BMA

Performative not practiced: a qualitative cross – sectional survey study on UK medical schools’ welfare provisions

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Abstract

Background:
The BMA's Medical Students Committee (MSC) devised the wellbeing checklist in 2021 in response to declines in medical student mental health and wellbeing, notably since COVID-19 (Nair, et al., 2023). We hypothesise there are variable levels of support for students across UK medical schools. The checklist aims to identify such discrepancies and act as guidance about what measures UK medical schools should be providing to best support their students.

Methods:
We created a survey on Microsoft forms with the wellbeing checklist questions. We attached to the BMA website and requested our MSC representatives to distribute the survey link within their medical schools.

Results:
We collected 534 responses from all 43 medical schools in the UK.

There are discrepancies in welfare provisions across medical schools in the UK which need to be rectified. When there are poor wellbeing provisions or culture, it leads to worse medical student mental health (Medisauskaite, et al., 2023). Despite most medical schools claiming to have implemented the criteria in our wellbeing checklist, unfortunately, this is not the case in practice. Some wellbeing measures have been performative not actually practised.

The lack of psychological support and negative cultures surrounding seeking support in medical schools is disheartening. Especially considering the difficult climate students live in as highlighted with this report, such as inadequate rest facilities, lack of protected mealtimes and insufficient funding. If such tangible measures were solved, there could be potentially lower need for support.

To be able to study medicine, one should not just be able to look after others but also themselves. Medical schools should be catalysts to conversations about mental health and support, not adding fuel to the fire. Next steps involve presenting this research to the medical school council, conducting further research into individual medical school support and advocating for change.

Background:

The medical students committee (MSC) represents medical students in the UK (British Medical Association, 2024). The MSC has long advocated for the importance of prioritising and maintaining student wellbeing and welfare to ensure that students have access to support services (British Medical Association, 2024). BMA Wellbeing Services continue to offer support to both BMA members and non-members, and we are pleased that this has now been extended to dependents of medical students and doctors too (British Medical Association, 2024).

The MSC have continually supported medical student wellbeing for years. During the pandemic, many students experienced even more severe mental health concerns, along with safety and wellbeing anxieties around contracting COVID-19 should they enter certain clinical settings (Rich, et al., 2022). In response, we published a statement of expectations of Trusts, health boards and medical schools around wellbeing support for medical students during the pandemic (British Medical Association , 2020).

Similarly, we supported our members to adapt to medical training during a global pandemic. We provided guidance on returning to university and clinical placements, supported students in receiving COVID-19 vaccinations by writing to deans of all medical schools in England and continued to provide employment support to those students volunteering and working during this time to support the NHS (British Medical Association , 2020).

We devised the wellbeing checklist in 2021 in response to a decline in medical student mental health and wellbeing, notably seen since COVID-19 (Nair, et al., 2023). We hypothesise there are variable levels of support for students across UK medical schools. The checklist aims to identify discrepancies in welfare provisions across medical schools in the UK and identify those which are providing the most and least support as well as to act as guidance to medical schools as to what measures they should be providing to best support their students.

Methods:

We created a survey on Microsoft forms with the wellbeing checklist questions as seen in the appendix. We attached this survey link onto the BMA website and posted it on the bma. students Instagram. Similarly, we requested Medical Student Committee representatives from each medical school to distribute the survey link within their medical schools. Methods of distribution included sharing in WhatsApp group chats, email chains and QR codes around the medical schools.

We collected 534 responses from all 43 medical schools in the UK including new medical schools Brunel University of London, Kent and Medway medical school and University of Lincoln between October 2023 and May 2024. The majority of responses were received from the University of Nottingham (8.8%), University of Leeds (7.7%) and the University of Dundee (6.6%). We accepted responses from all year groups within medical school, they were split as following: foundation year (0.2%), year 1 (16.5%), year 2 (18.0%), year 3 (18.7%), year 4 (22.1%), intercalating (2.8%), year 5/6 if intercalated (18.3%) and other (1.1%).

Results:

The well-being checklist was split into 4 domains: structure, self-organisation, feedback and workload.

Structure

Mental health Support

It has been historically noted that medical students have a higher level of stress and depression compared to other undergraduate student groups and suicide ideation (Yiu, 2005) (Munn, 2017). With many contributory factors such as stress, sleep deprivation, academic rigour, exposure to traumatic clinical situations, debt, and poor support networks, welfare support is crucial (Nair, et al., 2023).

