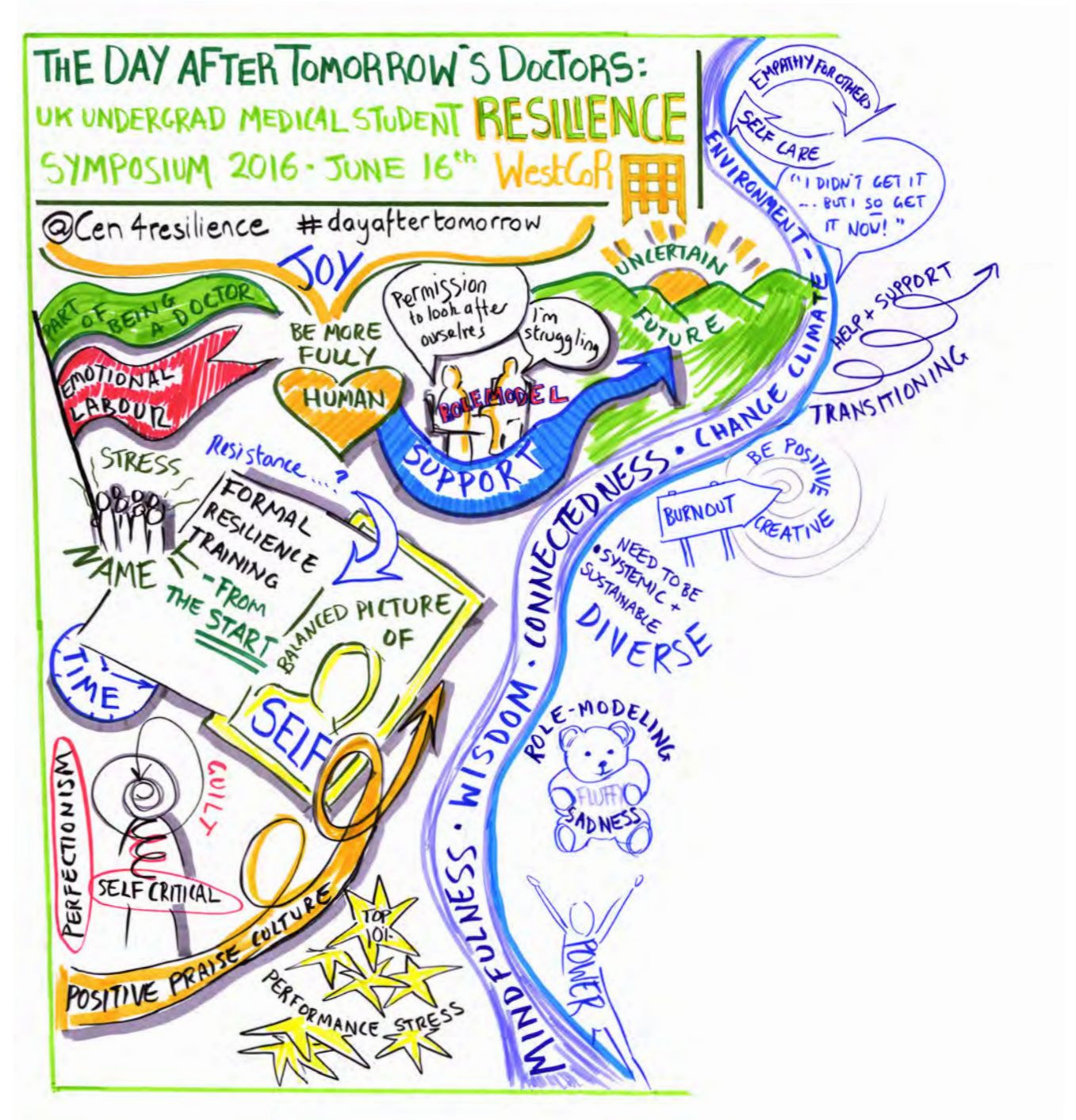


SYMPOSIUM REPORT 2016



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INTRODUCTION

There is growing evidence that students and qualified doctors' are experiencing high levels of workplace stress and burnout. Many medical students find student training and subsequently the transition to foundation year difficult. Medical schools have been tasked by the GMC to teach personal resilience as part of professional development. Despite this responsibility, it is far from clear whether medical schools have in fact integrated topics such as stress management, resilience training and self-care into their professional development curriculum. As far as we can establish this is the first meeting of UK medical educators to specifically address this topic.

Resilience can be defined pragmatically as the ability to make safe and appropriate decisions while retaining emotional awareness and empathy, and to achieve this without too high a personal cost. Our aim was to consider how more attention to personal resilience within the medical curriculum might establish a foundation for safe and consistent professional practice. How, by recognising their duty of care to students and promoting a humane learning environment might UK medical schools reduce medical student, foundation and post-foundation dropout, burnout, career dissatisfaction, and consequent staff wastage?

Four main themes were identified along with problems they represent and possible solutions:

Starting at medical school

Do current selection processes identify students who are most likely flourish in medicine? Is the current focus on grade point average appropriate for a sustainable lifelong medical career? Do medical schools adequately prepare students for the emotional and intellectual demands of a medical career? How might new curriculum content about neuroscience, the physiology of emotion, an understanding of mindfulness, body-awareness help support resilience, self-care and wellbeing?

Training gaps

Students felt the need to better prepare themselves for the potential stresses of professional practice. It is not widely enough acknowledged that a career in medicine can be emotionally as well as intellectually demanding. Is this indicative of a wider denial of the emotional labour that medical practice entails? Current systems for mentoring students and young doctors and for identifying problems early on were felt to be inadequate.

Transitioning to practice

A newly qualified doctor's way of adapting to the shift from the relative security of student-hood to the uncertainty of foundation year doctoring may shape their coping-style career-long. Insight into this transition and how medical schools can better support it could help ensure a safer and more sustainable career.

Emerging educational strategies

Among the promising evidence-based approaches considered were mindfulness training (Monash Medical School, Melbourne), Schwartz Rounds (introduced at University College London), SafeMed (University of Cork) and two models for professional development (Plymouth University and QML), see Appendix 1. Tea and Sympathy network is an example of an extra-curricular resource that could be extended to undergraduates.

RECOMMENDATIONS

- Develop ways of teaching about the personal and inter-personal challenges of a medical career.
- Develop curricular content to support resilience and self-care so that career paths become safer and more sustainable.
- Explore the feasibility and effectiveness of relevant educational interventions.
- Develop a research programme focusing on resilience-enhancing interventions and their outcomes.
- Explore the feasibility of delivering on-line and extra-curricular resilience resources to augment existing development curriculum.
- Support a network of medical educators to develop resilience and self-care interventions and work collaboratively on their delivery and evaluation.

FUTURE PLANS

The organisers (the University of Westminster Centre for Resilience) intend to seek funding to enable this network and to hold a further meeting in a year's time. develop online resources, share information and support further collaboration.

On 16 June 2016 the University of Westminster's Centre for Resilience brought together professionals for a symposium for those who teach about or support medical students' and young doctors' resilience (FY1s). This was, as far as we know, the first time people with this shared concern have come together – a milestone in itself. 65 delegates from 28 of the 34 UK medical schools attended the conference.

The delegates had a wide variety of backgrounds but all were involved in undergraduate education and had a real understanding of the issues facing students. The majority of educators attending were providing 'resilience training' in one form or another within UK medical schools often as part of the 'professional development' curriculum. A few were researching this area. Details of the participant's organisations and projects can be found in Appendix 2. Despite our having defined self-care and resilience quite loosely in the invitation letter, our call for interest attracted colleagues from almost all UK medical schools. Those attending included medical students, young doctors, senior doctors (both academics and clinicians), medical educators with a variety of academic backgrounds, mindfulness teachers engaged in medical education and one medical school Dean.

Prior to the workshop, we collected brief CVs of the individuals involved and short accounts of their contribution to their undergraduate curriculum. In the main, participants worked in the context of professional development programmes, largely using models of self-care and mindfulness training.

The day was initiated by a panel comprising two students and two FY1 doctors. Their opening presentation of the issues and problems they faced provided the benchmark for our day's work. A selected group of teachers then presented the novel ways in which they had been addressing the GMC recommendations concerning the teaching of resilience and patient centred care in their own medical schools.

This symposium was designed to allow maximum participation and engagement from participants; formal presentations were few in order to maximize space for discussion. In the morning, the World Café allowed us to range broadly over issues of resilience in the medical professions. In the afternoon the Open Space was designed so as to focus small groups on the issues arising from the morning which were seen to deserve most attention.

SYMPOSIUM AIMS

There were five central aims:

1. Bring together colleagues who are teaching medical students about resilience
2. Explore what is happening in this area in UK medical schools
3. Explore our willingness to work together
4. Develop some consensus about a way forward
5. To set an agenda for initiatives that an emerging network might take forward.

FUNDING AND CONFLICT OF INTEREST

This symposium was funded through the Westminster Centre for Resilience. Participants did not pay for attending and Westminster University funded the conference and the production of this report.

1. RESILIENCE: A CHALLENGE FOR MEDICAL SCHOOLS

A UK medical school's task is to train students for a lifetime in medicine. A significant part of their career is likely to be in the NHS, which justifies medical schools state funding. Therefore, a core product of their endeavour for the public good should be to ensure that students understand how to develop and retain the resilience that a twenty first century medical career demands of its practitioners. Extensive evidence suggests that student stress, burnout, and early career drop out are growing problems. This underpins the argument for these fundamental issues to be considered as a matter of urgency.

THE PROBLEM

The high incidence of burnout and depression in medical students and young doctors undermines their wellbeing and all too often damages their own physical and mental health — sometimes with catastrophic consequences. Doctors' are twice as likely as their patients to take their own lives, but women doctors are four times more prone to suicide than their female patients are^{1,2}. The evidence that medical students experience considerable and damaging levels of stress has been available for decades.^{3,4,5,6} Mental distress during medical school predicts subsequent problems and this individual personal-professional suffering, in many cases, impacts negatively on safety patient and care^{7,8}. It is known too that unwell medical students and doctors often fail to seek professional help.^{9,10,11,12} It seems that doctors perceive 'not to be coping' as something that puts medical careers (or self-esteem) at risk. In all probability the same obstacle is what makes medical students unwilling to seek help.^{13,14,15}

Most young doctors initially intend to enter UK training schemes after their two foundation years, but approximately 20—30 per cent of those completing their foundation years now plan either to take a 'career break' with no certainty of returning to practice, or intend to train

outside the UK.¹⁶ While there could be many explanations for these career choices, we cannot discount the possibility that many view a medical career in the UK's under resourced NHS as being an unwise choice.

Perhaps working life in the NHS will in time change for the better but in the meantime we need to consider what can we do to help students and junior doctors stay well. The need to do so needs to be considered in the context of an industrialised public sector healthcare system dealing with a million people every 24 hours. Those who provide undergraduate (and early postgraduate) education must reflect on how best to prepare the UK's future doctors to better deal with this increasing challenging workplace.

Research has consistently found that the proportion of medical students who experience high levels of psychological distress is significantly greater than that found in the general population. The personality traits of emotional resilience and to a lesser extent self-control, together with level of social support, are significant predictors of a wide range of indicators of both psychological distress and well-being. While confirmatory research with larger and better studies is essential, we suggest that the current data supports the need for emotional resilience-skills training should be embedded within medical school curricula. This could reduce the experience of psychological distress for medical students and perhaps provide resilience skills that could be utilised in their future professional development and practice of medicine.

Miles Bore, Brian Kelly,
Balakrishnan Nair.

Potential predictors of psychological distress and well-being in medical students: a cross-sectional pilot study

The students who introduced the day advocated some cultural shifts

- We need more of a positive praise culture. "Now, when someone says: 'Do you remember that patient...?' That triggers the reaction of: 'Oh dear what have I done wrong.'"
- We would like an 'it's ok to look after yourself culture' and an 'it's ok to say you struggle culture.'
- In the NHS and universities the rules are very strict, e.g. very little compassionate leave for a close relative's death. "Hard to hear as an 18 year old when your gran dies that you get only one day off."
- Several of us have found learning mindfulness-based approaches very helpful "it can overcome peoples' dread of interacting'.
- The students said; "We can't always recognise the stresses but we still feel them."
- Being a medical student is stressful in many ways. The strains are more often felt than they are fully understood and talked about. We need to be taught about these issues and what we could do about them (see Table 1).

2. DEFINING RESILIENCE

Resilience is a contested term within medicine and a difficult one to define clearly. Resilience can be defined pragmatically as the ability to make appropriate decisions while retaining emotional awareness and empathy, and to achieve this without too high a personal cost. Some protest that 'resilience' is a term denoting endurance at any price, implying a false expectation that doctors should soldier on no matter how great the challenges. In a similar vein, others feel that 'resilience' suggests those who 'lack it' are to blame.

The aim of good medical education is to create doctors who can deliver effective, safe care while retaining a professional, empathic, patient-centred approach. If these abilities are to be maintained throughout a medical career some attention to personal resilience will be required. Endurance, while at times essential in clinical practice, will not sustain a healthy or prolonged medical career.

