



Depressed British medical students: An ignored demographic?

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Letters to the Editor

One-to-one peer tutoring for failing medical students: A novel intervention

Dear Sir

Failing medical students are of great concern to medical educators. Poor exam performance is a significant source of stress in medical students (Sreeramareddy et al. 2007), with consequent effects on personal health. Consistent sub-par exam performance leads to student drop-out (Maher et al. 2013), which has substantial financial and emotional costs for the student. Also, there is a financial cost to society associated with student attrition, with long-term impact on workforce planning for health services. Faculty time and resources will be under significant stress in dealing with failing students. Therefore, it is imperative that a support system, that is accessible and effective, exists for failing students.

We identified a crucial need for academic support for failing Year 1 & 2 students at our institution. In response, we implemented a novel one-to-one peer tutoring support system.

At our institution, organ systems-based modules are taught in Year 1 & 2, with in-course assessments (ICA) testing students' knowledge. Failure to pass ICAs can prevent students sitting the end-of-year examinations, and predicts strong likelihood of failing these examinations.

Senior medical students volunteered as peer tutors and were paired one-to-one with students who failed an ICA. Confidential tutoring sessions were held once a week until their end-of-year examinations. Tutoring efficacy was measured with paired T-tests.

Forty-seven students (22 male, 25 female) failed an ICA and received tutoring between 2011 and 2013. 15/47 (32%) and 12/47 (26%) consented to share their ICA and end-of-year results, respectively.

Mean post-tutoring ICA scores improved by 11% (44.7% to 55.7%, $p < 0.001$). Mean post-tutoring end-of-year exam scores improved by 13.5% in comparison to mean pre-tutoring ICA scores (45.2% to 58.9%, $p < 0.001$).

Overall, 40 students (85%) passed the respective year: 31 (66%) at first attempt, 9 (19%) after resits. 5 students (11%) failed resits: of which, 3 retook the year and 2 were de-registered. 2 students withdrew before end-of-year exams.

To our knowledge, this is the first such peer tutoring programme designed to support failing medical students.

Our one-to-one peer tutoring support system improves failing students' mean ICA and end-of-year results by 11% and 13.5%, respectively ($p < 0.001$). Statistically significant increases in post-tutoring results demonstrate the effectiveness of a low-cost, peer-led and peer-taught tutoring programme.

The limited response rate for examination results in our study affects the power of the analysis of pre- and post-tutoring results. However, strong statistical significance and large post-tutoring improvements indicate the efficacy of our results.

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Depressed British medical students: An ignored demographic?

Dear Sir

Psychological well-being is important for students, their peers and their future medical practice. International studies have reported significant prevalence (12–37%) of depression among medical students. However, these results cannot be generalised to the UK due to differences in course structure, intensity, and environmental factors. Despite the scarcity of research in depressed British medical students, only two studies have been conducted in the past decade. Studies reported wide variations in prevalence (5.6–32.4%) depending on the year of study. The studies had significant limitations which included

one or more of: no data on past medical or family history of depression, use of a cross-sectional design and assessing students at only one time point, which was prior to or immediately after exams or at the beginning of the academic year. Current research on depression in British medical students is inadequate and neglected. The General Medical Council (GMC) must encourage medical schools to conduct prospective longitudinal cohort studies to identify prevalence, predictive individual and environmental factors and local barriers to seeking treatment.

International studies have reported higher rates of depression in medical students than age-matched peers. However these studies are not generalizable to the UK due to differences in course structure and environment. Despite this, research to identify prevalence of depression in British medical students has been scarce, with only two studies conducted in the past decade.

Quince et al. (2012) reported 5.7–10.6% of pre-clinical students and 2.7–8.2% of clinical students at Cambridge University were depressed. In contrast Honney et al. (2010) at University College London reported 32.4%, 10.8% and 5.6% of students in all year groups had mild, moderate or severe depression respectively. However both studies had numerous limitations.

Quince did not identify which students were already diagnosed with depression prior to medical school, making it difficult to ascertain whether depression occurred due to factors prior to or during medical school. Furthermore Cambridge utilises a pastoral system where there is a much higher level of contact with tutors compared to other schools and so vulnerable students may have been given much more support to prevent depression.

Finally, due to the fluctuating nature of mood disorders, measurements at one time point are not a reliable indicators of prevalence in individuals as a number of factors such as: exams and holidays can affect mood through the year. Only the Cambridge study followed students over several years, but it failed to make any significant conclusions due to a high rate of non-responders.

The lack of reliable prevalence and causative data on depression in this vulnerable group is a worrying sign. Medical students with depression are more likely to drop out of the course resulting in time and money inefficiently spent on incomplete education. Furthermore, as medical students form the foundation of the future National Health Service (NHS), the social impact can be significant. Regulatory organisations for UK medical schools such as the GMC need to encourage schools to frequently collect data and analyse it locally to identify prevalence rates, predictive individual and environmental factors and local barriers to seeking help and treatment. Data also needs to be pooled nationally so the GMC in concert with the NHS and the Royal College of Psychiatrists can implement national strategies aimed at the general factors affecting all medical students.

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The doctor who performs poorly in simulation: An approach

Dear Sir

As large scale clinical simulation programmes roll out, we are forced to confront the scenario where the performance of a trainee in simulation falls short of what is expected. Whilst policies and guidance are in place to address such an issue occurring in clinical practice, we are aware of no such guidance when applied to simulation. There is a responsibility on us as clinicians and educators to raise concerns about the performance of a colleague where patient safety is perceived to be threatened. Our protocol has been accepted for use in a region wide medical emergencies course (GMC 2013; National Association of Clinical Tutors 2013).

The maintenance of a safe psychological learning environment, whilst assessing competence and identifying potential threats to patient safety is a difficult balance. It must also be recognised that the learner may respond differently in simulated scenarios to clinical practice. There may not be the opportunity to observe a learner on multiple occasions.

Recognising these difficulties, we have agreed that where serious issues are identified (as defined by practice likely to lead to patient harm, or unprofessional behaviour likely to lead to patient distress), or the learner fails to recognise their own learning needs, the 'red' pathway is followed. Where available, all facilitators on the course will discuss and triangulate their views, with an action plan to be followed. The trainee will have face to face feedback with facilitators away from other trainees and the concerns will be recorded on a Mini-CEX and ACAT assessment tool. The course director will liaise with the trainee's educational supervisor and an action plan will be agreed with support provided as required.

For areas of poor performance which do not meet the criteria above, and where the trainee recognises learning needs, there is discretion available to the facilitators as to the course of action to be taken. Once again, the Mini-CEX and ACAT assessments are completed to document concerns, and an action plan is agreed. This is usually followed by repeat assessment once agreed actions are completed.