Two mainstays to a medical school's welfare support system are an elected student welfare officer who formally reports to senior leaders, and easily accessible psychological support services. 52.5% of students 'agreed' or 'strongly agreed' that their medical schools carried out the former whilst 45.9% the latter, respectively. It is important to distinguish between the actual availability of these services and student awareness of them. As the solution would differ if the services existed but students are unaware of them compared to if services do not exist at all.

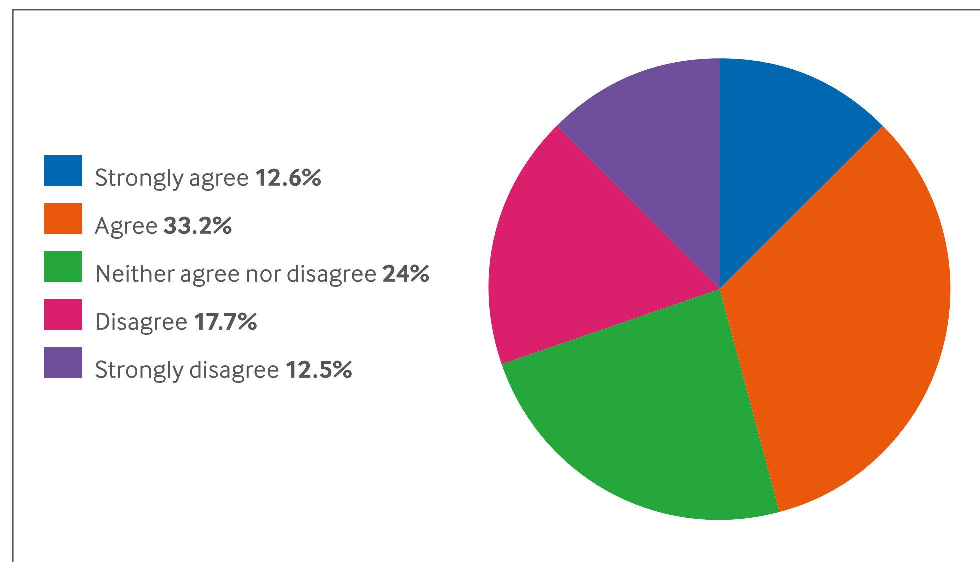

Figure 1: pie chart depicting results for the question "My medical school ensures students have easy access to psychological support services"

Awareness around elected welfare officers varied between medical schools, with nearly all welfare officers being integrated in their university medical society. Meanwhile, other medical school students queried whether course reps did the same jobs or if it was even a student role. Yet either way, it was clear most welfare officers do not have official report mechanisms to senior leadership committees nor feed into university wellbeing oversight reporting processes.

Student input concerning welfare is imperative. Welfare officers provide a non-hierarchical, non-judgemental, informal space for students to share their concerns. Similarly, they can anonymously raise them to higher staff. This is especially important as often the culture about reporting complaints in medical school is unpleasant. Some students highlighted how if they raise a complaint, they are labelled by senior staff a "troublemaker and gaslit to feel the issue is their fault." Unfortunately, these terrible sentiments were commonly shared between many students and students said having a welfare officer, provided a non-personal way to share complaints- even if they were rarely rectified.

This sentiment of unpleasant culture and poor support was seen when considering if medical schools have easily accessibly psychological support services. There were some notable exceptions, including the University of Leeds, Anglia Ruskin and St Georges who were frequently praised for excellent support services. Otherwise, the consensus was either "Where? Who? How? What is the service available?" or from students who had accessed it, that it was inadequate. A number of medical schools only offer one support counsellor for

over 400 students, while others do not even respond to emails requesting support on a regular basis. Although the number of support counsellors may not correlate with better support, having a larger number means they may be more available for appointments.

Furthermore, it was very disappointing to discover that students were indirectly dissuaded from seeking psychological support by their medical school staff due to potential consequences on their studies. This was indirect due to formal psychiatric diagnosis or support plans due to mental health sometimes leading to consequences such as threats with "Fitness to Practice" hearings, being recommended to defer or that they could not be suitable clinicians. It was incredibly disheartening that some students felt that "people get kicked off if it seems like they are struggling with mental health to prevent more suicides."

This is a worrying discovery, and the lack of awareness of wellbeing support and available support needs to improve. To be able to study medicine, one should not just be able to look after others but also themselves and most medical schools are not promoting this.

Facilities

Large contributory factors to a medical student's wellbeing are adequate facilities at medical school and placements (GMC, n.d.). We asked if medical students agreed their medical school had (1) adequate rest and changing facilities, (2) protected mealtimes, (3) affordable and accessible parking facilities and (4) accessible and streamlined process to claim travel expenses back.