The notion of 'building resilience' sparked debate about whether it simply entails bouncing back to a baseline state after a stressful event, or whether it involves adapting in positive ways to adversity and challenge. Clearly, such a learning process may require more than individual adaptation: organisations have to learn and change too. For instance, a group of individuals resilient enough to whistle-blow could be demonstrating their resilience by pressing for organisational change.

For those who feel uneasy discussing medicine's emotional challenges, and who dismiss the need to foster students' 'emotional intelligence', the need to build individual and organisational resilience raises uncomfortable issues. It has been suggested that; 'students just need to toughen up like we did.' Nonetheless, given the evidence that the practice of medicine is increasingly stressful and that the doctors' role is ever more demanding, the pressure for new approaches to training and professional development seems strong.

3. THE SYMPOSIUM' PROCESS FOR BUILDING CONSENSUS

WORLD CAFÉ

The *World Café* methodology is a flexible format for hosting large group dialogue. Its aim is to give all participants as much airtime for creative conversation, through a series of small group discussions. Participants met at small tables for three rounds of discussion, each table addressing common questions facilitated by one person who remains at their table throughout the exercise. At the end of each round participants changed tables to form new groups for the next question. At the end of the final round, the conversations are drawn together during a plenary discussion. The outcomes were shared on flipcharts but also as a simultaneously evolving graphic recording.

- There were then three rounds of 'world cafe' in the morning; theworldcafe.com/key-concepts-resources/world-cafe-method/ Shared personal and systems stories of resilience and lack of it.
- Addressing the issues of developing personal resilience and an individual level; what works and what is unhelpful?
 - What are the issues in developing resilience training in medical schools?
 - What interventions show promise?

OPEN SPACE

openspaceworld.org/files/tmfiles/2pageos.htm

Open Space methodology is an approach to participative discussion that allows participants to be self-organizing and to generate their own agenda. In the opening plenary, participants identified twelve priority issues, they felt had arisen from the morning's World Café and which warranted further focused attention. Participants then chose which of the first six topics they wished to contribute to and joined the appropriate table. The conversation was then chaired by the colleague who had nominated the topic in the Open Space plenary.

A second round of table discussions covered the second six topics.

- Changing organisational cultures
- Avoiding misconduct
- What enabled us on our own educational journey?
- Emotional education
- Connecting: culture, community, spirituality
- Components of a programme to foster resilience through body awareness
- Engaging students through the use of apps
- Vulnerability of teachers – how honest should we be?
- Who should teach mindfulness?
- How to manage a student in crisis
- How to make assessment less competitive
- Building resilience in first year students

4. CONTRIBUTING FACTORS: MEDICAL STUDENT EXPERIENCE AND WHY WE NEED TO CONSIDER THIS PERSPECTIVE

What came through from this highly experienced group of participants was the perception that many medical students share life experiences that may increase their susceptibility to burnout and depression. Medical students are generally selected are because of their exam grades; they tend to be intelligent but also highly goal-orientated, meticulous and competitive. These attributes contribute little to relationship making, but may well set students up for maladaptive perfectionism. In the context of current NHS language and culture, with very limited tolerance for 'mistakes', over-regulation and rising rates of defensive practice these character traits invite burnout.

Medical schools are undoubtedly competitive high-pressure environments. Hospital environments in their way even more so. The experience of first starting work on a ward comes to many as a shock.

"Med schools do not prepare us for the reality of the job."

"I remember witnessing my first death on a ward and having to move straight to the next patient without a minute to mourn."

We were grounded by the experience of students and what they felt they needed in order to become effective, compassionate, patient-centred, lifelong medical professionals.

"Do not expect people and yourself to get everything right. Teach them about your own learning through your own mistakes."

"Exposure to adversity creates resilience."

TABLE 1: IMPRESSIONS FROM MEDICAL STUDENTS

Personality traits of medical students
Highly intelligent, perfectionist, self-critical, ambitious, goal oriented
Science orientated, emphasis on rational thinking
Their likely life experience so far
Used to being top of the class
Medical school may be their first time in a highly competitive environment among 'equals'
Selected largely on the basis of their academic science results
Young, still developing their self-awareness and emotional intelligence
Medical school and hospital environment
Medical schools and hospitals are by their nature stressful environments.
Medical schools are typically set up to be competitive in their testing.
Hospitals are full of ill and dying patients, sad relatives and stressed staff with little time for reflection, guidance and praise.
"Med schools do not prepare us for the reality of the job."
Because their tutors are doctors, distress in students can become 'medicalised'.
Inadequate systems for supporting students and young doctors in distress and identifying early on those who actually are ill .
Observations about being a medical student, how could it be improved?
Many middle class children face less adversity in growing up and then do not know how to deal with it later in life. Will they be less resilient as a consequence?
Most people need some positive reinforcement, validation and praise. Equally if you receive constant systemic validation you do not learn to self-validate.
Relationships with senior colleagues can foster resilience. Is the personal tutor system working well enough.
Resilient students tend to seek feedback more and to make that kind of learning-relationship.
Do we need to train students in resilience to cope with the system or is there a need for system reform? Or both?
What is the right balance between changing the system and changing individuals' knowledge, values, beliefs and behaviour?
Does responsibility for resilience reside with the individual or should the medical school acknowledge resilience training as a central element in their duty of care.
Does change always start with the individual?

5. DEVELOPING SOLUTIONS

If we want to improve student wellbeing and resilience, decrease the incidence of burnout and depression and enable good, effective, professional and reliable doctors we must consider the environment medical students and young doctors learn and work in. We must enable them to become the effective and reflective professionals they aspire to be. This is not about teaching facts but mentoring personal development.

Medical schools are organised to comply with GMC requirements for training and competence. Within medical schools concerns about doctors' personal vulnerability and poor self-care have not as yet been much focused on. However, it is increasingly apparent that some of the educational attitudes and values that were fit for purpose 40 years ago will no longer meet the needs of those who must face the challenges of providing healthcare in twenty first century systems. This appears to be an international issue and not simply one that is UK or NHS based.

The systemic elements are 'themed' into four sections:

- The medical students' career path and selection
- Starting at medical school
- Training
- Qualification and transitioning to Foundation Year One

We considered the systemic issues and processes that govern student selection and to be relatively consistent throughout UK medical schools. The processes of GMC governance are designed to create a consistent level of education that results in safe effective and professional clinical training and performance across all UK medical schools.

Student selection

The average first year dropout rate in the 1990–92 UK cohort was 3.5 per cent but it had risen to 4.9 per cent for the 1998–2000 cohort. Intelligence alone does not necessarily predict a successful medical career. However, the evidence suggests that students with good A levels are less

likely to drop out. Arulampalam et al¹⁷ comment that relaxation of traditional academic entry requirements is likely to be to the detriment of medical schools retention rates unless accompanied by focused student support. Given the government's policy on widening access, Deans are increasingly broadening their selection criteria. It is probable that professional development and a 'resilience curriculum' may improve retention and progression.

TABLE 2: STUDENT SELECTION

Problem/issue	Recommendation
The admissions process largely favours science-educated individuals.	Broaden intake criteria beyond the purely academic. However, a shift away from traditional academic entry requirements would require appropriately focused student support and possibly a modified curriculum. Deans may be interested in developing this aspect of their 'offer' in view of government policy to widen access, particularly in this approach improve long-term professional retention, which currently show signs of deteriorating.

The mindfulness program at Monash University presents evidence over the last two decades that suggests it improved students' health and wellbeing.^{18,19}

"We want to be told about Mindfulness in the first year and that it is part of becoming a good doctor, not an additional thing for weird people."

TABLE 3: STARTING AT MEDICAL SCHOOL

Problem/issue	Recommendation
Students tend to come across Mindfulness for the first time usually in connection with a problem that stress-related or a mental health issue.	Offer Mindfulness courses pro-actively throughout to all students, tutors and staff. Can mindfulness be taught in a peer-led way?
Developing this process in major US medical schools appears to suggest this is a valuable approach (21)	Develop a simple curriculum for neuroscience of emotion, body-awareness, resilience, self-care, wellbeing. The book 'Time To Care' was recommended.
A student going through difficult times and who needs accessible help and sign posting which may not be obvious.	Build in support systems that are easy to access and have clinical relevance.
Students feel a lack of connectedness.	The possibility of creating extra-curricular safe spaces for mutual support is an emergent model. "Tea and Empathy" is an existing professional framework that offered to provide this nationally.
"If people feel they need safety in numbers [before reporting poor or unsafe practice] something is wrong."	Medical schools and hospitals must support a culture that tolerates (and even encourages) whistle blowing.
What would encourage Deans to institutionalise safe spaces?	Medical schools need empowering leadership <i>from the top</i> to create safe spaces for sharing and also for whistle blowing; It is very difficult for recommend that changes should occur without modelling humility and service throughout the training organisation.
The curriculum will be slow to change. Would it be possible to create alternative resources.	Apps as a delivery option for a resilience curriculum pre- and post-qualification. The possibilities for developing a parallel online accessible support network and a learning platform has potential for breaking down institutional hierarchies.

Table 4 Training

Problem / issue	Recommendation
Medical training is very science focused and knowledge based.	Take a more holistic approach and include life skills to cope with situations and people. Humanities in medicine is an area of growing interest where there are some excellent examples of good medical education practice.
The training culture seems very error-averse: having a mistake pointed out can be perceived as a personal attack on one's credibility and competence.	Teach how to own, reflect and learn from mistakes. Important for the teachers to be honest about their own experiences (and mistakes) when learning in this way.
Students seldom experience praise. Good practice is seldom noticed or highlighted. They are seldom asked to reflect on the factors (human and structural) that contribute to a team's working well.	Positive reinforcement is basic to learning. It is also a hallmark of a healthy work culture. We should be encouraging students to learn from good practice, and to expect to feel rewarded when things go well.
Doctors often model unhealthy work patterns. There is evidence that doctors do not treat themselves in the same way they recommend their patients treat themselves.	Making self-care and resilience an essential part of the curriculum would enable long-term capacity and commitment to a safe and rewarding medical career.
Students feel a lack of connectedness and caring.	Is there experience of a "peer support system" for students with those slightly senior to them? A buddying system for young doctors on wards has been suggested. Make it a progress requirement that medical students need to engage, recognising the value of relationships.
Why do students not speak up about their needs? Why is the curriculum not more student-centred?	It should be a key principle to involve students in developing courses and their presentation as they have a valuable view of what works for them and what they feel they may need.

TABLE 5 QUALIFICATION AND TRANSITIONING TO FOUNDATION YEAR 1

Problem/issue	Recommendation
Assessment is overly competitive and so is postgraduate medicine in general.	Swansea University is introducing a simple pass and fail framework. Outcome of the trial?
Moving from relative certainty as a student at medical school to uncertainty as a foundation doctor on a ward is a big step.	Facilitate the transition from pre- to post-medical school. Help students move from a mind-set where they feel they can control things and 'being right' to clinical uncertainty. How would this sit in our error-averse medical culture?

TABLE 6 CREATING LEARNING ENVIRONMENTS THAT ENHANCE RESILIENCE

Problem/issue	Recommendation
There is a lack of agreement about what constitutes or supports resilience.	Review the literature Achieve a consensus definition of resilience.
Resilience training may be used as a response to wider systemic problems.	Take a proactive approach. Demonstrate the additional, positive effects of increased individual resilience on creativity and effectiveness (Schwartz rounds for instance).
Current medical culture seems ambivalent about the role of compassion and suspicious of self-compassion. These ideas might be better embedded into the process of training and professionalisation.	As well as making self-care and resilience learning part of the curriculum, senior staff need to enable an atmosphere of self-compassion for themselves and those around them.
Certain events, e.g. seeing a death (perhaps even seeing a patient dying in the first week on a ward) can have a profound impact. Secondary traumatisation is probably more common than we realise. We should recognise that having feelings and sometimes being disturbed by certain encounters is normal and does not imply a mental health problem. Adequate student support and supervision should be available for those who need it.	Support should be accessible during major events such as witnessing a death, or a traumatic incident. Greater awareness of the emotional impact of these events among senior staff and preparedness to speak out about it will help achieve a more humane training environment. The advent of undergraduate Schwartz rounds would be a significant development.
Admitting that the emotional impact of difficult encounters is stigmatised.	Students need to be offered the space and language to articulate feelings of fear, sadness, stress and guilt. It would help if senior staff and faculty modelled emotional intelligence. Acknowledging that these emotions are shared and learning how to recognise and safely manage them would encourage students to validate their own and others' emotional needs. Students need the tools and "permissions" for self-care.
Interest in a psychiatric or GP career is stigmatised.	We need to address stigmatising attitudes around psychiatry. This means not ridiculing people for wanting to go into psychiatry and understanding that mental and physical health (and illness) are intimately intertwined. The culturally higher status of hard sciences and is not balanced by respect for those who choose the more uncertain territories of psychiatry and family medicine.
Mental health issues are still stigmatised and felt to threaten career development.	Expressing feelings or experiencing distress are not synonymous with having mental health problems. This false assumption exists in medical education and a counter-cultural attitude to emotions and the realities of human suffering could be modelled by emotionally intelligent and reflective faculty members. Students who do develop frank mental health difficulties need to be identified and helped as early as possible.
Lack of a supportive environment and feeling of belonging; people manage distress better if they are in a reflective supportive environment.	Consultants and senior faculty can improve the overall atmosphere on wards by holding team breakfasts for example at hand-over point and similar initiatives that cultivate good working relationships and make junior doctors feel more part of the team.
Who are the wise people in an organisation to go to?	Designated mentors should be invited into faculty and considered important to student retention.
Learn from already established good institutional practice.	Schwartz rounds. "We all be all patients eventually". In an organisation that is genuinely interested in learning successes and failures should be shared openly. This allows individuals, teams and whole organisations to develop better insights into what they do and how they work.

