: a series of studies from around the world has shown high rates of stress and burnout among medical students internationally, and that broadly similar factors are contributory. Despite the challenge of defining and measuring burnout, these studies indicate an urgent need for changes in methods of teaching, alongside rapid access to support. Medical schools have a moral and ethical obligation to ensure the well-being of their students in these stressful times.

Bhugra D & Molodynski A (2022) Well-being and burnout in medical students: Challenges and solutions. *Irish Journal of Psychological Medicine,* 1–4. doi:10.1017/ipm.2022.26

Levels of stress in medical students due to Covid-19

Medical students' mental health was already poorer than that of the general population even before the pandemic. Academic stress is a chief predictor and the Covid-19 pandemic led to rapid exam and curricular restructuring and significant changes to clinical attachments. In this online, cross-sectional study the majority (54.5%) of respondents reported stress levels ranging from moderate to extreme. Female students and international students reported significantly higher levels of stress. Other major factors were the transition to online learning, online assessment, concerns for personal health and for the health of family members. Students who were less confident in their government's management of the crisis reported higher stress levels. Students who felt strongly that their medical school had responded appropriately to the crisis, and those who said they trusted their schools' future plans, reported lower levels of stress.

O'Byrne L, Gavin B *et al* (2021) Levels of stress in medical students due to Covid-19. *Journal of Medical Ethics*, 47, 383-388.https://jme.bmj.com/content/47/6/383

The need for empathetic healthcare systems

Medicine is not merely a job that requires technical expertise, but a profession concerned with making the best decisions and recommendations with reference to, and in consultation with the patient. This means that the skillset required for healthcare professionals in order to provide good care is a combination of scientific knowledge, technical aptitude, and affective qualities or virtues such as compassion and empathy. Being able to exercise empathy in healthcare depends not simply on the individual healthcare practitioner, but also on the environment in which they work. This article develops a broader account of healthcare-relevant empathy that encompasses healthcare systems and their role. It discusses conditions for empathetic interaction between healthcare professionals and patients at the micro level, and at the macro-level/meso-level governing policies that allow healthcare professionals to develop and exercise empathy, and patients to benefit from it.

Jumat MR, Chow PKH *et al* (2020) Grit protects medical students from burnout: a longitudinal study. *BMC Med Educ*, 20, 266. https://doi.org/10.1186/s12909-020-02187-1.

The medical student wellbeing index

This online tool allows students to self-assess their distress and wellbeing anonymously as often as once a month. Invented by Mayo Clinic, the Wellbeing Index measures six dimensions of distress and wellbeing in just nine questions. It allows participants to compare their results with peers' and national averages and provides customised resources designed to reduce distress. based on an individual's results. It includes the ability to track well-being over time.

www.mywellbeingindex.org/medical-student-burnout

Medical student burnout: causes, effects, and prevention

This narrative review considers the causes and effects of burnout, their impact on professional performance and personal lives, protective factors and the potential for its prevention. The authors note various structural components and preventive programs that have helped reduce burnout risk in medical students and residents. They summarise the leading sources of professional stress: lack of time for leisure activities, inordinate workloads and sleep deprivation, emotional drain stemming from sick and dying patients, and training coinciding with major events of life.

Mian A, Kim D, Chen D, Ward WL (2018) Medical student and resident burnout: a review of causes, effects, and prevention. *J Fam Med Dis Prev* 4(094). doi.org/10.23937/2469-5793/1510094.

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holistic healthcare
AND INTEGRATIVE MEDICINE

About the BHMA

In the heady days of 1983 while the Greenham Common Women's Camp was being born, a group of doctors formed the British Holistic Medical Association (BHMA). They too were full of idealism. They wanted to halt the relentless slide of mainstream healthcare towards industrialised monoculture. They wanted medicine to understand the world in all its fuzzy complexity, and to embrace health and healing; healing that involves body, mind and spirit. They wanted to free medicine from the grip of old institutions, from over-reliance on drugs and to explore the potential of other therapies. They wanted practitioners to care for themselves, understanding that practitioners who cannot care for their own bodies and feelings will be so much less able to care for others.

The motto, 'Physician heal thyself' is a rallying call for the healing of individuals and communities; a reminder to all humankind that we cannot rely on those in power to solve all our problems. And this motto is even more relevant now than it was in 1983. Since then, the BHMA has worked to promote holism in medicine, evolving to embrace new challenges, particularly the over-arching issue of sustainability of vital NHS human and social capital, as well as ecological and economic systems, and to understand how they are intertwined.

The BHMA now stands for five linked and overlapping dimensions of holistic healthcare:

Whole person medicine

Whole person healthcare seeks to understand the complex influences – from the genome to the ozone layer – that build up or break down the body–mind: what promotes vitality adaptation and repair, what undermines them? Practitioners are interested not just in the biochemistry and pathology of disease but in the lived body, emotions and beliefs, experiences and relationships, the impact of the family, community and the physical environment. As well as treating illness and disease, whole person medicine aims to create resilience and wellbeing. Its practitioners strive to work compassionately while recognising that they too have limitations and vulnerabilities of their own.

Self-care

All practitioners need to be aware that the medical and nursing professions are at higher risk of poor mental health and burnout. Difficult and demanding work, sometimes in toxic organisations, can foster defensive cynicism, 'presenteeism' or burnout. Healthcare workers have to understand the origins of health, and must learn to attend to their wellbeing. Certain core skills can help us, yet our resilience will often depend greatly on support from family and colleagues, and on the culture of the organisations in which we work.

Humane care

Compassion must become a core value for healthcare and be affirmed and fully supported as an essential marker of good practice through policy, training and good management. We have a historical duty to pay special attention to deprived and excluded groups, especially those who are poor, mentally ill, disabled and elderly. Planning compassionate healthcare organisations calls for social and economic creativity. More literally, the wider use of the arts and artistic therapies can help create more humane healing spaces and may elevate the clinical encounter so that the art of healthcare can take its place alongside appropriately applied medical science.

Integrating complementary therapies

Because holistic healthcare is patient-centred and concerned about patient choice, it must be open to the possibility that forms of treatment other than conventional medicine might benefit a patient. It is not unscientific to consider that certain complementary therapies might be integrated into mainstream practice. There is already some evidence to support its use in the care and management of relapsing long-term illness and chronic disease where pharmaceutics have relatively little to offer. A collaborative approach based on mutual respect informed by critical openness and honest evaluation of outcomes should encourage more widespread co-operation between 'orthodox' and complementary clinicians.

Sustainability

Climate change is the biggest threat to the health of human and the other-than-human species on planet Earth. The science is clear enough: what builds health and wellbeing is better diet, more exercise, less loneliness, more access to green spaces, breathing clean air and drinking uncontaminated water. If the seeds of mental ill-health are often planted in an over-stressed childhood, this is less likely in supportive communities where life feels meaningful. Wars are bad for people, and disastrous for the biosphere. In so many ways what is good for the planet is good for people too.

Medical science now has very effective ways of rescuing people from end-stage disease. But if healthcare is to become sustainable it must begin to do more than just repair bodies and minds damaged by an unsustainable culture. Holistic healthcare practitioners can help people lead healthier lives, and take the lead in developing more sustainable communities, creating more appropriate models of healthcare, and living more sustainable ways of life. If the earth is to sustain us, inaction is not a choice.

"The Journal of Holistic Healthcare…
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and what a bargain!"
Dr Michael Dixon

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Re-imagining healthcare