40.6% of students 'agreed' or 'strongly agreed' their medical school has "adequate rest and changing facilities in any new refurbishments and campus build projects." The main complaint surrounded common rooms being too small to accommodate ever-expanding cohorts of students or no provisions (e.g. microwave) to bring in their own lunch. Ironically, the lack of rest facilities, is combined with the lack of opportunities to use it with limited breaks. One student uniquely noted they were unable to use the common room "during ward time as it is not a teaching or learning opportunity" even when nothing else was happening. Although this raises another discussion regarding productive use of time during placement, rest facilities should be always accessible to students (GMC, n.d.).

Mealtimes in clinical placement should be an opportunity to use rest facilities but only 27.4% of students 'agreed' or 'strongly agreed' that they were protected in their circumstances. Mealtimes appeared to be placement dependant and at the "mercy" of the clinician, some more generous than others. Some students noted how they could have "up to 12–13-hour shifts" without a dedicated break or mealtime. Whilst occasional long shifts can be expected, it becomes unacceptable and problematic if a regular occurrence, especially considering doctors' rights from the European Working Time Directive (British Medical Association, 2024). Students should have such rights at a minimum. It was highlighted how there were occasionally loopholes in 'protected mealtimes' such as having to travel to a different placement site and teaching sessions. These occur to the detriment of students' mental health and should not occur.

Only 12.1% of students 'agreed' or 'strongly agreed' their medical school ensures affordable and accessible parking facilities around the university and 37.7% 'agreed' or 'strongly agreed' there is an accessible and streamlined process to submit travel expenses (public transport or parking) for clinical placements.

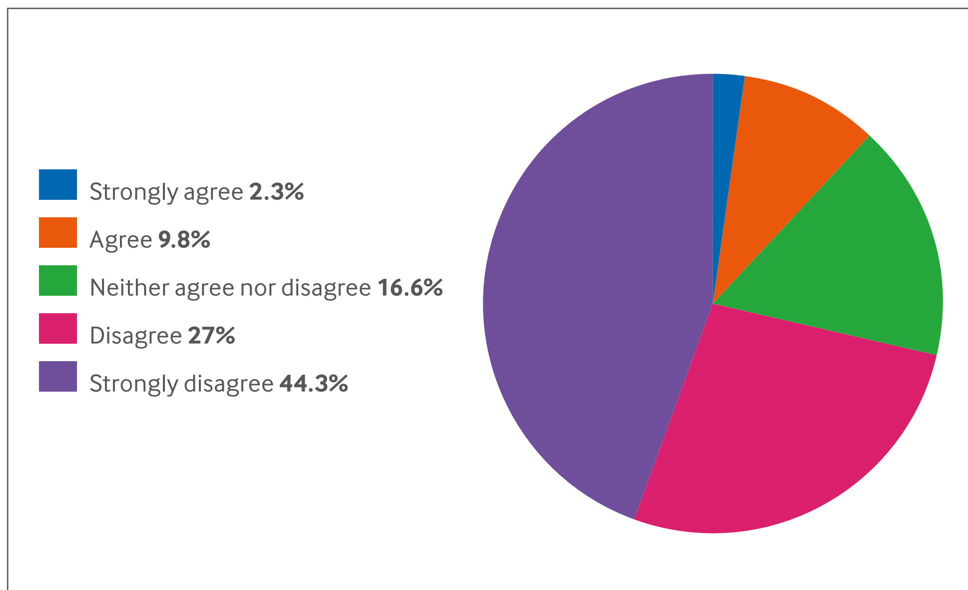

Figure 2: pie chart depicting results from question "My medical school ensures there are affordable and accessible parking facilities around the university."

University of Dundee students noted that there is free bus travel for under 22s in Scotland and most of their hospitals are well connected with public transport. Evidently, it may be exclusionary to graduate entry students especially who may be over 22 years old, but it is positive for younger undergraduate students. Most other responses were negative, highlighting the lack of free parking and parking spaces with students paying up to £8 a day to park at hospital sites which could not be reimbursed.

This sentiment continued when considering if the process to submit travel expenses was accessible and streamlined. The system varies between medical schools, but most appear inaccessible and bureaucratic. Some medical schools cap students at a cost per week which is usually insufficient thus meaning they must cover some of the placement cost out of pocket (Murray, 2022). Others have strict guidelines on what expenses can be claimed. One student discussed how when they are expected to arrive early in the morning before public transport starts, they must get a taxi which is not covered so out of pocket. However, if they did not attend, they would risk a fitness to practice hearing.