6. WAYS FORWARD

TABLE 7: RECOMMENDATIONS WE COULD IMPLEMENT IMMEDIATELY

If senior doctors were to admit that their work has an emotional impact, they could act as role models and be more authentic and transparent with juniors. Those of us who can manage to do this need to reflect on what has enabled us to achieve this.
Senior doctors need to model the behaviours we seek in others that will enable attitudes, behaviours and practices to be the best they can be.
We should be more honest with students about what the job is and prepare them for the leap into an environment where strong emotions, difficult encounters, and witnessing trauma are part of daily life. A resilience curriculum should consider ways of acknowledging and tackling this reality and resourcing students develop appropriately.
The medical curriculum should embrace the many humanistic challenges that doctoring requires. In order to accept and respect the humanity and limitations of our patients, we have to come to terms with our own. On this journey, learning to accept uncertainty and the inevitability of mistakes will be crucial. How to deal in healthy ways with risk and how to learn to live with error and failure should be included in the curriculum.
Those who teach medicine need to model self-compassion and the great value of self-care as a foundation for a sustainable career.
We need to be authentic.

"We heard a story about a macho surgeon who went into the operating theatre to harvest an organ, with his team all pumped up. A teddy bear fell on the floor and the surgeon realised that he was about to harvest an organ from a small child."

7. CONCLUSION

We have considered our initial aims for the symposium and the issues we hoped to address. We believe that we have largely fulfilled these hopes and expectations. We wish to continue to work together and to meet and develop our ideas. We believe we have identified some key issues that may be important in selection and retention of medical students in the current climate. Medical schools are largely publically funded institutions in the UK and therefore have an obligation to deliver safe and effective doctors to serve a growing public need. We believe that self-care and insight into the psychological challenges of good medical practice will become essential survival skills for clinicians that will have to deal with an aging and medically complex population.

We have identified evidence that medical schools should consider in relation to their selection procedures. It suggests that current medical education is associated with a high degree of student distress, burnout and rising attrition rates. We have also provided some sound preliminary evidence that it may be possible to intervene to improve resilience, clinical competence and professional wellbeing through programmes such as the SAFEMED programme, Schwartz rounds, and undergraduate resilience and life skills training. If medical schools are to consider 'training for a lifetime in medicine' as the basis of core responsibility towards the tax payers who provide their state funding and a core product of their endeavour for the public good then these are fundamental issues that must be taken seriously.

Some of the initiatives discussed or presented can be further developed as elements of the core medical school curriculum. All of them are currently embedded somewhere in a UK medical school but these examples of good practice are not yet widely enough known or accepted. We see the project of promoting the importance of student wellbeing and resilience as being in line with current GMC policy. A wider understanding of their relevance and the

broader implementation of appropriate programmes and research in this crucial area would enhance the image of medicine as a career that is not only exciting and rewarding but also self-compassionate. As the profession adapts to the demands of twenty-first century medicine, and with recent political storms perhaps reducing its appeal, medical schools too must make adjustments.

We have started up a dialogue. We hope to have inspired activity and the desire within the broad UK medical education community to support students in their development. We have initiated an on-going, collaborative and (we hope), productive national conversation.

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APPENDIX 1 PRESENTATIONS

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Convenor Action for NHS Wellbeing
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1. CURRENT STATUS OF SELF-CARE TRAINING IN UK MEDICAL SCHOOLS

Miss Eunice J Minford MA FRCS Ed.
 Consultant general surgeon and honorary lecturer, Queen's University, Belfast.

Dr Chris Manning MRCGP
 Convenor Action for NHS Wellbeing

INTRO AND METHODS

- Need for self-care – addiction, suicide, burnout
- Informally aware of different programs
- Establish attitudes towards and current status of self-care training in UK medical schools
- Survey monkey questionnaire to 34 medical schools Deans / head of Med Ed.
- Follow up email one month later
- Quantitative and Qualitative

Things to go	Things to stay/add
<ul style="list-style-type: none"> • Didactic professionalism • Excessive assessments • Culture that disclosure leads to FPI • Rationalise curriculum 	<ul style="list-style-type: none"> • Resilience training • Healthy Dr – healthy pt • Values /self-awareness • Mindfulness • Talks by sick Drs • Drug & alcohol misuse • Student stress • Rel with counsellors • Medical humanities • Staff training

'Self-care should be evident throughout every element of the course, present in every teacher and spoken about amongst peers. We need a culture change where students come to self-care through their own choice rather than have it forced upon them in order to make them 'better' doctors. Self-care should be strategies that can help students feel more at ease with themselves in the present, for themselves and their own wellbeing and pleasure in life'.

Conclusions

- Most MS have some form of self-care training – widely disparate, no uniformity
- Divided re effects of patient first and benefits of Dr first
- Need for true self-care education for those in charge of medical education to understand and appreciate the role of self-care in personal health and wellbeing, empowerment it brings to address toxic environment and ability to enhance patient wellbeing.

RESULTS

- Response rate 44 per cent (n=15). 93 per cent offer something
- 80 per cent agreed quality of care given by Dr depends on quality of self-care; only 67 per cent agreed that self-responsibility/daily life choices was key to health and wellbeing
- Two/three felt no harm from GMC reqm to put pts first but 73 per cent felt self-care could address current rates of burnout etc
- Completely divided re: Dr's first concern to self-care 53per cent score five or less & 47 per cent score 6 or more. Wt Avg 5.5. CD to CA
- 87 per cent (n=13) needed to improve wellbeing.
- 73 per cent (n=11) self-care needed to advise pts on self-care & turnaround burnout etc
- 60 per cent feel should be mandatory – currently 40 per cent
- 20 per cent nationally agreed curriculum
- Concerns – a) another 'to do' b) student engagement c) toxic systems and environments

2. SHAPING THE UNDERGRADUATE CURRICULUM TO PROMOTE WELLBEING AND RESILIENCE

Professor Ania Korszun, PhD, MD, FRCPsych.

Professor of psychiatry and education, Barts and The London School of Medicine, Queen Mary University of London

University league tables for medical schools

Queen Mary College
 2012 bottom of the table
 2017 number 2 (below Cambridge)



3. THE MONASH HEALTH ENHANCEMENT PROGRAM (HEP)

Dr John Hales BSc, PGCE, PhD.
Senior lecturer and the health enhancement programme lead, Leicester Medical School

- A resilience building course for first year medical students.
- Introduced as a compulsory, assessable course at Monash Medical School, Melbourne in 2002, by Dr Craig Hassed.
- Now delivered across the Monash campus.
- Comprises a mindfulness-based stress management course, embedded in a modified lifestyle programme
- Lectures (highly evidence-based) and six tutor group sessions
 - **E**ducation
 - **S**tress management
 - **S**pirituality
 - **E**xercise
 - **N**utrition
 - **C**onnectiveness
 - **E**nvironment

Outcomes of HEP for 2006 Monash Medical Students			
Symptom Checklist comprises nine subscales and an overall score (GSI)			
Symptom	Time 1 (N=239)	Time 2 (N=162)	Normative ref. adolescents
Somatization	.62	.49	.61
Obsessive Compulsive	1.13	1.01	.91
Interpersonal sensitivity	.99	.85	.99
Depression	.91	.77	.80
Anxiety	.65	.54	.66
Hostility	.67	.50	.88
Phobic Anxiety	.33	.25	.39
Paranoid Ideation	.75	.59	.91
Psychoticism	.67	.50	.63
Global severity Index	.78	.64	.76
Number of Positive Symptom	38.7	22.7	39.81
Intensity of Symptoms (Distress Index) ¹	1.63	1.53	1.57

¹ Hassed C, de Lisle S, Sullivan G, Pier C. Adv Health Sci Educ Theory Pract. 2008 May 31. [Epub ahead of print]

4. SAFEMED SOLUTION: KEEPING DOCTORS WELL – BUILDING SAFETY FROM WITHIN

Dr Margaret O'Rourke, MA, MApp Sci, PsychD, C.Psychol.
Director Behavioural Science and Psychological Medicine, School of Medicine, University College Cork

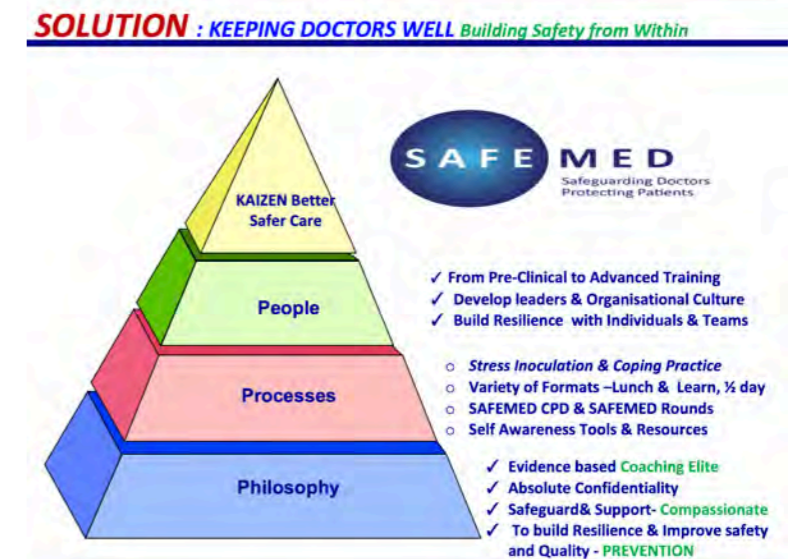
- Students' health falters in medical school.¹
 - Alcohol / drug consumption increases. Later 3Ds
 - Stress incr, Awareness low, warning signs frequently missed
 - Fatigue increases, Socialization and exercise decrease,
 - unchecked Stress is safety enemy Number 1.
- Depression is related to poorer health habits.¹
- Environment has low tolerance for fallibility Empathy & Compassion "Maladaptive behaviours" form if not corrected.²
- Going to work when sick, self-prescribing/medicating
- Guilt and Perfectionism, Low EI, Stress unchecked
- Poor Habits: gambling, poor sleep hygiene, and under use of medical care.
- Internships can further erode wellness.^{3,4}

What medics have said about SAFEMED

How can we together Act to Protect ourselves and our colleagues?

- This programme meets unmet need
- (EK – Great Ormond Street)
- SAFEMED transforms work & life in medical practice (CF, Cleveland Clinic)
- I am leaving the moan zone...NOW !
- (EE Harvard Medical School)
- Time invested in SAFEMED will be well spent-it will benefit you those close to you and your patients! (GS UCC)

SOLUTION: KEEPING DOCTORS WELL Building Safety from Within



SAFEMED Solutions: Skills are Measurable, Teachable, Sustainable

SAFEMED Solutions : Skills are Measurable, Teachable, Sustainable



SAFEMED builds doctors' health, wellbeing & resilience
EVIDENCE BASED

5 TOWARDS A HOLISTIC APPROACH TO WELLBEING – TOOLKIT

Dr Theresa Compton MB, BS, BSc, FHEA
Lecturer in Biomedical Science.
Lead for pastoral care, Plymouth University Peninsula School of Medicine and Dentistry

Dr Seema Bhandari BSc, MB,ChB, MRCP, MRCGP, DRCOG, DRSRH
Academic tutor, Plymouth University, Peninsular School of Medicine and Dentistry



6. INCORPORATING SCHWARTZ ROUNDS (SRS) INTO THE MEDICAL SCHOOL CURRICULUM AT UCL TO ENHANCE COMMUNICATION AND COMPASSION

Dr Faye Gishen BSc MBBS FRCP SFHEA
Consultant in palliative medicine, Royal Free London. Academic lead for clinical and professional practice, UCLMS



Student wellbeing is a complex and multifactorial issue. Whilst wellbeing correlates with better academic performance (Ansari, 2010). Recent surveys by the National Union of Students revealed that eight out of ten students experience mental health problems whilst studying, but 50 per cent don't seek formal help. In medicine, this impacts on career development with doctors own stress and illness being linked to poor communication with patients and colleagues, medical errors and burnout (Shanafelt, 2002). Many doctors are unprepared for some of the personal demands of the job, such as time management, communication and managing their own health and stress (Monrouxe et al, 2014).

At Plymouth University Peninsula Schools of medicine and dentistry all students have access to student mentors and reflection is encouraged. All students have access to psychological work in the form of university counselling services. Mindfulness training and Schwarz rounds were previously only available as an introductory session, or only for a few students. The toolkit is currently informing and shaping our approach to student wellbeing and we expect future developments to be based on these ten strategies.

