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We Burn Out, We Break, We Die: Medical Schools Must Change Their Culture to Preserve Medical Student Mental Health

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Abstract

The author explores medical student depression and suicide through the lens of the author's personal struggle during the first 2 years of medical school. While the author’s story is unique, other medical students have also faced challenges that have led them to consider a permanent solution to a temporary problem. Although resources are available, stigma represents a significant barrier for students as they decide whether to seek help. Students fear that showing the slightest hint of vulnerability or imperfection will be used against them in an advancement committee, a course evaluation, or the dean’s letter for residency applications. This difficulty asking for help and the subsequent suppression of feelings can lead to burnout and ultimately to increased risk of suicide.

The author calls for medical schools to make changes to their culture to preserve medical student mental health. These include committing to helping students who are struggling academically or psychologically; implementing an institution-wide program to screen for individuals at risk for suicide; educating members of the institution’s community about depression to destigmatize seeking help for mental health; and ensuring confidential mental health services are readily available to those who need them. But, most importantly, medical schools must create a culture that normalizes the need for self-care and includes vulnerability as part of training in professionalism.
My hands shook uncontrollably as I arrived at the Office of Medical Education. I held them tightly as the dean informed me I had not passed the course remediation that was mandated after I failed a final exam by a single point. As the dean continued to speak, I started to sweat. All of a sudden, I heard a ringing noise in my ears. Then the dean spoke the words that I feared the most: “Are you sure you really want to become a doctor?” The ringing stopped, and I sat there, feeling breathless. I could see the dean was still talking, but I heard nothing. I only felt the soul crushing pain of failure, the pain I had struggled to keep at bay since my first day of medical school 18 months prior. Softly and slowly, my mother’s oft-repeated words “failure is not an option” echoed in my mind. I left the dean’s office, entered an enclosed stairwell, dropped to my knees, and cried.

Later, as I walked outside and through a snowstorm to my car, I made the plan. I would drive at full speed into the traffic light pole at the busiest intersection in town. I reasoned that my family would assume my death was an accident in the heavy snow, and they would find a way to move on without the knowledge of my death’s true origin.

I got into my car, closed the door, and sat staring at my windshield as the snow built up. A voice within me told me to call the mother of my late best friend, who had taken own his life by suicide 6 months before I began medical school. I chose her because I knew she would listen. In the aftermath of her son’s death and our shared grief, she and her husband—a pathologist and neurologist, respectively—had kept in touch and were mentoring me as I attended medical school. I texted her to ask if she was available to talk, and she took my call immediately. I told her I just wanted to check in, but she did not believe me. I eventually told her what was going on, but not how close I had come to taking my life.
She talked to me as I drove home that night, refusing to get off the phone until we had an action plan. She advised me to take a medical leave of absence to finally address the depression that I had desperately fought alone for years. After we got off the phone, I called back to ask if I could come stay with them while I took leave and studied for my United States Medical Licensing Examination Step 1 exam. The thought of trading late winter in cold and dark Vermont by myself for warm and sunny California with them gave me hope. She and her husband offered me their support and home, where I lived for the next 4 months. I dedicated my time to healing the wounds I had neglected for far too long. Her husband suggested cognitive behavioral therapy (CBT), which served as a turning point in my mental health journey.

**Failure Is an Option: Recognizing the Need for Growth and Support**

Although I failed the Step 1 exam on my first attempt, the coping skills I learned through CBT helped me prepare to retake and pass the exam just a few months later. I learned that failure is an option, and it can be used as an agent for growth and change. I embraced my need for a tutor and a therapist. Taken together, these changes allowed me to do more than just pass the Step 1 exam—they helped me get my life back. Through my third-year clerkships and into the start of my final year, I began to feel I was becoming the physician I was destined to be.

Yet my feeling of mastery came to an abrupt halt when I learned of the suicide of another friend and fellow medical student at the beginning of his third-year clerkships. His death hit me like a train. I felt guilty for not doing more—for not telling first- and second-year students, especially students like me from groups underrepresented in medicine (URM), what can happen if you do not get help, how dark your thoughts can be, and how isolated you can feel. In medical school, students are constantly evaluated on our professionalism and behavior. After countless conversations with my peers, I have come to understand that students fear that if we seek help or
if we show even the slightest hint of vulnerability or imperfection, it will be used against us in an advancement committee, a course evaluation, or our dean’s letter for our residency applications. This is supported by a 2002 study in *Academic Medicine* that found 24% of depressed medical students reported being reluctant to use mental health counseling services because they feared it would be documented on their academic record.¹ The immense internal pressure we feel does not leave room for outside stress. As a result, we burn out, we break, we die.

I do not know why my colleague chose a permanent solution for his hopelessness during his moment of despair. But from my own experience with depression and candid conversations with classmates about their personal struggles, I know that each of us had our own unique situation, and each of us reached a breaking point at which we had limited support from the medical school. Support is critical--self-advocacy in the midst of depression is almost impossible.