Attending placement is necessary for learning and mandated. Medical students should be able to attend without having to pay to travel to placement or at least more than their cost to medical school. There are already excessive costs, insufficient funding and limited time to work (Murray, 2022).

Self-organisation

Albeit support should be constant, in medical school, 2 key times when support should be given is when students begin and conclude their studies (Medical Schools Council, n.d.). These times of change can be incredibly difficult for students due to new routine, workload and friendships. Every student will need to adjust to the new requirements and expectations and can struggle. Thus, it is imperative medical schools offer adequate 'transition' provisions such as peer-to-peer mentorship schemes and assistantships/ transition to FY1 programmes (GMC, n.d.).

Pleasantly, 71.1% of students 'agreed' or 'strongly agreed' that their medical school has a peer-to-peer mentorship programme for interested students, especially entering first year. Schemes are in place through a wide variety of programmes such as buddies, medic parents or mentors and organised by different teams such as MedSoc, the central university or school of medical. However, the success of such schemes appears variable. At some universities, students report the lack of formalities of the scheme leads to disbanding of the mentorship weeks after it begins despite it meaning to last one's whole medical school

journey. This was echoed by most respondents, saying that engagement is highly variable due to the onus being on students. Sadly, some students also highlighted how such scheme was thoroughly set up for undergraduate students but limited for graduate entry students and mused how it was as "we have more life experience and are resilient."

The latter concern should be easily and swiftly solved. However, the prior poses a more difficult problem. Through formalisation of the scheme and forced meeting dates, it risks students being disengaged due to it feeling like a chore and another timetabled session. Yet, when informal there is no responsibility to continue with the mentorship. This is an area that needs to be more thoroughly investigated to see how it can run most effectively.

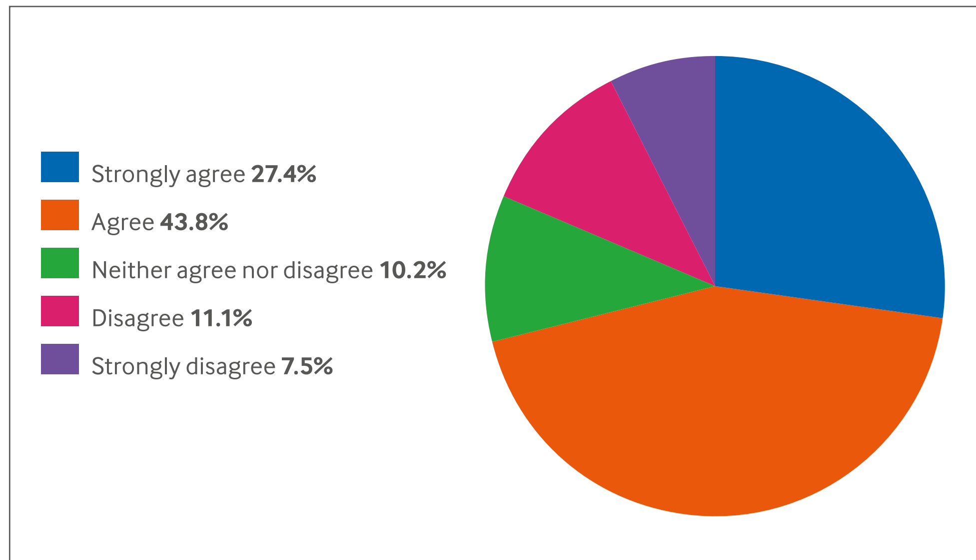

Figure 3: pie chart depicting results from question "My medical school creates a peer-to-peer mentorship programme for all interested students, especially for those entering their first year of university."

Unfortunately, transition to FY1 support is sparser than that for entering medical school. Some medical schools offer "transition to FY1" weeks or assistanceships lasting months but there is no formal transition training or expectations. We received notable positive feedback from the University of Central Lancashire that they offer specific F1 doctor classes. Yet, for most other medical schools, students said "they couldn't feel less prepared." There was feedback that on assistantships, students were often "patronised and treated like petulant children" despite being weeks away from F1. Similarly, some felt they were expected to act outside of their remit of placement (out of hours or excessive workload) despite it being unpaid.

Lastly, in order to full participate in placement, students need access to all parts of the clinical site including trust software (GMC, n.d.). Yet only 38.3% of students 'agreed' or 'strongly agreed' they had access. This is ridiculous considering access to patient notes is a basic requirement of placement. It was noted that this is often up to the discretion of a trust and is variable. This should be easily solvable.