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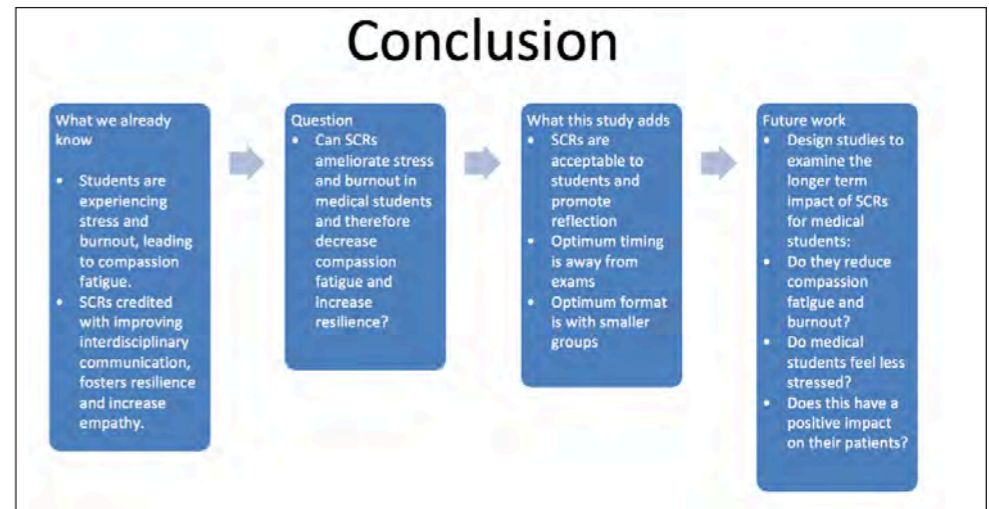
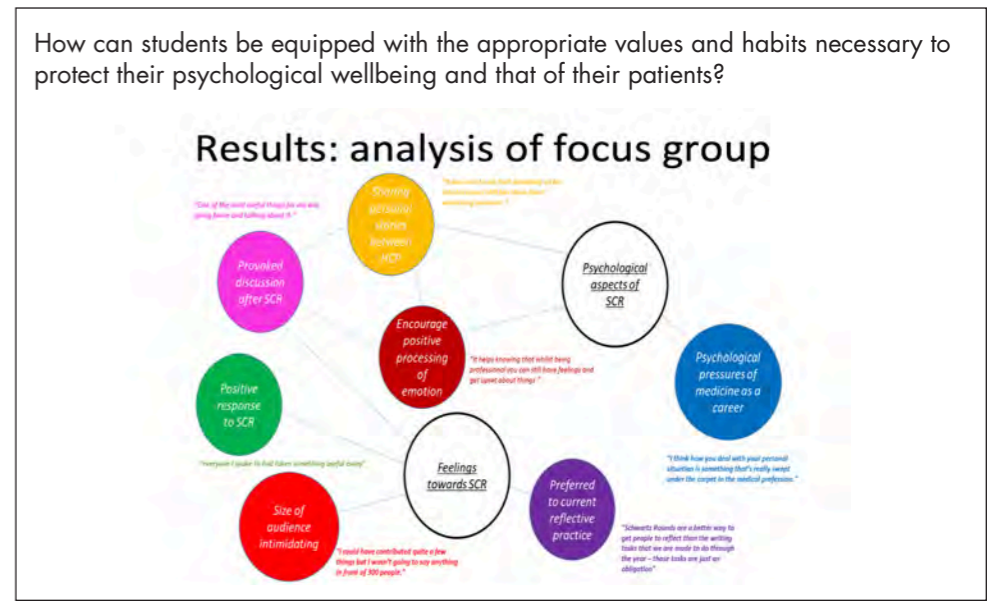
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Michael S. Krasner, MD, Ronald M. Epstein, MD, Howard Beckman, MD, Anthony L. Suchman, MD, MA, Benjamin Chapman, PhD, Christopher J. Mooney, MA, Timothy E. Quill, MD
Zwack J, Schweitzer J If every fifth physician is affected by burnout, what about the other four? Resilience strategies of experienced physicians. Acad Med. 2013 Mar;88(3):382-9.
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- Studies in the US¹ and UK² have found that SRs lead to an increase in
- staff confidence in handling sensitive issues
 - a greater understanding between HCPs of one another's roles
 - empathy with patients
 - confidence in handling non-clinical aspects of care
 - openness to expressing thoughts, questions and feelings
 - mentioned in Francis Report: positively impact patient experience
 - Burnout is already prevalent among medical students⁴
 - A significant decrease in empathy levels is reported to take place during medical school⁵
 - Stress and burnout are significant predictors of empathy^{6,7}
 - Social support ameliorates stress in medical students⁶
 - With a clear relationship between the well being of staff and patients' wellbeing⁸

Key findings

- Large majority of students:
- found SCR helpful
 - would attend again
 - thought they gave insight into how others feel
 - thought they promoted reflection
 - think they should form part of curriculum



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7. GRAPHIC RECORD OF THE DAY

Karen Mortimore
graphic rapporteur



APPENDIX 2

PARTICIPANTS AND THEIR PROJECTS

ABERDEEN

FIONA PARKER

Fiona Parker has 17 years of clinical experience as a GP and initially developed her interest in medical education at Portlethen Medical Centre achieving GP Trainer status in 2003.

She has worked for the University of Aberdeen as a Clinical Tutor since 2009 and currently combines this role with regular GP clinical sessions.

She completed her Postgraduate Certificate in Medical Education in 2011 and was Deputy Year Two MBChB Coordinator for five years.

In 2015 she obtained the role of Lead in Clinical Communication/ Professionalism in the Institute of Education for Medical and Dental Sciences in Aberdeen.

Fiona is involved with the delivery and development of undergraduate teaching of professionalism in Aberdeen. She attended the UK Council of Teachers in Professionalism meeting in 2016 and is a member of the Resilience group.

2016 Outline of Resilience

Related Teaching at the University of Aberdeen Medical Institute of Education for Medical and Dental Sciences.

Free mindfulness taster sessions were provided for medical, dental and physician associate students between April and June 2016. These were voluntary. The following provides details of the seven hours of core undergraduate curriculum teaching on resilience to date.

Year 1 MBChB

Lecture format to whole year group – “How to Succeed in Medicine?” and consists of several presentations from staff members including topics such as Health and Wellbeing, stressing the importance of registering with a local GP and the GMC health requirements for medical students.

Peers from the year above give their experiences and tips for junior year one students.

Year 2 MBChB

As part of the Professional Practice Block teaching the year two students have a one and a half hour small group facilitated tutorial on Resilience and Wellbeing. This teaching involves:

- Defining what resilience is and the behaviours supporting resilience e.g. time management, reflective practice and good work-life balance.
- Asking for students’ experiences and how they demonstrated resilience.
- Asking students what they know about the presentation and management of stress related symptoms.

Introducing mindfulness as a technique for students to use to reduce stress and enhance their performance. Providing them with resources eg. [mindfulness for students.co.uk](http://mindfulnessforstudents.co.uk) and Mindfulness: Finding Peace in a Frantic World.

Year 3 MBChB

A seminar (three hours) which introduces the use of non-technical skills in clinical settings to promote one’s own health and wellbeing. Medical humanities block has a mindfulness course as an option for some students.

Year 5 MBChB

The Professional Practice Block teaching at the beginning of Year Five has a one-hour timetabled lecture on Stress and Conflict – this covers the ability to recognise the symptoms and signs of stress in themselves and others and introduces students to conflict and how it can affect effective team working in the workplace.

BIRMINGHAM

JUNE JONES

I am a Senior Lecturer in Biomedical Ethics and Law with a National Teaching Fellowship from the Higher Education Academy, 2015. My primary areas of research are in religious and cultural diversity and medical education. I am the MB ChB Lead on Equality and Diversity and play a key role in supporting students, as Year Tutor on the MB

ChB for six years, as College Head of Graduate Student Support since 2008, and as College Lead on Religious and Cultural Diversity since 2008. In 2010 I was awarded the Birmingham University Teaching Fellowship in recognition of my work to enhance diversity opportunities within the College of Medical and Dental Sciences. I combine my research interests in religious and cultural diversity and medical education. I am Chair of religious and Cultural Beliefs Forum, a voluntary forum for staff and students to debate issues that relate to the health needs of patients and beliefs of colleagues. I lead the Religion and Health theme at the Edward Cadbury Centre for the Public Understanding of Religion.

ALI GRAY

I am a consultant psychiatrist, leading the Mental Health Liaison team in the Hereford County Hospital. I have a long interest in religion, spirituality and health and am an ordained Anglican Church minister. Having started out as a natural scientist at Cambridge University, I transferred into medicine and then trained in psychiatry in the West Midlands. I worked for several years in the National Deaf Mental Health Service in Birmingham, leaving there in 2006 to train for ordination at Queens Foundation for Ecumenical Theological Education. After being ordained in the Church of England I returned to psychiatry in 2010. Having worked with the RAID team in Birmingham I set up and continues to run the Mental Health Liaison team in Hereford. I am Honorary Research Fellow in the Edward Cadbury Centre for the Public Understanding of Religion.

Resilience Project at University of Birmingham

In this project we are replicating the longitudinal study currently being undertaken in Lübeck, Germany on factors in medical student resilience. We are adding extra questions about spirituality and religion as our cohorts report high levels of religiosity and

spirituality across a diverse range of religions and ethnicities.

The group in Lübeck Germany are undertaking a longitudinal study of medical students with a comparator group of STEM (science, technology, engineering Mathematics) students. They are looking at various factors which may influence resilience, (sports, music, relaxation, voluntary service) including ‘Activity in a religious community one hour or more per week’). They have found that around nine per cent of medical students and four per cent of STEM students report such involvement, which is very low compared eg. to Queens University Belfast, where 93 per cent of fourth year medical students self-identified as ‘religious’ and 80 per cent reported they pray regularly.

This will be mixed methods research project, collecting data using questionnaires and interviewing a small group of students who self-identify as demonstrating high religiosity at initial assessment. They will be compared to students who identify as being a regular member of teams, such as sports teams, orchestras etc. We want to investigate whether it’s belonging to a religious or faith group per se, or whether its belonging to a cohesive group that increases resilience. Our purpose in investigating this is to raise student awareness about the ways in which resilience can be built into life style choices they are already making.

Students will be given questionnaires during first, third and fifth year at medical school. We will use four self-assessment questionnaires, taking in total less than forty five minutes to complete. The questionnaires are:

- Quality of life: WHOQOL-SRPB- brief. This measures physical health, psychological
- health, relationships and environment, spirituality, religion, and personal beliefs
- Duke University religion (DUREL) FIVE items on religion and its significance to the individual.
- General Health Questionnaire (GHQ-12). 12 items.

CONNOR BROWN

I am a final year medical student at the University of Birmingham. I spent my medical elective shadowing Robin Youngson, learning more about his efforts to rehumanise healthcare. Since returning, I have helped set up a ‘medics’ mindfulness’ society in an attempt to support student wellbeing. I am really interested in how compassionate care can improve patient outcomes and also doctors’ own wellbeing. I believe medical schools are in a unique position to support wellbeing and prevent burnout in medical students and doctors by fostering positive habits in students from the outset. In August I will be starting as a junior doctor in Oxford, and hope to put some of what I’ve learnt into practice on the wards.

BRIGHTON

CRAIG BROWN

Retired General Practitioner, past President of UK Healers, and former the Chairman of the British Holistic Medical Association. He was a part of a group that published the training programme, ‘Values in Healthcare, a Spiritual Approach,’ (VIHASA) in 2004 and has facilitated VIHASA courses in this country and overseas. He has been running an SSC (student selected component) for third year medical students at Brighton for the last nine years and gives a lecture on stress to all first year medics.

The SSC is a self-selected course of eight three-hour sessions for third year medics. There are six to twelve students in each group. In the past there were four SSC’s per year and now are two. The SSC was known as ‘Holistic health’, and more recently as ‘Resilience.’ The aim is to help the students deal with current issues and be equipped for the challenges of being a doctor. The course is a facilitated group that is safe and confidential for the students. To some extent they have a say in the content. It usually starts with some silence and reflecting on what has gone well in the week and what were

their challenges. We discuss and do exercises on self-care, values, group work, communication and health. We practice mindfulness and meditation. Typically there are session on yoga, hypnotherapy, and visits to try out alternative therapies. On good days we walk on the nearby Brighton beach. We often do some art, and creative writing.

The course is assessed by writing a reflective journal or an essay of 1,500 words. A student from Brighton has won five times out of the last eight in the annual essay competitions in the Journal of holistic healthcare. The resilience SSC is not available for all students. More recently the students have helped with feedback on a podcast for medical students called ‘mindfulness for everyone.’ soundcloud.com/mindfulnessforeveryone/ses

ELEANOR CROSSLEY

Eleanor is currently a foundation year one doctor at the Royal Sussex County Hospital, Brighton, on an Academic Management and Leadership training programme. She is also the College of Medicine Student Engagement Manager and organises its popular annual student conference. Eleanor graduated from the University of Birmingham in July 2015 with two distinctions and a Wellcome Trust INSPIRE Prize in Research. During her time at Birmingham she also undertook an intercalated BMedSc degree in Public Health (2012). She is passionate about research which she has undertaken in the UK and abroad, and has a strong interest in multi-disciplinary working.

