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Editorial

Teaching suicide prevention: a Canadian medical education conundrum

Enseigner la prévention du suicide : une énigme pour l'éducation médicale canadienne

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Dilemmas and contradictions are ubiquitous in this human journey and often the source of humour. For example: "If I know one thing, it's that I know nothing" and "I work best under pressure, but I hate being stressed!" There are also several contradictions in medical education that are not funny at all. I recently wrote that medical school curricula were not designed for long term retention.[1] I've explained how we inadvertently or unwittingly promote and encourage among medical students sleep deprivation and self-medication.[2] In 2007, I wrote about the perils of the hidden curriculum, which has not been tamed and still roams the halls and clinic spaces of medical schools.[3] These and other dilemmas are not unique to Canadian medical education, but the tension around suicide prevention and offering Medical Assistance in Dying (MAiD) for patients with mental disorders certainly is. What are we educators to do when we find ourselves needing to teach about MAiD for mentally ill patients alongside suicide prevention and what we might consider for MAiD in general? Here we argue that medical educators ought to engage in an open discussion about how best to educate and form medical students and residents given a wide and vastly divergent range of reasonable opinions and perspectives found locally and internationally.

At White Coat Warm (he)Art (International Congress on Academic Medicine, 2024), I was struck by the artwork and accompanying text by Nicole Graziano (University of Alberta) published in this issue of the CMEJ.[4] Nicole's art poignantly depicts what she called "the torment, grief, and freedom of suicide."[4] The white noose portrayed over a backdrop of light and dark sheds small white flowers filling the space. Her enigmatic set of words on its own caused me to pause. For me, her art juxtaposed the tragedy of suicide, liberation, and the expansion of MAiD, especially for those with psychiatric disorders. How does one help students and residents grasp the need to prevent suicide while offering MAiD to the psychiatrically ill? In the next few paragraphs, we present some of the dilemmas and sensible and valuable counter points to MAiD that we feel ought to be taught and discussed as part of a learner's formation and education around MAiD.

The application of the term "suicide" to MAiD is said to be problematic or, at least, inaccurate. To many, MAiD seems to be suicide by name and definition: Medical Assistance in Dying. Physicians only provide "assistance" and facilitate the death the patient requests. The Center for Disease Control defines suicide as "death caused by injuring oneself with the intent to die."[5] In MAiD, the decision and agency are always the patient's, hence, suicide. Dr. John Mayer, editor of the Journal of Ethics in Mental Health, has also pointed this out.[6] How are educators then, supposed to teach students to provide suicide prevention to some patients who exhibit "self-directed behaviour with an intent to die" and simultaneously assist patients who request MAiD thus also demonstrating "self-directed behaviour with an intent to die"? Learners will notice this incongruence and have questions. We need to help them find some resolution.

Beyond contesting the definition of suicide, within Canada there are individuals and groups of physicians opposed to MAiD, particularly for psychiatric patients. While among the Canadian population, physicians, and many others, there is widespread support for the current policy and practice of MAiD, most disability advocacy and support group in the country and many Indigenous groups strongly oppose MAiD, even now. Many palliative care physicians do not want MAiD included in their practices or to be considered end of life care.[7] Furthermore, the World Medical Association condemns MAiD as an abandonment of the nature and essence of medical practice.[8] These views cannot be summarily dismissed and ought to be surfaced and addressed among medical learners. We cannot protect them from dissenting views.

For a broad discussion of this topic, we could also explain the history of human rights in Canada and around the world where Canada was considered a pioneer and model for other countries.[9] But here too there are controversy and opposition: the United Nations' Special Rapporteur on the rights of persons with disabilities; Independent Expert on the enjoyment of all human rights by older persons; and Special Rapporteur on extreme poverty and human rights declared that MAID in Canada was not consistent with human rights.[10] We need to acknowledge this wide range of local and international opinions on MAiD, including relevant rulings by the Supreme Court of Canada, and allow our learners to discuss these openly and transparently without repercussions.