Feedback on submitted work

We positively received feedback that 75.3% of students 'agree' or 'strongly agree' their medical school creates measures for students to provide continuous feedback on the curriculum and clinical placements (with the option to anonymise) to facilitate plans of action for any identified issues. However, while the majority agree to the statement, they only do so partially. This is due to issues such as inaction on feedback and not anonymous feedback leading to professionalism concerns. The potential of one's feedback to lead to punitive measures is unacceptable; like whistleblowing, it needs to be fairly considered. Secondly, many highlight the issue of feedback fatigue due to it being "overkill with no action" as they believe feedback is a performative measure. This suggests students are often not given a response to their feedback; even if their concerns have been heard but are unable to be resolved.

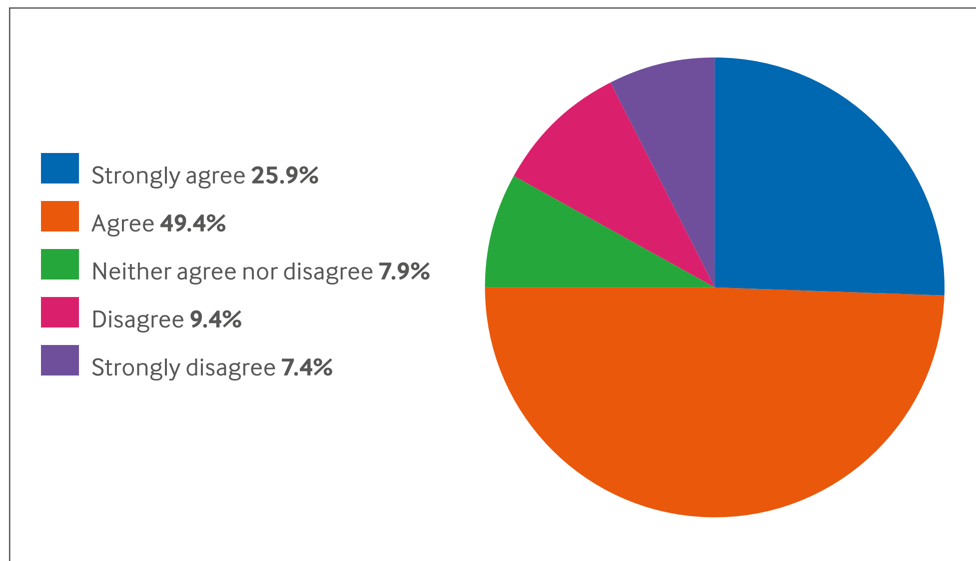

Figure 4: a pie chart depicting results from question "my medical school creates measures for students to provide continuous feedback on the curriculum and clinical placements (with the option to anonymise) to facilitate plans of action for any identified issues"

Regarding performative measures, only 44.0% of students 'agreed' or 'strongly agreed' their medical schools offer voluntary wellbeing sessions. Yet, despite such provisions, it appears frequently their actual implementation is poor. From being timetabled during placement days to not being advertised, most students highlighted how it is a "tick box exercise rather than genuine care about students' welfare". Numerous studies have discussed how the importance is not just the provision of wellbeing sessions, but more importantly their uptake and impact on students (Dyrbye, et al., 2019).

This was similarly seen regarding if medical schools made students aware of structures in place to support their mental and physical wellbeing which was poor with only 59.3% of students 'agreeing' or 'strongly agreeing. Such information should be readily available and easy to find as students have highlighted how when they are struggling, if it takes a lot of energy to find the resource, they will not engage.