BRISTOL

ALICE MALPASS

Currently an NSPCR Mid-career Research Fellow and MBCT tutor at the School of Social and Community Medicine at Bristol University where she combines research and teaching in Mindfulness. Alice has a longstanding meditation practice within the Tiratna Buddhist Order and has

worked in mental health research for the last decade. Alice trained in mindfulness based approaches at the Centre for Mindfulness Research and Practice at Bangor University (2009–12). Alice has instigated mindfulness training for medical students at Bristol and is involved in both delivering mindfulness courses as well as supervising students interested in taking a mindfulness elective in years four and five of training.

Alice was invited to give evidence at the All Party Parliamentary Group (APPG) inquiry in November 2015 on the role of mindfulness training in medical education. She is part of a working group at Bristol Medical School to implement GMC recommendations on supporting students mental health needs. She is involved in developing the helical theme on self-care and resiliency in the new curriculum to be launched in 2017.

Since 2011 Bristol medical students have been able to train in mindfulness-based approaches. There are two pathways through which medical students can currently access mindfulness training at Bristol: either as part of their core curriculum in year 2 as an opt in self-selected component (SSC), or as a 'referral course' which is open to all year groups. Students at Bristol are taught the manualised eight week curriculum in Mindfulness based cognitive therapy (MBCT). In addition to this, SSC students are taught about clinical applications of mindfulness. Attendance on both the SSC and 'referral courses' has remained steady and is sometimes over-prescribed. Referral courses are offered twice a year, meaning access is limited to a small number of students but attendance is extremely high, sometimes 100 per cent for the whole group for the entire eight weeks. One-off sessions on mindfulness are also offered across year groups

- Wellbeing days offered with taught workshops
- Whole person care: one hour lecture/one hour seminar
- SSC: 24 hours taught (plus home practice and assignment)

- Referral MBCT (16 hours taught plus home practice)

We offer both voluntary and compulsory, compulsory aspects are shorter in terms of taught contact time.

CAMBRIDGE

RACHEL WILLIAMS

Rachel trained in medicine at the University of Edinburgh taking an intercalated degree in Biochemistry and a year out working in the department of Biology at MIT.

Following early clinical training, Rachel undertook a research fellowship within the Dept Paediatrics with Professor David Dunger. The project used physiological techniques to evaluate the effects of growth hormone on insulin sensitivity in type 1 diabetes. Thereafter she completed her training in general paediatrics in the Eastern Region and in paediatric endocrinology as a clinical lecturer in the Department of paediatrics between 2006 and 2012. She was appointed as a Consultant in Paediatric endocrinology and diabetes at Addenbrookes hospital in Cambridge in 2012.

Since 2014, has been the director and senior examiner for the clinical communication course for clinical medical students at the university of cambridge and is also the component chair for the final MB exam (part II) in paediatrics which students sit in their penultimate year.

Clinical interests include severe insulin resistance, lipodystrophy, adolescent polycystic ovarian disease and transition to adult services. Research interests include the effects of insulin treatment on weight gain in young women with type 1 diabetes.

CARDIFF

JONATHAN COE

My background is in mental health services, including working in community settings and running advocacy groups. I have been working for organisations concerned with professional conduct

for 13 years and have specialised in working with professionals dealing with the aftermath of misconduct issues for the last six years. I run intensive small-group remedial programmes on professional boundaries, probity issues and inter-professional relationships as well as courses on Values and Listening. I have been working with Cardiff University Medical School for the last three years, including work with a large group of students facing disciplinary issues.

The course is a work in progress – a two hour slot offered in year three is an integrated part of part of the faculty's professional development course/teaching programme. So far it has covered boundaries and self-care, core personal and professional values, vulnerability in practice and avoiding/noticing assumptions.

CORK

MARGARET O'ROURKE

A practicing forensic and clinical psychologist, author and academic. Director of the SAFEMED Programme at School of Medicine UCC and SAFEVET with the Veterinary Council of Ireland, Margaret is passionate about safeguarding and building wellbeing and resilience with health professionals. She has designed, delivered and evaluated programmes in mental health, Addictions, psychological well-being, risk, safety and stress inoculation training for patients, public and professionals in high intensity people services such as Medicine, Veterinary Medicine, health services, police, prison and probation service.

THE SAFEMED PROGRAMME: Safeguarding Doctors, Safer Patients

The SAFEMED Programme is an evidence based stress management, wellbeing and resilience programme that runs over eight hours and has compulsory elements; these are embedded into the all the five years of undergraduate training. The programme uses Cognitive Behaviour Therapy (CBT)

tools, developed to promote emotional health and proactive self-care for healthcare professionals in training and in practice.

SAFEMED utilises stress inoculation training concepts. Coping skills taught in the resilience training employ CBT techniques (cognitive behavioural therapy). CBT is a systematic approach to building healthy thinking and emotions.

SIT consists of three phases: Awareness and conceptualisation of stress, coping skills Acquisition, and Application/exposure. Consistent with the way vaccines promote the production of antibodies, the exposure component of SIT builds and strengthens coping through the development of personal support plans.

The intervention can be delivered in a variety of formats including lunch and learn, half day or full day sessions. The SAFEMED framework and tools are tailored to the individual and are taught in such a way that they are generalizable and transfer easily and safely to patients, peers, future work and home life.

Essentially what SAFEMED does is provide a methodology to promote health, well-being and optimal functioning. The programme has been delivered to more than 4,000 doctors and students.

EDINBURGH

Students are offered optional workshops focused on emotional resilience. Two workshops are linked to neuroscience teaching in year two, and two workshops are linked to psychiatry teaching in year five. Workshops are delivered by the Foundation for Positive Mental Health (a registered Scottish charity). Content includes the neurobiology of distress and recovery, and all students receive free access to audio materials teaching relaxation, mindfulness and visualisation. The aim is to help students develop their own capacities for personal resilience, and to help their understanding of how to support others experiencing stress. In addition, short pieces of reflective

writing are submitted, once each year, and are intended to enhance conversations between student and personal tutor. Students choose from a carefully selected range of blog posts (example here), and write a reflection based on their response to the blog post. This activity is compulsory and connects students to the writing of a wider community of doctors who publish narrative accounts of their experiences balancing the personal and professional dimensions of working in medicine. The aim is to help students make sense of their own experiences as they become medical professionals, and to ensure their development is supported by a senior colleague.

Workshops each last two hours; writing task plus tutor meeting equates to approximately five hours across each academic year. Workshops are optional; writing task is compulsory. Workshops are offered in years two and four; writing tasks are required in years one, two, four and five.

EXETER (UEMS)

MARIANNA NEWTON

I have an interest in neuropsychology and have worked with acquired brain injury and also still work as a Psychology Research Assistant for neuro-cognitive research. Since working at Exeter Medical School I have developed an enthusiasm for wellbeing within higher education. I love performing arts and I am in a performance of *Grease* this year. Throughout my time at Exeter I have engaged in many training courses that focus on mental health awareness and the promotion of positive functioning. The nature of my work means that these sorts of courses influence my everyday practice; my role adopts an approach which employs strategies to foster personal resilience, reflexivity and emotional flexibility. I have worked with first year medicine students on a session that focused on dealing with and recognising

stress. The presentation is aimed at teaching the signs and characteristics of stress, providing tips on management and self-care as well as introducing a holistic approach to psychological and physical wellbeing within their chosen career. This encourages students to recognise the warning signs and the positive uses of stress and enables self-management. I have set up hourly workshops for students dealing with exam pressure, confronting perfectionism and coping with procrastination. These sessions offer strategies and demonstrate techniques that student's often find complements their training. My work adopts a ubiquitous teaching approach to students of all years; it interacts and is consistent with welfare provisions within UEMS and beyond. This system aims to support the student's personal and professional development.

GLASGOW

GENEVIEVE STAPLETON

I moved into my position as a University Teacher at the University of Glasgow Medical School six years ago, after a career as a cell biologist.

My interests in medical education include innovation in teaching and learning, assessment of professionalism, and supporting the student transition from secondary school into Medical School. I am primarily responsible for 'phase one' which is the first 13 weeks of the first year. In addition to delivering the curriculum, I see this period as an opportunity to facilitate the transition to medicine and establish important skill sets (study skills, life skills, etc) in students that will enable their progression throughout medical school and beyond.

The university offers a number of courses throughout the academic year to students, such as Compassionate Mind Training, How to cope with exam stress, and Mindfulness-based stress reduction. The Medical School at Glasgow is in the process of designing a 'resilience

programme' to run alongside its established welfare services programme.

Currently, the medical school has just initiated a Peer Support Programme where students can either train as a peer supporter or use the service. Peer Support Programmes are primarily aimed to provide support and guidance for students however such programmes are also important ways of developing life skills from peers. We also include lectures (such as Life Skills) during Preparation for Practice, which highlight the issue of 'burnout' in junior doctors and the importance of a work/life balance. This also covers situations and coping strategies where the pressures of practice will be challenging.

Our long term plan is to integrate 'wellbeing' sessions across each of the five undergraduate years that teach students how to look after themselves. We plan to place particular emphasis on years one and two, where resilience skills and approaches to will be taught alongside the curriculum.

Any lecture sessions delivered at Glasgow are viewed as compulsory attendance however the Peer Support Programme is run on a voluntary and confidential basis.

HULL/YORK

POONAM BAGGA

I am an ophthalmic surgeon and have been a Consultant for 17 years. My interest in Mindfulness spans a time period of over a decade. I currently offer Mindfulness training to the hospital staff on regular basis and having seen the benefits of it personally in addition to the burgeoning scientific evidence, I am convinced that it could alter the mind set of a lot of medical students.

I am also a Director of clinical studies for HYMS for the Northern Lincolnshire and Goole NHS Trust. In that role, I am in close contact with a fairly large number of students and am aware of the pressures they are under. Resilience is a core

component of Mindfulness as it teaches you a wider world view of different situations. I am currently engaged in obtaining a Certification in teaching Mindfulness from Centre for Mindfulness, University of Massachusetts. Already there are medical schools in the USA and Australia where it is part of the curriculum. With Mindful Nation UK being the current policy, this would be an appropriate time to incorporate in to our resilience training for medical students. It will have far reaching beneficial consequences as these future doctors will be taking these core principles in to managing their patients.

At Hull York Medical School we are keen to develop ways to support students and help them develop resilience.

Students are assigned a Problem Based Learning tutor in phase one, who also acts as a personal tutor for the first two years of study. Tutors provide an extremely important source of support for students.

In preparation for full time clinical placement, all year three students attend workshops on 'resilience' and 'managing emotionally challenging encounters' at the beginning of the university year. These workshops encourage student to develop insights into these areas and to consider how they might manage and prepare for clinical encounters that could arouse in them very strong, potentially disruptive emotions. Incorporating principles of mindfulness in to this training are being considered.

Students complete a number of mandatory reflective essays throughout the five years on topics relevant to resilience, with a view to students gaining insight into their own personal and professional development needs and how these might be managed.

Other activities include a yearlong 'special interest course' that students can do on the topic of 'reflecting on mental health and illness', including examining issues around the mental health of students and doctors.

Also in recent years we have sought to strengthen the support available to

students, including introducing personal and peer mentoring schemes for years three to five students, building on support provided already by e.g. tutors, Educational Supervisors, and the Student Liaison Officers.

IMPERIAL COLLEGE LONDON

MIKE EMERSON

I am a research scientist working in the field of Cardiovascular Pharmacology at the National Heart and Lung Institute at Imperial. I am involved in teaching years one and two of the MBBS/BSc course and have been an early years Senior Tutor for seven years. My approach to welfare is to equip students with solid learning skills and to drive an awareness of opportunities to access support. In addition, I directly support students with a range of welfare needs.

DR JULIA HILLIER

I am the Director of Student Tutoring and Support at Imperial College School of Medicine and a consultant radiologist at Chelsea and Westminster and a Director of Medical Education at the Trust. I have been involved in undergraduate and postgraduate education for many years. We offer compulsory personal tutoring sessions in years two and six to help students develop strategies to deal with difficult issues; this involves three hour tutorials and four hours self-study in year two and three hours lectures in Transition course in year six.

All students attend the Personal and Professional Development (PPD) course in year two. Students complete a Belbin personality test and resilience quotient questionnaire. There is group discussion on resilience and teamwork.

The students perform an activity named 'prescription for resilience'. The concept is explained using analogies with rubber bands and material properties. Each student writes down one issue they are struggling with currently or in the past on a 'prescription' This sheet is then passed

around a group of four to five students and each fills in a section with ideas for possible solutions.

The underlying concepts:-

1. Give permission to students to share issues with colleagues
 2. Ensure we are ready to offer support to one another
 3. Open up further discussion about the three concepts of resilience compassion and self-compassion
- Students then analyse an FY1 'on-call' diary for aspects of resilience and compassion and relate this to aspects seen on ward in a three week placement.

In year six Transition course designed for preparation for practice, students discuss aspects of resilience in small groups and are introduced to the concept of mindfulness.

GAIL DAVIES

(teaching by invitation)

I am a scientist/academic by background and worked at Imperial College in the Medical school for 18 years designing and running Masters courses as well as teaching medical students biochemistry and genetics. I have a longstanding interest in self-care and building resilience, starting by practicing yoga and meditation when I was an undergraduate at Oxford. While working at Imperial I trained as both a yoga teacher and as a yoga therapist using mindfulness and am registered with the CNHC.

