Let’s Talk More about Our Mental Health in Medical School

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This August, a recent NYU medical school graduate walked past the student health center on the first floor of his residence hall, climbed to the roof, and fell 26 stories to his death. He has been and will be joined by an estimated 399 other US physicians who decide to take their lives this year.\(^1\) Those who decide to pursue this field are all well aware of how mentally and emotionally challenging it can be, but this critical issue demands more of our attention. This essay aims to briefly discuss some of the apparent and not so apparent sources of poor mental health during medical education before suggesting some individual and communal strategies for addressing this important issue.

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The fact of the matter seems to be that medical education can change us in some negative ways. Before entering medical school, students have similar mental health to other groups, but as physicians, men and women are 1.41 and 2.27 times more likely to commit suicide than the general population, respectively.\(^2\) The CDC reports the prevalence of current depression (major or other depression) and suicidal ideation among US adults to be 9.1% and 3.7%, respectively.\(^3,4\) Studies vary significantly in reported rates of burnout, depression, and suicidal ideation among medical students and residents. Two larger studies found that 49.6% experienced burnout, 12% had symptoms of major depression, 9.2% had symptoms of mild/moderate depression, and 11.2% reported suicidal ideation.\(^5,6\)

To explain these troubling statistics, past authors have suggested both apparent and less apparent sources of poor mental health during medical education. Often studies point to lack of sleep, financial debt, large work load, high competition, and lack of sexual activity;\(^7\) but these are not unique to graduate students pursuing medicine.

It seems likely that a stressful environment contributes to medical student mental health in combination with deeper characteristics such as the psychology of those who choose to pursue medicine and medical culture itself. The “physician personality type” can make one more prone to poor mental health as well as academic success. For example, physicians tend to feel a heightened sense of personal responsibility. This can make them self-sufficient and responsible students but also less likely to forgive themselves or ask for help.\(^8\)
Medical education can then add to this perfect storm for poor mental health. Beyond the stress, medical education transitions students from uninformed outsiders to clinicians. At first clinical uncertainty is turned inward and we tend to self-diagnose, but as we progress, we push this uncertainty aside and turn our focus outward toward our patients. It soon becomes difficult for us to look inward again and re-identify with the role of patient. Furthermore, there seems to be an underlying message of control in medical education: knowing is control and control of one’s emotions is a virtue in clinical situations. It can seem as though one either has “what it takes” to make it in medicine or not, and thus we are quick to neglect our personal health in an effort to do what it takes to achieve our professional goals.

Finally, it is worth mentioning a common fear of stigma. Students often fear that asking for help will affect their academic records or cause others to not respect them. It is important to realize that we are not alone, and mental health services are strictly confidential. However, it does seem that we could be more understanding of our classmates. A 2009 study at the University of Michigan reported that 38% of non-depressed medical students surveyed felt those students with depression were to blame for their own problems.

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With the many sources of poor mental health during medical education, how are we to address this issue? One important effort has been making mental health services more available to students. Although students may be reluctant to seek out these services, many schools have made great efforts to make them more available. Personally, I think anyone can benefit from therapy if they are open to it. I was very skeptical, until circumstances in my life landed me in a psychologist’s office. I felt like a failure needing to ask for help, but I gave it a chance and it slowly worked.

Although treatment is important, it seems reasonable to also focus on prevention. Richard Gunderman said it well that “when it comes to physician burnout, an ounce of prevention is worth a pound of cure.” Medical education will likely remain challenging, but perhaps we can better equip ourselves to meet those demands both personally and as a medical community.

As an individual, exercise and adequate sleep can significantly improve one’s mental health. Regular exercise has been shown to be comparable to antidepressants in improving depressive symptoms, whereas inactivity has been associated with various psychological disorders. Anything from running to dancing can release endorphins and build confidence while functioning as a positive coping mechanism. REM sleep also seems to be associated with emotional health in complex ways. Sleep and mental health are intricately connected in ways we are just beginning to understand. Pathology affecting one often affects the other. Thus regular exercise and sleep can be powerful tools for preventing poor mental health. It can be difficult to squeeze these into our hectic schedules, but it seems well worth the investment.

Healthy coping mechanisms are also powerful tools for prevention. These of course vary with the individual, but I thought I would share some strategies which work for me. I, like many medical students, put a tremendous amount of pressure on myself which can make small roadblocks seem enormous and defeating. One question I often ask myself is “What will it matter in
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10 years?” Will I remember how I did on that test? Will I remember everything I had to do on August 9th, 2014? Perhaps, but it will likely not matter much to me.

Another approach is avoiding the “what ifs.” When I start feeling the pressure of medical school, I tend to start worrying about a series of “what ifs.” What if I don’t get that research position? What if I can’t get into the residency I want? These are not unfounded concerns, but fixating on those questions can add a lot of unnecessary stress.

I also try to stop and remember what is under my control. Often we spend a lot of time trying to be something, emulate someone, or focusing on our faults. I do not think there is anything inherently wrong with these thoughts as long as they are balanced with an appreciation of one’s strengths and an understanding that the only person I have to be is me.

Finally there may be value in reflecting upon how we view the medical profession. Often articles discussing rising levels of physician dissatisfaction blame differences in professional expectations.17–19 For example, a physician may enter medicine with plans of spending most of his/her time treating patients only to find him/herself consumed by administrative paperwork and rushing clinical encounters in response to diminished reimbursements. Viewing medicine as a calling rather than a simple career choice can help redirect one’s focus.12 Medicine may instead be viewed as a humble service to the health of one’s community. This does not eliminate professional frustrations, but it can add meaning and direction to the personal sacrifice demanded of physicians.

Beyond these individual prevention strategies, we can also strive to create a more supportive medical culture as future physicians. Unfortunately, we are often reluctant to use one of our greatest resources: each other. Additionally, there seem to be two primary complications to efforts to promote personal well-being during medical education: there is not a single best approach for everyone, and students are likely to neglect their mental health if they believe it is necessary to succeed. Thoughtful discussions between groups of students and mentors may help in addressing these issues.20 While it may be tempting to try to fit teaching wellness into a system akin to principle-based ethics and give students “skills and concrete rules,” a more honest reflection of wellness development is that it requires students to go on their own journey to appreciate and internalize the values that they support in medicine and in their own lives.

Openly discussing these issues with our peers and mentors can work on multiple levels. Meaningful self-reflection can help us better understand our motivations and values while offering catharsis for our insecurities. Furthermore, it can help us connect with those around us and realize that many of our colleagues and mentors share similar insecurities. We are then able to explore and share various coping skills and mental attitudes to select which approaches work best for our personal journeys.

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Of course this may raise concerns about how to squeeze such discussions into demanding medical curricula, but some schools have already made such efforts. Students at the David Geffen School of Medicine (UCLA) participate in well-being groups led by faculty advisers. Northwestern University’s Feinberg School of Medicine has students share blog posts and meet to discuss topics related to our adjustment to the medical lifestyle, such as maintaining relationships or coping with stress. Much like any of these strategies it’s an investment.

The mental health of medical students is a major issue facing US medical education, and it demands continued efforts to promote mental wellbeing. Individually, exercise, sleep, and healthy coping mechanisms can help prevent poor mental health. As a community, we need to talk to and support our colleagues. However, prevention will not always be successful. Student mental health services are excellent, confidential resources, which can help tremendously. It may be extremely difficult for students to ask for help, but their lives are well worth the investment.

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REFERENCES