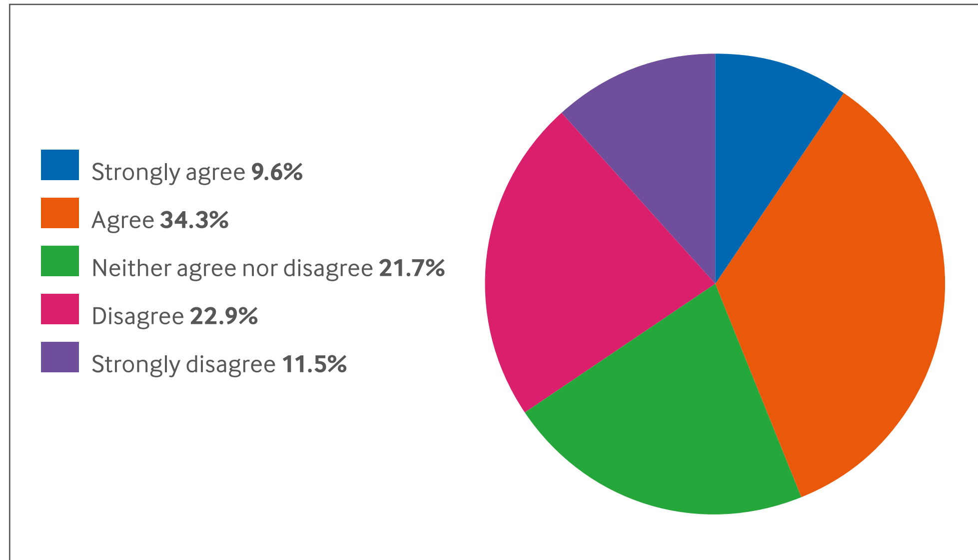

Figure 5: a pie chart depicting results from question "My medical school provides voluntary wellbeing sessions (e.g. Baliant groups, confidential wellbeing drop-in sessions and reflective practice sessions.")

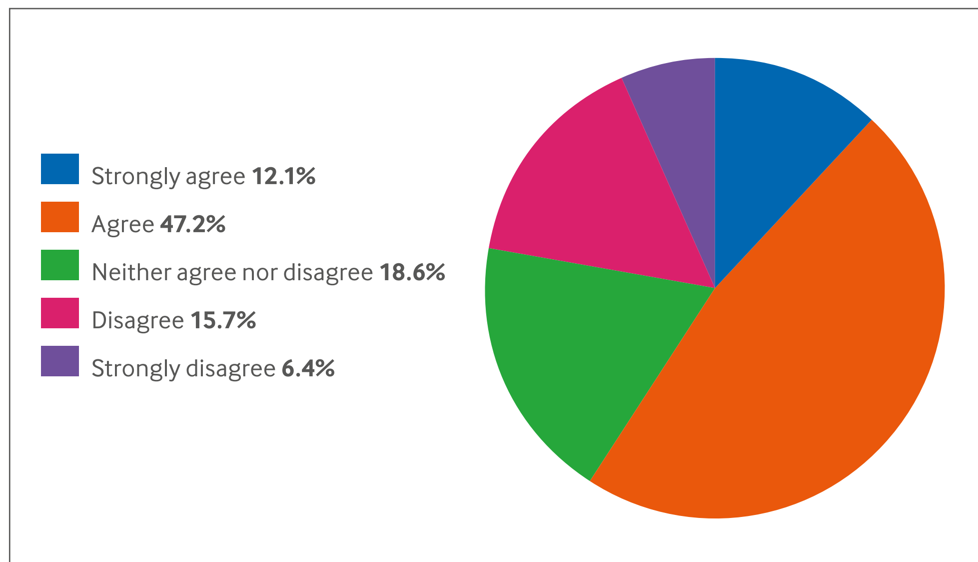

Figure 6: a pie chart depicting results from question ". My medical school ensures students are aware of the structures in place, both internal and external to the organisation, that support students' physical and mental wellbeing"

Workload

Only 21.0% of medical students 'agreed' or 'strongly agreed' their medical school commits to annual reviews of student work intensity at all stages of the course and ensure it is reasonable. In further comments, we received mixed positive and negative feedback. While some universities received positive feedback (Swansea and Lancaster), most were negative. The majority of responses explained they were unsure if there were annual reviews, which is concerning as student opinion should be at the forefront of these reviews to drive change.

A frequent occurring comment was the struggle students face balancing 9-5 placement and self-directed learning which can be summarised by two key comments: "there is no time to learn content let alone live our lives" and "No one really cares how much we do because apparently being burnt out is just part of being a med student." This is reinforced by existing published studies which have found excessive workload can lead to high levels of medical student burnout (Morcos & Awan, 2023).