Since leaving Imperial I have been working developing and delivering mindfulness courses across a variety of settings from medical schools to corporates and supporting clinical research. I am trained in MBSR (Jon Kabat-Zinn) and MBCT (Mark Williams) and have additional specialist training in mindfulness including delivering Finding Peace in a Frantic World, a shorter adapted version of MBCT. I also have a Masters in Mindfulness-based cognitive therapy from Oxford University.

I have been developing and delivering short mindfulness courses into the workplace since 2011 and am co-founder of Mindlab which works with corporates and is partnered with Nuffield Health. I deliver sessions and courses for medical and university students in an SSC to students at Imperial.

I use mixed learning combining live bespoke introductory sessions followed by an accessible flexible web based course. Following on from this format and my experience of teaching medical students I am currently working on a course specifically for students and young doctors.

KEELE

CAROLYN CHEW-GRAHAM

I am a GP Principal in Central Manchester and Professor of General Practice Research at Keele University, with expertise around the primary care management of patients with depression, multimorbidity and unexplained symptoms. I am Royal College of General Practitioners 'Curriculum Advisor, Mental Health'. I have been a GP trainer, Course Organiser and GP mentor. I mentor and support medical students at Keele University.

I have conducted research exploring stress in medical students, and currently have two projects investigating stress and burnout in GPs, and barriers and facilitators to help-seeking.

bristol.ac.uk/primaryhealthcare/researchthemes/improving-support/
I do not have a teaching/ education role at Keele University; however, I teach medical students from the University of Manchester in my practice, and aim to discuss the importance of self-care and self-reflection. I am a personal tutor for medical students at Keele University, and focus in this role on the importance of maintaining well-being.

KING'S COLLEGE (GKT) LONDON

DEREK CHASE

I have a background in medical education, and have been involved in the organisation of the wider NHS but my main role has been as a GP for the last 35 years. For the last 13 years I worked at King's College London looking after students and staff.

My experience of the level of distress amongst medical students led me to run 'Mindfulness and Resilience' courses to try to enhance their learning experience — both personal and professional — and thereby make them better doctors of the future. I have been co-running a student selected seminar course for either year three and four medical students at King's College, London.

The course for up to 15 students runs weekly over three months, each seminar lasting two and a half hours. Tamara Russell (a psychologist and neuroscientist) and myself (a retired GP) run the group and the content includes elements addressing stress management, wellbeing and lifestyle, communication and relationship skills, neuroscience, and emotional intelligence with the thread of mindfulness running throughout. As the course has been repeated we have increased the mindfulness element. It is explicitly a confidential, safe and supportive environment.

The first group was formally evaluated as part of an MSc project — the quantitative analysis on 12 students revealed a significant increase in self-compassion ($p < .05$), and a trend towards a decrease in perceived stress ($p = 0.083$) from above average to average levels. There was no significant impact in the wellbeing measure. These results were supported by a further 18 students who completed the pre and post questionnaires on the other courses. The qualitative and quantitative results were complementary and three major themes emerged: a growing sense of self awareness, an increasing ability to respond with kindness

and the positive impact of a 'safe environment' in the group. Many students expressed the wish that the course could be more widely available.

Traditionally self-care and personal development has been the responsibility of the individual while professional development has been the terrain of the medical school. This course suggests that not only is there a need for a more proactive approach towards improving the resilience of students by the medical schools (as advocated by the GMC) but that the students themselves are keen for it to be so.

ANNE STEVENSON

I am an academic general practitioner and my interest is in the education and professional development of undergraduate medical students, particularly in the general practice and the community settings.

In my roles at the GKT School of Medicine, and as lead of professionalism and student well-being and resilience in the new curriculum starting September 2016, I am very interested to share plans and ideas with others. My thoughts are that resilience is important but not as a defence mechanism against a toxic culture. My focus would be on self-care, wellbeing, and creating a kind and supportive training and working environment with a culture of allowing vulnerability.

We plan specific student selected components in the new MB BS 2020 for years 1 and 4 of which will be starting 2016-17 academic year. There will be opportunities in each of the years (part of scenario teaching Year 1, GP and mental health longitudinal placements in Years 2 and 3 and reflective small group work Years 4 and 5. This will be compulsory but the hours are not fully determined as yet.

LEICESTER

JONATHAN M. HALES

I am a non-clinical senior lecturer and coordinated the first half of Leicester's MB ChB for several years. I have spent twelve years providing pastoral support

to medical students, gaining a feel for the issues that detract from their wellbeing. I now have responsibilities for basic science as for the introduction of mindfulness (embedded in a Health Enhancement Program) as core curriculum for first year medical students next academic year. This will be a 14 hour compulsory course

The HEP was devised by Craig Hasted (Monash Medical School, Melbourne) who has been using it to teach medical students successfully for approximately 14 years. Craig has been generous in advising several other medical schools in Australia, the USA and Canada, as well as schools, community and patient groups, about stress reduction and wellbeing. He has helped to explain and model the course on recent visits.

The HEP is an informative, practical and experiential course, in which mindfulness is the major longitudinal theme, but which also teaches other 'pillars of health' (exercise, nutrition, connectedness, spirituality and environment). Its lectures provide important background information, research and theoretical underpinning, while its small group tutorials provide a practical and experiential approach to teaching so as to facilitate deep and practical, rather than solely theoretical, learning.

Deep learning ensures greater personal benefit as well as a greater ability to practically apply knowledge. Research has also shown that deep learning in students is associated with greater coping, better performance and reduced stress. The aims of the HEP are to:

- improve personal stress management skills
- raise awareness about our lifestyle choices
- empower the ability to change behaviours to healthier patterns if desired
- foster peer support and communication
- help integrate the relationship between biological science and wellbeing
- lay foundations for development of clinical and counselling skills.

LIVERPOOL

PAULA BYRNE

Paula Byrne's background is in the social sciences and is the theme Lead for Psychology and Sociology as Applied to Medicine (PSM) and Co-Director of Student Wellbeing and Development within the School of Medicine at Liverpool. Dr Byrne's research interests include: developing wellbeing across all years of study; transitions and coping strategies during the life course; identification and remediation for struggling students.

Psychology and sociology as applied to medicine run this; it is not part of the faculty's professional development curriculum. With the Introduction of a revised medical curriculum in 2014, we have created a number of compulsory approaches to wellbeing and resilience including;

- A 'Wellbeing for Doctor's in Training' strand in the PSM theme throughout the years which includes for example, Understanding stress and developing coping skills; Exploration of uncertainty and ambivalence; Realistic expectations of the course.
- In year one, PSM lectures and group work focus solely on students' development, to allow them to understand and reflect upon their own experiences and understanding, before any clinical encounters from year two onwards.
- Self-coaching year one: a virtual self-coaching course which is being rolled out to all years from 2016/17.
- A wellbeing conference at the start of year one, where our students are introduced to the five ways to wellbeing, and encouraged maintain or strengthen their wellbeing throughout their undergraduate career.
- Year one students have taken part in an Army Leadership course at Altcar, this is also being rolled out into year four.

MANCHESTER

JUDY STOKES

Is a consultant anaesthetist who has moved into an almost full time post in medical education. Her current areas of responsibility are Consultation Skills Lead, Academic Advisor/ Portfolio Lead and Associate Hospital Dean (AHD) for Student Welfare and Professionalism Support (SWAPS). She is also an Educational Supervisor for six Foundation trainees. All of these roles are based at Central Manchester University NHS Foundation Trust (CMFT). She recently completed a diploma in Medical Education at the University of Manchester.

ALLISON BOOTH

Has worked in the Undergraduate team for almost ten years, having started as year five Placement Coordinator and moving on to become the Assessment Manager running OSCEs. Five years ago she was appointed SWAPS Manager and has continued to use her experience to develop this service for Manchester students, working closely with the AHD for SWAPS and the Hospital Dean at CMFT and the Central SWAPS team at the Medical School.

We feel we are good at reaching and supporting students in difficulty (highlighted as good practice at our last GMC review). However, we are aware that we are perhaps not doing enough to promote resilience and general well-being in the wider medical student population, which in turn would hopefully reduce the number of students in difficulty. Last academic year the SWAPS team saw 154 new appointments and 309 follow ups.

Recent initiatives to address this include the proposed development of a Medical Student Wellness Programme and the imminent appointment of a Student Experience Lead to work within the undergraduate team at CMFT. Students at the CMFT site have been surveyed to see what they would find helpful and the results cover a wide range of activities such as yoga, mindfulness, mentoring and

social events. The implementation of such events is currently being considered.

For the last twelve months Health Education North West and Manchester Medical School have been promoting the importance of building resilience in all their staff and students. This has been a topic at recent medical education events in Manchester for staff involved in the training and mentoring of students and trainees. We have also recently attended an Academy of Medical Educators conference in Swansea on Mental Health and Wellbeing in which resilience was a key consideration.

Being able to cope with the pressures of the undergraduate programme and especially the transition points from non-clinical to clinical learning and from undergraduate to postgraduate training is vitally important. Therefore we are actively exploring all opportunities to develop our skills in this area and in turn promote strategies to develop a resilient student body.

NEWCASTLE

DOMINIC JOHNSTONE

I am a Clinical Sub Dean of the MBBS course at Newcastle University and a Honorary Consultant Forensic Psychiatrist. I lead on the professionalism strand and resilience currently falls under that umbrella.

Overview:

Phase one: stage one and two. There are two didactic lectures covering time management, self-care and dealing with stress as well as all the information that students get re pastoral support. There is an established peer mentor system.

There are professional reflection theme running through stage one, two and four. There is a stage one lecture and stage one, two and four, tutor led seminars where we teach the professional reflective process and then give the students time tabled, explicit time to reflect on clinical experiences and also provide constructive feedback and support to colleagues mirroring a peer support group.

In our phase I mental health teaching we cover stigma and it's potential to prevent a person getting the help they need. We also introduce basic CBT self-care and mental health promotion including use of exercise. These are within the context of patient care but could readily include medical student self-care and resilience.

There are drop-in mindfulness sessions open to all students, these are based in Newcastle.

Phase two — stage three: in the Foundations of Clinical practice course that runs for 16 weeks at the beginning of the year and introduces student to full time clinical practice, some units do reflective groups discussing clinical issues that the students are processing for the first time.

Phase two — stage four: We run a session on Myers-Briggs allowing the students to understand their characteristics that people will inevitably be different from them and how this may play out in the working environment.

There is teaching on patient safety across the course (Stages one to five) and within that, human factors, where stress may be discussed on how it can affect patient safety.

Phase two — stage five: A number of Units run scenarios that simulated a 'Bad Day On Call'. The students are de-briefed on how they coped and will cope in the future in these stressful situations.

OXFORD

JEREMY HOWICK

Jeremy Howick is a senior researcher at the University of Oxford. His main research area involves an interdisciplinary exploration of placebos (ethics, effects, definitions). His interest in resilience grew out two things: his placebo research and the finding that reduced anxiety has health benefits, and his traditional (meditative) yoga practice (he is a qualified teacher and runs a yoga academy).

- Jeremy Howick teaches yoga to his colleagues on a weekly basis.

- He has taught resilience for leadership at the Said Business School.
- He is developing a resilience programme with colleagues at the Said School.

Based on feedback from GP's and medical students, resilience training is important. However there is a sense that we are getting the wrong end of the stick. Medical students and doctors are forced to be the most resilient people on the planet because they are overloaded with stressful work, and they survive. Asking them to do additional training, while it will be beneficial, will simultaneously exacerbate the problem by adding additional work to their already overloaded workload. So I think that the underlying forces of medical students and GP's being overloaded needs to be addressed.

PLYMOUTH

TERESA COMPTON AND SEEMA BHANDARI

Theresa Compton is a lecturer and lead for pastoral care at Plymouth University Peninsula Schools of Medicine and Dentistry. Theresa trained as a doctor and began a specialist training post in obstetrics before leaving the medical profession after experiencing burnout. She now works full time in medical education. She aims to prepare her students for medical practice so they can avoid going through the same experience.

Seema Bhandari is a GP and small group facilitator for the school with an interest in wellbeing.

Together they have developed of a toolkit to promote wellbeing and resilience in medical students. The toolkit comprises 10 different strategies to support the wellbeing of students.

Student wellbeing is a complex and multifactorial issue, whilst wellbeing correlates with better academic performance (Ansari, 2010). Recent surveys by the National Union of Students revealed that eight of ten students

experience mental health problems whilst studying, but 50 per cent don't seek formal help. In medicine, this impacts on career development with doctors own stress and illness being linked to poor communication with patients and colleagues, medical errors and burnout. Many doctors are unprepared for some of the personal demands of the job, such as time management, communication and managing their own health and stress.

We have based the toolkit on:

1. Lessons learned from our personal experiences of coping at medical school and as doctors.
2. Ours and others experiences of working in pastoral care and the common problems students face.
3. Using the literature examples of strategies likely to be helpful to medical students.

We will examine how successfully these strategies are already implemented and where there is opportunity to provide more comprehensive student support.