Will we also address patient autonomy in the same manner? Will we make our learners aware that autonomy as an over-riding imperative is problematic? First, that there are no choices that are completely and wholly autonomous. We all live in a context with intertwining relationships and limitations where our decisions are made, at least in part, after consideration of what is possible and desirable within our unique situations. Our teaching about the social determinants of health affirms this perspective. Patients with mental disorders face longer waits for care, have less access to state-of-the-art expertise in certain conditions, and are generally far less economically resourced then people with other illnesses. How could these circumstance *not* shape the MAiD decision?

Second, autonomy is an instrumental value. Autonomy helps us lead a fuller, better life, one of our choosing. Self Determination Theory[11] posits that autonomy supports two other major motivators in our lives. Namely, it helps us make a world of our choosing and to enhance our sense of both accomplishment and belonging. Looking back, we reflect and learn from what we ourselves have chosen, good and not so good. But the exercise of autonomy in the MAiD decision does not lead to a fuller life, and we do not get to live with an enhanced sense of accomplishment or belonging. For those who chose MAiD, they cannot ever say of their MAiD choice, the one facilitated by medical professionals, "I'm proud of what I've done" and hence their exercise of autonomy was for naught.

Diverse thinking is valued and cultivated at graduate schools. Will such diversity be honoured at medical schools and residency programs where we could encourage curiosity and freedom of thought? Where inclusion is a key value of medical school and post-graduate programs, will we embrace dissenting opinions on this issue of care? Is there and will there be room for disagreement and honest dialogue and if not, what message does that send to our students and residents, and at what cost? We believe some learners may experience some degree of cognitive dissonance and therefore it would be worthwhile to surface any tensions and differences proactively rather than allowing these issues to bubble up haphazardly and without guidance.

As educators with a fiduciary responsibility to our learners, the profession of medicine, and the Canadian public, we must take sufficient care with professional identify formation in the face of the many ethical and clinical issues that confront us, especially when MAiD is extended to patients with psychiatric disorder. This is an education and professional formation dilemma worth addressing.

Please read the articles in this issue, many of which identify other dilemma's and incongruencies in medical education and propose actions to remedy them.

Original Research

"Everything new is happening all at once": a qualitative study of early career obstetrician and gynaecologists' preparedness for independent practice by Nicole Wiebe and co-authors[12] explored the transition from residency to independent practice for recent Obstetrics and Gynaecology graduates. Their findings suggested that there are gaps not fully addressed during residency. The authors emphasized the need for mentorship and training opportunities beyond residency to better prepare new graduates for the complexities of independent practice.

Chua and team's article, *'What would my peers say?' Comparing the opinion-based method with the prediction-*

based method in Continuing Medical Education course evaluation,[13] compared two methods of evaluating a large continuing medical education course: expressing personal opinions on a five-point Likert scale and predicting the percentage of their peers choosing each Likert scale option. They found that the prediction-based method required fewer respondents to obtain similar results.

Velez et al.'s article, Medical students' perspectives on a longitudinal wellness curriculum: a qualitative investigation,[14] examined the effectiveness of a Longitudinal Wellness Curriculum (LWC) at a Canadian medical school. Their study identified key themes related to the impact of LWC, including the importance of student-centered approaches, and underscored the need to support student well-being in medical education.

Brief Reports

Karabacak et al. wrote Factors associated with substance use among preclinical medical students in Turkey: a cross-sectional study.[15] This Brief Report looked at substance use habits of medical students, and the effects on their mental health. They hope their findings inform interventions to improve the mental health for medical students.

An evaluation of mindful clinical congruence in medical students after course-based teaching Hutchinson and team[16] aimed to address the declines in patient compassion during the clerkship phase due to the intensity of clinical training. The authors introduced a Mindful Clinical Congruence course intended to help students see themselves and their patients as persons in the clinical context.

In their report, The impact of systematically repairing multiple choice questions with low discrimination on assessment reliability: an interrupted time series analysis,[17] Desy et al. introduced a continuous quality improvement (CQI) initiative to fix multiple-choice questions (MCQ) with a low discrimination index. Their study demonstrated that the initiative had a positive impact on test reliability.

Reviews, Theoretical Papers, and Meta-Analyses

What do we know about Objective Structured Clinical Examination in Sport and Exercise Medicine? A scoping review by El Sherif and team[18] reviewed studies on the use of Objective Structured Clinical Examinations (OSCEs) in Sport and Exercise Medicine. They highlighted the underdeveloped nature of existing literature, and called for more research to validate the effectiveness of OSCEs.