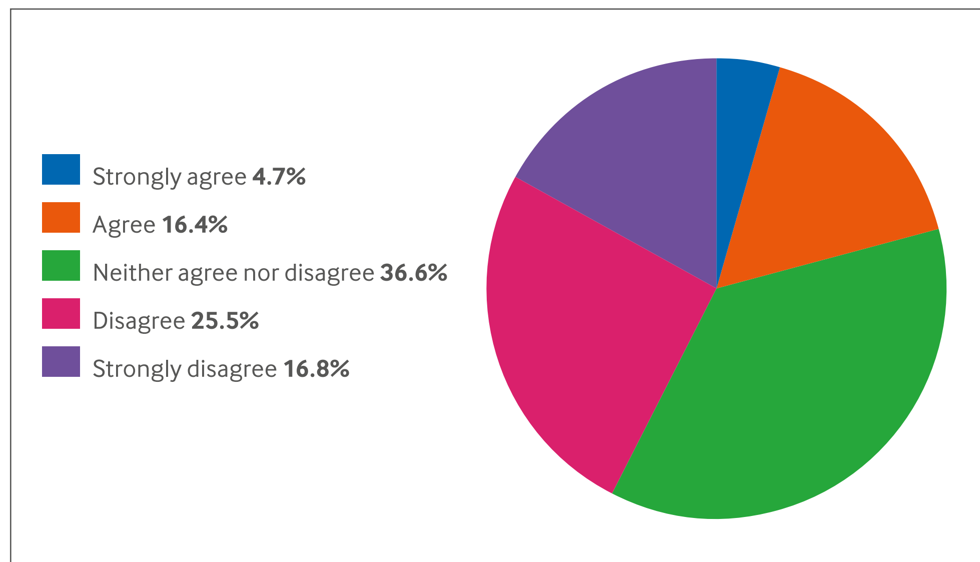

Figure 7: a pie chart depicting the results from the question "my medical school commits to annual reviews of student work intensity at all stages of the course and ensure it is reasonable."

Such sentiment was echoed when we enquired if students agreed their medical school incorporates an agreed period of designated protected study time per week into the student timetable during placement of which only 30.7% 'agreed' or 'strongly agreed'. Students often echoed how no protected time means they are "forced to "skip" placement to find time to study. This is unacceptable. Self-directed learning is the foundation for which students can build their clinical knowledge on (Thota, et al., 2022). When such protected time is lacking, it leads to missed opportunities, overworking and burnout.

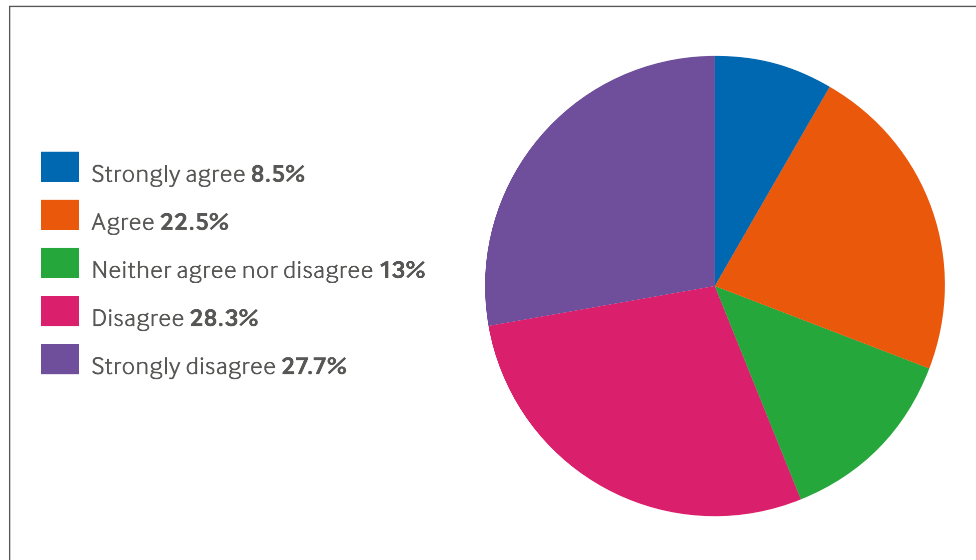

Figure 8: a pie chart depicting the results from the question "my medical school incorporates an agreed period of designated protected study time per week into the student timetable."

Conclusion

Evidently, there are discrepancies in welfare provisions across medical schools in the UK which we aimed to uncover. When there are poor wellbeing provisions or culture, it has been found to lead to worse medical student mental health (Medisauskaite, et al., 2023). Therefore, these discrepancies need to be confronted and rectified. Despite most medical schools claiming to have implemented the criteria in our wellbeing checklist, unfortunately, this is not the case in practice. Some wellbeing measures have been performative not actually practised.

We acknowledge several limitations with this report. Firstly, the sample was not random as it was a self-selecting survey so there may be selection bias. Therefore, we do not know how representative it was of the population of medical students in the UK. Due to limited socio-demographic background of the respondents, we are unable to do further analysis to determine how representative it was. Also, we did not include a 'don't know' option in the survey, thus students may have answered 'neither agree nor disagree' when they did not know the answer.