**Changing Culture by Destigmatizing Self-Care and Redefining Professionalism to Include Vulnerability**

A 2019 report from the American Medical Association’s Council on Medical Education indicated “medical students are three times more likely to commit suicide than the rest of the general population in their age range in other educational settings.”² A 2016 systematic review in the *Journal of the American Medical Association* estimated the prevalence of suicidal ideation among medical students to be 11.1% and the prevalence of depression or depressive symptoms among medical students to be 27.2%.³ Yet of the students who screened positive for depression, only 15.7% sought psychiatric treatment.³ This is consistent with a University of Michigan study that found medical students who screened positive for moderate to severe depression were less likely to seek treatment than medical students with mild or no depression.⁴
The same University of Michigan study found that medical students with moderate to severe depression more frequently agreed that “If I were depressed, fellow medical students would respect my opinions less” and that “faculty members would view them as being unable to handle their responsibilities” compared with students who were minimally or not depressed. These responses underscore the significant barrier that stigma represents for medical students when deciding whether to get help. Difficulty asking for help and the subsequent suppression of feelings lead to burnout and ultimately to increased risk of suicide among both medical students and physicians.

What do academic medicine leaders need to do to change medical school culture and preserve student mental health? Medical school leaders should explicitly recognize the immense investment in each student—by the school, by society, and by the student’s family—and how much pressure this investment puts on the student. In this context, one failed exam or course can feel like the end of the highway instead of a bump in the road. Tutoring and other resources should be offered proactively to students based on exam scores. Vogan et al emphasize this as an essential component of preventing burnout among medical students.

Medical school leaders should clearly articulate to first-year students that the school’s goal is to ensure that all students will graduate and they will help any students who are struggling academically or psychologically. This was one of many reforms at the University of California, San Diego (UCSD) School of Medicine, where the dean and the CEO of the academic medical center voiced messages of institutional support to trainees and faculty, with the dean emphasizing “no stigma should be attached to mental illness.”

Medical schools should implement institution-wide programs to screen for individuals at risk for suicide and educate members of the institution’s community about depression to help
destigmatize seeking help for mental health. This is a concept that was pioneered at UCSD School of Medicine, after a disturbing trend of physician suicides forced the institution to re-think the way it addressed mental health in its community. The Suicide Prevention and Depression Awareness Program implemented at UCSD in 2009 used an online screening program to connect individuals anonymously with counselors and promote mental health service engagement. The educational component of the program included institution-wide grand rounds centered on topics like physician burnout, depression, and suicide, with a focus on how these topics impact trainees.

Schools should also provide students with crisis resources, such as those provided by the American Foundation for Suicide Prevention (www.afsp.org) and the National Suicide Prevention Lifeline (https://suicidepreventionlifeline.org; 1-800-273-8255*). Confidential mental health services must be readily available, and an internal hotline should exist for confidentially identifying someone who may need help. Faculty should be educated on risk factors and methods for effective communication with students about depression and suicide. The University of Hawaii School of Medicine did this by developing a program that incorporated communication education for faculty with expanded counseling services for third-year medical students and greater anonymity in referrals for those services.

But, most importantly, schools must create a culture that normalizes the need for self-care and includes vulnerability as part of professionalism. Schwenk et al share this recommendation, concluding the “care of professional colleagues with mental illness” should be taught in the “professional guidance that medical students receive as part of their curriculum in

* At the time of writing (January 2021), the National Suicide Prevention Lifeline uses this 10-digit telephone number. By summer 2022, the 3-digit number 988 is expected to be implemented as the telephone number for the National Suicide Prevention Lifeline, under the National Suicide Hotline Designation Act.
One way of doing this is by adopting a statement of institutional support for mental health, as the United States Air Force did by including a strong message from senior ranking USAF members destigmatizing depression in its suicide prevention program.\textsuperscript{7} A more comprehensive method at the Saint Louis University School of Medicine required students to engage in a “resilience and mindfulness program” focused on reducing stress, cultivating mindfulness, and restructuring cognitive distortions while providing students with practical skills to use on their own in times of distress.\textsuperscript{10}

**The Necessity of Change in an Era Defined by It**

As my story illustrates, each student possesses a complex set of traumas and recoveries. As I write in January 2021, students face additional challenges related to the changes in medical school brought forth by the COVID-19 pandemic. Students, especially those from URM groups, may also feel burdened by the complex nature of the current racial reckoning in the United States.

Pandemic safety guidelines have isolated us all and forced changes in curricula, teaching methods, and clerkships, creating new stressors for medical students. Offering students more one-on-one virtual meetings with faculty to discuss how they are coping with this remarkable time could help students feel less alone.

Also, from a personal standpoint, I believe that having more faculty members from URM groups, like my own, would have made me feel less isolated during my preclinical years. I am not alone in this sentiment, as studies have revealed that mentorship by URM faculty has a profound positive impact on URM medical students.\textsuperscript{11} A well-funded diversity office could help facilitate these mentorships and should have explicit support from the dean’s office to provide support for URM groups.
I urge leaders in academic medicine to consider these recommendations without delay. I believe implementing the changes outlined in this article would improve the culture of medical schools and afford medical students the opportunity to reach their true potential while also preserving their mental health.
References