Medical training to effectively support patients who use substances across practice settings: a scoping review of recommended competencies by Christine Ausman and co-authors[19] identified the competencies taught in medical education for addressing the healthcare needs of people who use substances. To improve quality of care for this demographic, the authors suggested including addiction specialists as educators.

Black Ice

Five ways to get a grip on the personal emotional cost of breaking bad news by Preti and Sanatani[20] proposed five ways to help trainees with the emotional distress and burnout that can come with breaking bad news. They hope their tips will help alleviate some of the stress that comes from repeatedly giving patients bad news.

Eight ways to get a grip on validity as a social imperative by Mélanie Marceau and team[21] outlined eight methods to incorporate *validity as a social imperative* in assessment practices. These steps, including regularly reviewing and evaluated evidence quality to maintain its integrity, aimed to help assessment development focus on social consequences and the integration of quality.

Canadiana

In the article, Uprooting the CanMEDS flower? Equity, social justice, and the medical expert role by Najeeb and Kumagai,[22] the authors underscored the importance of values such as anti-racism, equity, and inclusion in medical education. However, they expressed concern over the proposal to de-emphasize the Medical Expert role. They contended the need for enhancing patient care and education without compromising medical expertise.

You Should Try This

Lai et al. wrote Evaluation of a novel virtual reality Immersive Clinical Experience to enhance medical education curriculum.[23] They developed a novel immersive clinical experience of a patient encounter in a virtual emergency setting to enhance pre-clerkship medical education.

Mazze et al. wrote Resident Support Network: a supportive approach to resident physician wellness[24] to describe the McMaster University's Resident Support Network for the pediatrics residency. The network is designed to address the high burnout rates among medical trainees by offering additional training and resources for resident wellness.

The study by Milena Markovski and co-authors in Resident and teacher perceptions of the preceptor field note: a

qualitative analysis,[25] documented residents' and teachers' first impressions of the novel preceptor field note as an tool for clinical teacher assessments to provide more immediate feedback.

Walk with a Future Doc program allows Canadian medical students to promote physical activity and health education in local communities by Wilson and team[26] described a program where medical students host walks for healthcare workers with the community. The program aimed to show medical professionals leading by example of healthy, active living.

Commentary and Opinions

Aristizabal Londono and co-authors' opinion piece, Harnessing Artificial Intelligence's potential in undergraduate medical education: an analysis of application and implication,[27] explored the use of AI as a learning tool for undergraduate medical trainees. They highlighted benefits and existing gaps in the field of AI and medical education, and outlines direction for future medical education.

In the commentary, Medical school admissions consulting: more harm than good? by Laurie Yang,[28] Yang argued against the use of for-profit admissions consulting services citing the lack of equity for those who cannot afford these services and concerns that consulting services may take advantage of aspiring medical students for profit.

Large language models in medical education: new tools for experimentation and discovery by Rajaram[29] described limitations and benefits large language models (LLMs) have as tools for teaching and learning within medical education.

Dhara and team's commentary, Centring equity in medicine: pushback to challenging power,[30] called for continued and ongoing CanMEDS renewal to address unjust systems and to integrate social justice and anti-racism principles into medical education.

Images

Sleep deprivation[31] by Zieneldien and Kim is a digital image that addresses the issue of a consistent lack of sleep among medical students.

Nicole Graziano's Threads of Life[4] is a mixed-media piece that addresses the stigma surrounding suicide. This image is the cover artwork for this issue.

Works in Progress

Educational approaches for social accountability in health professions training: a scoping review protocol by Zaccagnini and team[32] described the scoping review protocol they plan to undertake to map the existing literature regarding educational approaches concerning social accountability implemented in health professions education programs.

Conferences

Finally, we published the International Congress on Academic Medicine: 2024 medical education abstracts for the Association of Faculties of Medicine of Canada.[33] This year's theme was "Bringing together learners and leaders in research and education."

Enjoy!

Marcel D'Eon
CMEJ Editor-in-Chief

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