From our study, criteria most medical schools meet are having a peer-to-peer mentorship scheme and measures for students to provide continuous feedback. However, the rest were rarely met. It is disheartening to notably see the lack of psychological support and negative cultures surrounding seeking support in medical schools. Especially considering the difficult climate students live in as highlighted with this report, such as inadequate rest facilities, lack of protected mealtimes and insufficient funding.

Such tangible measures (e.g. rest facilities, protected mealtimes) should be more easily solvable, and we hope that medical schools will take this feedback on board and implement change. Especially as if these areas were tackled, potentially the need for support would be lower. However, negative culture about seeking support should not be overlooked due to its often-taboo nature. In fact, it may be one of the most important findings. To be able to study medicine, one should not just be able to look after others but also themselves. Medical schools should be catalysts to conversations about mental health and support, not adding fuel to the fire.

Next steps

Now armed with the knowledge of discrepancies in wellbeing provisions across medical schools in the UK, the MSC hope to act on it. We plan to present this report to the Medical Schools Council and related key stakeholders to advocate for change. This knowledge also fits with and enhances our existing campaigns such as "fix medical student funding" while also being an igniter to start more.

To further understand and address the discrepancies in welfare provisions across UK medical schools, future research is essential. To develop upon this research piece particularly, a survey collecting more demographic data and including an 'I don't know item' would be ideal. It would be insightful to systematically evaluate and compare welfare services across UK medical schools specifically, to identify each medical school's gaps. Similarly, further research can be done into reasoning behind the discrepancies, whether they stem from funding disparities or institutional policies. Thus, crucial in developing standardised guidelines ensuring all medical schools offer equitable and comprehensive welfare support.

Appendix

Wellbeing checklist survey questions

1. What medical school do you go to?
2. Please select your year of study

For the statement questions answer: strongly agree, agree, neither agree nor disagree, disagree, strongly disagree

Structure

3. My medical school has an elected welfare officer formally reporting to the senior leadership board or committee of the school and feeding into the appropriate university wellbeing oversight reporting processes
4. Please provide further details on your elected welfare officer (e.g. MedSoc Welfare officer, course rep)
5. My medical school provides adequate rest and changing facilities in any new refurbishments and campus build projects
6. Please provide further details on the rest and changing facilities at your medical school
7. My medical school ensures there are affordable and accessible parking facilities around the university
8. Please provide further details on the type of parking facilities or benefits you receive (e.g. parking permit or free hospital parking for placement)
9. My medical school maintains an accessible and streamlined process for students to submit and claim back travel expenses for clinical placements
10. Please provide further details on the travel expense system (e.g. Full reimbursement? For all clinical placements? Provide accommodation when too far?)
11. My medical school incorporates protected mealtimes into clinical placement schedules
12. Please provide further details about protected mealtimes at your medical school (e.g. length, variation at placement sites etc.)
13. My medical school ensures students have easy access to psychological support services
14. Please provide further details on psychological support services you can receive (E.g. How long till first appointment? How many appointments offered?)

Self-actualisation

15. My medical school creates a peer-to-peer mentorship programme for all interested students, especially for those entering their first year of university
16. Please provide further details on the peer mentorship programme
17. My medical school ensures final year medical students feel adequately supported and prepared for the transition to FY1 by providing adequate resources and support services
18. Please provide further details on how you are supported for the transition to FY1
19. My medical school ensures all medical students can access all parts of the clinical site needed for their placements, including the use of trust software
20. Please provide further details on your access to clinical sites and their software

Feedback

21. My medical school creates measures for students to provide continuous feedback on their experiences of the curriculum and clinical placements (with the option to anonymise) to facilitate plans of action for any identified issues
22. Please provide further detail on the feedback measures in place at your medical school
23. My medical school provides voluntary wellbeing sessions (eg Balint groups, confidential wellbeing drop-in sessions and reflective practice sessions)
24. Please provide further details on any voluntary wellbeing sessions you receive at your medical school

25. My medical school ensures students are aware of the structures in place, both internal and external to the organisation, that support students' physical and mental wellbeing
26. Please provide further details on the awareness of structures ion place to support wellbeing at your medical school (E.g. counselling services, support and wellbeing teams)
27. My medical school ensures students are aware of the university support available for students SpLDs and ADHD.
28. Please provide further details about support for students with SpLDs and ADHD (E.g. disability support services)

Workload

29. My medical school commits to annual reviews of student work intensity at all stages of the course and ensure it is reasonable
30. Please provide further details about any annual reviews of student work intensity at your medical school
31. My medical school incorporates an agreed period of designated protected study time per week into the student timetable.
32. lease provide further details about designated protected study time you receive

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