The Point of Care

The Point of Care foundation is promoting resilience and compassion in medical education

The Point of Care Foundation work to radically improve the way that people are cared for and to support the staff who deliver the care. One of our major programme areas is the provision of support and training to organisations to provide Schwartz Rounds (SR). SR are an innovation that have been shown to reduce stress, and build engagement and cohesion in multi-disciplinary teams, with the potential to improve the ability of healthcare staff to show empathy to others (both staff and patients). High levels of interest have been shown in introducing the Rounds into the context of professional health care education. We are currently piloting the Rounds in two education settings and exploring ways of introducing them more widely. The assumption behind this work is that the sooner reflective, multi-professional support and communication are introduced to

professionals in training, the greater the likelihood of enduring benefits.

In early 2016 we took part in a seminar of the Council of Teachers of Professionalism, involving representatives from medical schools across the UK. A number of key issues arose from this meeting that delegates wanted to pursue:

- How best to provide formal training related to reflection/resilience.
- Exploring Schwartz Rounds as a model that may be adapted to the student environment.
- The possibility of developing reflective, educational, workshops where students work through a number of scenarios in which they rehearse/enact situations which may arise in clinical practice.
- Developing and sharing evidence based models to teach communication and team-work. Methods are individualised for the different approaches/styles/preferences on part of both students and teachers.
- Transparency and speaking up.
- Thinking about where this work might sit within the medical student curriculum.

To address these issues it is proposed that a sounding board be set up, composed of clinicians, teachers, regulators and policy people. The group will meet two to three times over the course of a few months and would be task orientated to come up with a proposed list of recommendations which would be fed back to medical schools, the GMC, and other appropriate bodies.

RHIANNON BARKER

Rhiannon is Head of Business Development at The Point of Care Foundation (POCF). She spent her early career in overseas development conducting evaluations of food aid distributions and then managing an Oral History Project across Sahelian Africa. Following that she worked as a Research Manager at the Health Education Authority and then became a freelance consultant specialising in qualitative health research. She was a non-executive

director with East Sussex Downs Primary Care Trust.

At POCF Rhiannon has worked to roll out Schwartz Rounds across health organisations in the UK. She is also responsible for helping to identify, plan and test the development of new initiatives.

DEBBIE SANDFORD

The Point of Care Foundation is an independent charity working to improve patients' experience of care and increase support for healthcare staff. Debbie has a dual role: as COO she directs the business processes of the Foundation, while as Schwartz Rounds programme director she is responsible for the Foundation's largest programme.

Having read PPE at Oxford, Debbie joined management consulting firm McKinsey where she remained on and off for ten years – the 'off' being for an MBA at Harvard Business School and a sabbatical in the Health Studies division of the Audit Commission. Subsequently she was managing director of Random House Children's Books. She has also written a column for Management Today, been both vice chair of governors of a nursery school and chair of a social enterprise agency, and remains a JP sitting on the Central London Bench of the adult criminal court.

QUEEN MARY, LONDON

ANIA KORSZUN

Ania is a Psychiatrist and Education at Bart's and The London Medical School; Queen Mary University of London. Her research focuses on the interface of depression and stress with other medical condition, identifying predictors of psychological wellbeing in cancer patients and developing behavioural interventions to improve treatment outcomes and quality of life.

Ania is Academic Lead for Medical Professionalism at QMUL and Chair of the Undergraduate Education Forum at

the Royal College of Psychiatrists. Her projects focus on promoting mental health in the medical curriculum, on overcoming stigmatizing attitudes to mental health and improving professionalism standards and well-being in medical students and doctors.

Outline of Resilience Courses

Resilience and wellbeing is currently addressed at various stages of the curriculum at Bart's and The London Medical School (BTL). However, in response to GMC recommendations and the strong commitment of BTL to develop and support the wellbeing of its students, we are in the process of developing a new curriculum (Curriculum 18) with an integrated and defined component addressing wellbeing and resilience at all stages of the medical course. This will build on current components that promote wellbeing and resilience: introductory lectures and workshops on health and self-care beginning in Year 1, a self-reflection portfolio programme, faculty mentoring, a supervised peer mentoring scheme, courses on mindfulness-based stress reduction, Balint groups, and a programme of course-specific faculty development. The wellbeing curriculum will be delivered throughout the medical course and particularly address issues arising during transition phases and ending in Year 5 as students prepare for becoming Foundation year doctors. Throughout the curriculum we will have close integration with student support services. Our research has shown a majority of medical students reporting high levels of distress, with a significant proportion of unreported mental health problems with some students seriously considering giving up their studies. Curriculum 18 will therefore also address reducing known stressors in the curriculum such as volume and level of material to learn and excessive travelling between placements. The effects of curricular changes on student wellbeing will be monitored.

QUEEN'S BELFAST

EUNICE MINFORD

Eunice Minford is a general surgeon and have a strong interest in self-care and holistic care based on understanding the human being energetically. In addition to other trainings I also have a lot of life experience re healing/transforming my own life and what works and what doesn't and as such I do not see the answer lying in one modality or another but requires addressing one's way of life from many different aspects — in order to live truly harmoniously and without getting detrimentally affected by the work we do.

She runs a self-care programme for third year students as Student Selected Component based on a holistic and energetic understanding of the human person. It very much involves raising body awareness and understanding that the body is the marker of truth... so the students experiment with their daily choices and feel the effects on their bodies thus getting to know what works for them and what doesn't. It is also based on understanding and experiencing that everyone has a loving essence and thus it makes sense to consciously make choices that are self-caring and self-loving. It covers a wide range of topics including sleep, emotions, culture of medicine/university/relationships/finances/mental ill health, work and food to enhance mind-body awareness.

For me self-care is something that needs to be embedded into the curriculum and medical culture but requires people who are living it to present it as unlike most subjects at medical school it is not based on knowledge acquisition but the lived application. We have recently written to the GMC re self-care for medical students.

Current Status and Attitudes to Self-care Training in UK Medical Schools.

Objective: To establish the attitudes towards and current status of self-care training for medical students.

Methods: A short online questionnaire was emailed to the Deans of the 34 UK

medical schools concerning attitudes to self-care training and its status in each medical school.

Results: 44 per cent (n=15) responded. 80 per cent (n=12) of respondents agreed that the quality of care given by a doctor depends on the quality of care they give to themselves; only 67 per cent (10) agreed that self-responsibility through daily life choices is key to health and wellbeing. Medical schools were divided as to whether a doctor's first concern should be to care for themselves; 67 per cent (10) felt that the GMC requirement for doctors to put the patient's needs first did not lead to doctors subjugating their own needs while 73 per cent (n=11) felt self-care training had the potential to address current rates of burnout. Qualitative responses suggested self-care training should be part of medical culture. Some were keen to highlight that current toxic NHS environments need to be addressed.

Conclusions: Despite recognising the importance and benefits of self-care training and its potential to address current rates of burnout, only 10 medical school respondents felt that self-responsibility through daily life choices was the key to safe sustainable practice and personal health and wellbeing. This small survey had a limited response rate but suggests that Medical schools may be conflicted about the impact that 'putting patients first' has on rates of burnout and maladaptive coping strategies. More dialogue, research, education and discussion is needed.

SHEFFIELD

PIRASHANTHIE VIVEKANANDA-SCHMIDT

The team approach to embedding resilience within the undergraduate course is led by Deborah Murdoch-Eaton, Dean of Medical Education. Other members of the group include: Michelle Marshall, director of learning and teaching, Michael Nelson, director of student affairs, Pirashanthie Vivekananda-

Schmidt, lead for professionalism and patient safety, Jenny Swan, Lead for phase 3A, and Dyfrig Hughes.

We work from the standpoint that resilience cannot be developed through standalone courses but through an integration of appropriate core values, attributes and skills into all relevant areas; capacity for resilience underpins the ethos of the medical school. We have a number of teams supporting the development of the resilient graduate: the student affairs team supports every student towards their personal development to achieve their full potential by working in close collaboration with the University counseling service and careers service. The professionalism and patient safety team supports the students to develop an understanding of how self-care and appropriate self-management enables doctors to provide high quality care and to uphold patient safety. We also have an enhanced support programme for students who experience difficulties during the course.

Specific sessions are held regularly throughout the programme at resilience strategies are included. In the early years, students have opportunities to discuss the importance of approaches to study, stress management, self-care and the importance of self-care and self-management skills for patient safety; who a resilient doctor is and how to develop skills for resilience is integrated into these opportunities. Later on in the programme there are sessions specifically on resilience when the students begin extended core clinical placements and nearing graduation in effective preparation for finals and the workplace. This usually involves approximately 17 hours of core compulsory teaching during the course during the last three years of the course.

ST GEORGE'S HOSPITAL MEDICAL SCHOOL, LONDON

KAVITA PRASAD

In 2008 I completed further training in Complementary and Integrative Medicine at the Mayo Clinic and since then have been incorporating the Stress Management and Resiliency Training Program (SMART) as well as evidence-based Complementary and Integrative Medicine practices into patient care, education and research in the UK.

SMART is a structured, evidence-based stress management and resiliency training program developed at Mayo. It is designed to decrease symptoms of stress, anxiety and enhance well-being. In addition, it promotes resilience, and enhances mindfulness addressing two aspects of human experience attention and interpretation.

The core component of the intervention is a 60 minute one on one session that incorporates teaching mind-body skills. Outcomes include measures of resilience, stress, anxiety, fatigue, and overall quality of life by using psychometric tests.

Skills incorporated into the program include: gratitude, compassion, forgiveness, acceptance, finding a true meaning and purpose to one's life, as well as paced breathing meditation.

I have been at St George's Hospital since 2014 where we have opened clinics in cardiology and oncology, furthering this holistic practice of healthcare, improving patient's quality of life, working with the Full Circle Fund, a charity at St George's Hospital. In the summer, our cancer service within Full Circle was selected by the Professional Standards Authority (PSA) and our work was included in a high level report to Ministers. Following this, the PSA selected one of our case studies for their national forum on Complementary Therapies in the NHS aimed at demonstrating best practice and to serve as a guide to other NHS Trusts. Most recently our pediatric team was nominated for and received the

Trust's Values Award for 'a patient service which is an exemplar in upholding the Trust's values'.

In 2015, and thanks to the work of Dr. Chris Manning, I have ventured out and started a 'Wellness Clinic' for students at St George's, recognizing that beyond counseling and occupational health; little exists to support their wellbeing. In December I brought together medical students who have started societies to promote wellbeing with 'Mindfulness Society', and 'Student Mind' to see how we can all work together and co-create a better program to support students.

Students at St George's

James Brown is a graduate entry medical student and is one of the founding members of St George's University Union's Mindfulness Society. He has acted as the society's treasurer as well as leading sessions for the last two years. James has developed a regular meditation practice alongside the development of the society. He is particularly interested in how non-religious people can share with religious people a sense of "spiritual" wellbeing, enjoyment and meaning in life – especially in stressful healthcare professions.

As well as his role in the Mindfulness Society James is part of a working group setting up a wellbeing centre for students at St George's University.

James is a passionate activist working tirelessly on his work for the junior doctor contract dispute, in his role as President of St George's Protest and Activism Forum, and for the charity ENCA.

Jamie is a founding member and President of St George's University Union's Mindfulness Society. She trained as a mindfulness teacher with the Mindfulness Association and has been practicing mindfulness for the last 16 years. As part of her medical degree she carries out research on the mindfulness courses that she runs for health care staff and students, with a focus on the effect mindfulness has on resilience in the NHS. Jamie is part of a group working to set

up a wellbeing centre at St George's University of London.

Resilience education need to exist and be a valued part of the medical curriculum. I feel there needs to be a shift in consciousness in medical education away from an idea that the job should be hard. The idiom 'sleep is for the weak' needs to become a thing of the past. The pace of placement is intense. There is no time to reflect or compose ones feelings. I have many a time walked away from a patient's death bed straight back into the ward round, without a moment to stop or mourn. I think it helps to have an understanding that the job is hard, that we are humans and it is alright to struggle.

Therefore we need tools for, and an importance placed on, reflection. Mindfulness can provide us with an understanding of our experiences and allow us to give ourselves that moment to reflect and choose how to react. Students on our mindfulness courses have described their experience of challenging placements shifting to become a joy, through the effect of their mindfulness practice.

SOUTHAMPTON

STEPHANIE HUGHES

I am a GP in Hampshire and have been teaching medical students at the University of Southampton for 12 years; I was a Principal Clinical Teaching Fellow in the Faculty of Medicine for four years before moving on to my current post as Associate Dean for Wessex Appraisal Service. I am currently completing my Masters in Medical Education and am absolutely delighted at the prospect of working with you on this project.

GEORGE LEWITH

Is a researcher in Primary Care at Southampton University with almost 40 years of previous clinical experience in general practice and integrative medicine. He teaches at Southampton at

undergraduate and postgraduate level and also works at Westminster University in the Centre of Resilience with David Peters, Kate Fisser, and Justin Haroun and is involved with many others in developing and creating the centre, frontline teaching as well as course development and course evaluation for GPs and foundation doctors.

- Medical undergraduate education focuses on acquiring information rather than "emotional understanding" (of yourself and your patients).
- The largest effect size for almost all interventions in primary care is the consultation and the act of "caring or prescribing".
- A patient-centred and individualised approach is the most significant component of most care especially primary care.
- The main "tool" for delivering this evidence-based treatment is "the doctor".
- When we are unwell or overstretched, doctors tend to be unsafe and less clinically effective as well as more prone to illness (time off work) and self-harm.
- Looking at and understanding yourself and your strengths and weaknesses, as an individual, is a vital 'tool in the box' for delivering effective patient centred evidence-based medicine.
- Delivering safe, effective and vocationally driven care is a core element of your professional responsibility.
- This aspect of your medical education is evidence based but it is often much more difficult than simply acquiring information.
- Acquiring information successfully (passing exams) appears to be THE central component of medical school education.
- Does the evidence from clinical practice support this? Is medical school education 'fit for purpose'? If not what should we do about it?

SIOBHAN LYNCH

I am the PPD coordinator for the BM5 programme and have been in post since mid 2014. My PhD (Psychology) was on Mindfulness in Higher Education and I have also published on mindfulness for therapists. I also have a particular interest in technology enhanced learning, student engagement and feedback as dialogue.

Personal Professional Development (PPD) is taught as a subject in the BM5 programme at the University of Southampton. It was first introduced in 2013 and has evolved significantly over the last three years, based on feedback from staff and students. To date, the majority of development work has focused on the early years, although integration with years three to five is underway. In order to give a flavour of the curriculum, some examples are provided.

For the last two years we have run a pre-arrival task, which asks students to consider a blog on medical professionalism and to consider what being a professional means to them, with the aim of fostering engagement in professionalism. Students then submit three key words and write a 300 word contribution which they send in. We then create a word cloud with the key words and conduct a basic analysis of the 300 word contributions (with over 200 individual contributions). This is then used in the introductory PPD lecture. Students are then able to explore this further in small groups. This year we have piloted returning to the pre-arrival task in year two and using it as the foundation of exploring any changes in students' understanding of professionalism. We hope to establish further 'touch points' in each year, with the emphasis being on students' developing understanding of being a professional.

We are also working on a health, well-being and flourishing strand. This year we piloted a series of optional workshops, and while uptake was not high, the feedback was very good. Looking forward to the coming academic year, we hope to model the CPD framework in

year 1, by providing a student selected health and well-being workshop for the whole cohort. In year two, we plan to include a tutorial focusing on building resilience, starting with students' strengths and personal interests. Over the coming year we will explore how to develop this thread in years three to five, and how it can be linked to clinical placements and students' developing understanding of what it means to be a professional.

SWANSEA

ANDREW GRANT

Dean of Medical Education at Swansea University Medical School, qualified doctor and a practicing GP. AG carried out a study for the GMC looking at support for medical students with mental health concerns which has been used to form GMC policy.

AG set up the unit for study of doctors and medical students' mental health and wellbeing which has members from multiple institutions and professional backgrounds: swansea.ac.uk/medicine/research/researchthemes/patientpopulationhealthandinformatics/medprofmhw/

We deliver an interactive compulsory two hour session during year three or the four year graduate course on self-care and mental health among doctors and medical students. We specifically address the problems for doctors in accessing healthcare when needed; this is not a formal part of the faculty's programme.

TEA AND EMPATHY

NAOMI MANSER

I am a General Practitioner in a large practice just outside Newbury. As a medical student I was taught in an era where 'resilience training' comprised surviving the ward round without bursting into tears or being humiliated. The resultant 'tough doctor' was seemingly made of strong stuff, but the building material was brittle. This meant that

although I was very resistant to breaking, when I finally started to crack, I shattered. I was able to rebuild myself with completely different material – dynamic, malleable, bouncy 'resilience'. Now I'd like to help others 'bounce' rather than 'break' under the never-ending NHS stresses.

Tea and Empathy is a national, informal, peer-to-peer network for healthcare professionals in the NHS. Our aim is to foster an atmosphere of kindness and support where we all offer an empathic ear and meaningful support to anyone struggling in the world of medicine. We are the brainchild of Phyllida Rowe, a junior doctor who was moved to act by the disappearance, and recently confirmed suicide, of a young doctor in the south west.

On the 14 February 2016 the 'Tea and Empathy' group was created on Facebook. We now have 1,204 members divided into 17 regional subgroups, many of whom have connected in person as well as cyberspace. We are a forum in which members can nurture and build their own resilience to the unique stresses of the NHS.

One of our most powerful functions is that of shared stories. A staggering number of members have shared their truly harrowing experiences. Some members are through their ordeals. Others are not. But the sharing process enables those who need support to get it, whilst reducing the stigma and shame often associated with it. Reducing any stigma enables more members to ask for help and a positive feedback loop is born.

UNIVERSITY COLLEGE LONDON MEDICAL SCHOOL (UCLMS)

FAYE GISHEN

A consultant in palliative medicine and the academic lead for Clinical and Professional Practice. She is responsible for 16 modules that run throughout the six year MBBS curriculum, including areas such as professionalism, clinical communication and medical ethics.

Promoting resilience in medical students and making reflection more 'palatable' to them.

She has introduced reflective practice Schwartz Rounds into the undergraduate curriculum; the second medical school in the world to run dedicated rounds for medical students. Activities in the undergraduate programme which focus on Resilience are concentrated within the 'vertical' Clinical and Professional Practice part of the course, which runs throughout the spine of the six year course.

In year two there is a 'Resilience and Self-care' compulsory small group work session facilitated by a Clinical and Professional Practice tutor (commonly a visiting GP), in which a plenary presentation is viewed on Moodle, and associated questions and scenarios are addressed by the group. Part of the session focusses on Mindfulness, with a demonstration from YouTube. Other tools for managing stress and avoiding burnout are also discussed.

In years five and six Schwartz Rounds (SRs) are held, but are not compulsory to attend. These reflective practice rounds are facilitated by clinicians trained through the Point of Care Foundation. They involve a prepared multidisciplinary panel presenting their stories and feelings around complex clinical cases, with a confidential open discussion involving the medical students afterwards. Significant data has been collected and published.

This is the second medical school in the world to use dedicated SRs for medical students. The aim of introducing them in 2014, and embedding them in the undergraduate curriculum, is to attempt to combat compassion fatigue, increase empathy for patients and colleagues and reduce feelings of isolation.

We also run Balint groups to foster reflection and resilience.

Altogether, these activities, which are embedded in the Faculty teaching programme, take around ten hours.

WARWICK

SARAH STEWART-BROWN

I am a medically qualified Professor of Public Health working at Warwick Medical School. Becoming aware of the extent to which doctors mental health and wellbeing influences public health, I have become involved in personal and professional development teaching at the medical school, in the development of resilience training for junior doctors led by Westminster University and in training and CPD relating to personal wellbeing for professionals working in public health. I have a well-established personal meditation and body work practice and regard this as an essential underpinning for my own mental health resilience and personal development.

Warwick medical school offers all students a course in personal and professional development which focuses on their personal wellbeing, encouraging them to assess their own mental wellbeing, reflect on their wellbeing, make a personal wellbeing plan, learn about team work, cope with the stresses of the course and exams, learn to use their time most effectively. This course also introduces brief mindfulness exercises. This mandated course is complemented by SSCs in mindfulness and bodywork, and supported by mindfulness society. We have evaluated the course with both quantitative and qualitative approaches showing that mental health deteriorates in the first year and that mindfulness is protective against this decline. Qualitative data document the range of reactions to the course and to mindfulness in particular. These data show change over time in understanding and appreciation and the importance of facilitator skills. They also show a small group (five per cent) of students to be actively antagonistic to the course.

Around 12–15 hours for the universal course. 36 hours for the SSC courses.

Universal course is compulsory. It is compulsory for students to do an SSC but they state preferences for which ones they want to do.

At the moment only in phase 1 which involves the first 18 months of this graduate entry course. We have recently organised mindfulness training for the Faculty.

WESTMINSTER

CHRIS MANNING

I completed a Biochemistry degree at Sheffield University in 1973, qualified in Medicine from the University of London in 1978 and then worked as a GP in Twickenham for 17 years, retiring from the NHS in 1999 on medical grounds (major depression on and off since 1986). I founded the charity Primary care mental health and education (Primhe) in 1999 that, with the Doctors Support Network, set up the Doctors Support Line in 2003 and in 2008 established a Masters for GPs with a Special Interest in Mental Health. I was also Chair of Depression Alliance for seven years, served on the National Mental Health Task Force and contributed to a number of Department for Health initiatives to mitigate the stigma of mental illness, including the 2008 DfH report on mental health and illness in doctors and RCPsych National Institute for Mental Health in England (NIMHE) activities.

I am an ardent champion for mental health and wellbeing, especially of those working in and for the NHS and in 2013 convened a group of like-minded and concerned health and social care practitioners and trainers called Action for NHS Wellbeing that acts as a network for mutual support, the sharing of positive and promising work, research and ideas and lobbying. Humour, love and hope are also permitted within this network. I am chair of the Faculty for Mental Health at the College of Medicine and, as part of that role, helped to establish the PULSE Beating Burnout campaign and continuing associated activities, together with serving on the national suicide prevention strategy advisory group. I am a trustee of Richmond Health Voices, the charity responsible for operating the Richmond Healthwatch contract.

My family motto is: "Never wrestle a pig; you both get dirty and the pig enjoys it." And my favourite saying is: "Nothing is impossible if people don't need to claim the credit for doing it" (Tim Smit)

UNIVERSITY OF WESTMINSTER CENTRE FOR RESILIENCE

PROF DAVID PETERS

I trained as a GP and in osteopathic medicine and as a musculoskeletal physician. The combination of my clinical experience and expertise, research and the evidence of a need for resilience services in commercial, public and third sectors led me to establish the Centre. I have a career long concern with student and doctor wellbeing. Beginning in the late 1980s as Senior Research Fellow at St Marys Medical School Department of Primary Care I have devised and taught stress management courses to doctors ever since. Together with my colleagues in the Centre (Justin Haroun and Kate Fismer) we are developing resilience work in the NHS in collaboration with the RCGP, Guys and St Thomas' Trust, and Central NW London NHS Trust. The Centre also works intensively within the University with staff and students at all levels. The Centre is also providing resilience consultancy to leadership teams in international companies.

My research interests include implementing and evaluating non-pharmaceutical treatments in NHS settings, self-care in long-term conditions and the psycho-physiology of resilience and recovery. The Centre has an active interest in how technological advances provide insight into resilience.

JUSTIN HAROUN

Co-Founder and Educational Lead and Resilience Consultant. Centre for Resilience. Justin is a qualified, coach, musculoskeletal therapist, and Hakomi body-centered psychotherapist, who has been working with individual clients and designing, developing and running

courses in the UK and internationally since 2002.

His research, educational and therapeutic practices focus on personal and professional development especially improving function and performance, using applied mindfulness and reflective practice to help individuals and teams reach their full potential. Justin is also a qualified HeartMath Group Facilitator and Mindful Self-Compassion trainer, and is studying for a PhD.

KATE FISMER

Resilience Consultant and Operations Manager. Centre for Resilience

Kate previously worked in PR, helping to set up Vero Communications, a boutique Sports Communications and PR agency founded by Mike Lee, OBE (former Director of Communications, London 2012 bid). Before this she worked in the charitable sector, managing the Al Fayed Charitable Foundation. From 2010–14 she worked for the College of Medicine, a charity that explores sustainable solutions of health and wellbeing. There she was responsible for creating and implementing their student engagement strategy.

Kate then retrained at the University of Westminster in Health Sciences: Naturopathy. Since gaining a first class degree she has gone on to work with clients and groups providing support with lifestyle, nutrition and resilience building. Kate is a qualified HeartMath group facilitator and Mindful Self-Compassion trainer and has a special research interest in stress and sleep. She has a lifelong interest in techniques to support self-regulation and resilience.

PROFESSOR GEORGE LEWITH

Is a researcher in Primary Care at Southampton University with almost 40 years of previous clinical experience in general practice and integrative medicine. He teaches at Southampton at undergraduate and postgraduate level and also works at the University of Westminster in the Centre of Resilience. He is involved with many others in

the Centre's course development and evaluation of its courses for GPs and foundation doctors.

OTHER ATTENDEES

VENETIA YOUNG

I trained as a GP in Carlisle, Cumbria in the late 70s. In the late 80s I trained as a Family Therapist and was introduced to the concepts of individual and family resilience. In the mid 90s I trained as a solution focused brief therapist — a strength based model which helps to enhance resilient coping strategies. I have written a book called '10 minutes for the family' with Eia Asen and Dave Tomson.

When teaching GP trainees SFBT I include a section of questions about resilience. This starts with the trainees drawing around their hands and thinking of ten things that have caused them to be the resilient people they are. They are then asked to reflect on these with a colleague but do not have to share if they wish to keep it quiet. Then the themes are drawn out and compared with Froma Walsh's Family resilience themes. If you know how you got your strengths then you can find them easily in others. The trainees visibly relax and seem quite proud of themselves! Solution focused ways of working identify what people are already doing that is helping. It breaks problems into small chunks, identifies next steps up the scale and when a review would be helpful. It fits well with other consultation models but is more future oriented. A medical student observing it in action once in the surgery was able to use the model from a sheet of A4.