Incorporating Resilience into the Family Medicine Training Curriculum

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Abstract

Family Medicine training curricula are extensive documents that contain what needs to be taught and learned during a training programme. Emotional Stress and burn out is common in General Practitioners In the United Kingdom due to work load pressures in the National Health Service.

Resilience is the ability or capacity to regulate stress and resilience can be considered as an emotional competence and a behavior that can be developed or enhanced during training.

We recommend the consideration of incorporating resilience training and development into the curriculum design of family medicine training programmes to better prepare Family Physicians to cope with the emotional stress and burn out associated with working as a Family Physician.

Key words: Resilience, Curriculum Design, Medical Education, Family Medicine Training

Background

A country's family medicine training curriculum is of upmost importance in that it informs the learner what needs to be learned, the teacher what needs to be taught and also then determines that which is to be assessed [1]. The General Medical Council (GMC) in the United Kingdom (UK) regulates the development of undergraduate and postgraduate curricula as per the Medical Act 1983 in the UK. The GMC offers a definition of the term curriculum in its document entitled standards for curricula and assessment systems [2]:

'' A statement of the intended aims and objectives, content, experiences, outcomes and processes of a programme, including a description of the structure and expected methods of learning, teaching, feedback and supervision. The curriculum should set out what knowledge, skills and behaviours the trainee will achieve"

Thus the GMC through its policy directive is quite prescriptive in terms of what it expects of medical schools and Royal Colleges that are developing and designing both undergraduate and post graduate curriculum.

The Royal College of General Practitioners (RCGP) has produced an extensive 343 page curriculum for its General Practitioner trainees in the UK [3]. It has a more consolidated 60 page document that outlines the way the curriculum is structured into three broad areas. The first is the core curriculum statement of 'being a general practitioner' in which ''broad areas of capability'' are outlined in the document [4]. The second is the professional modules which include patient safety, quality of care and the GP in the wider professional environment. The third is the clinical modules which cover a range of specialities.

Developing Resilience in GP trainees

The hidden curriculum [5] is a process by which trainees learn things implicitly which are not part of the formal curriculum. In General Practice the hidden curriculum is important for the new GP trainee as lots of 'rules' are implicit. Burnout is very common in medical professionals and GPs in particular. A study conducted using the Maslach Burnout Inventory (MBI) surveyed 564 GPs. The results showed 46% had high levels of "emotional exhaustion and depersonalisation" and 34% reported low levels of personal accomplishment [6].

This high level of burnout is evident in the general practice workforce and morale is low and there is an unprecedented recruitment and retention crisis. A recent report in the Independent newspaper in April 2017 lamented how the NHS was "haemorrhaging GPs at an alarming rate" as GP numbers went down rather than up [7].

We feel one area of Family Medicine Training curricula can be enhanced by incorporating 'resilience' training into the formal curriculum. The GMC mention behaviours as well as knowledge in their definition of curriculum, so resilience could be a behaviour trait that is encouraged through curriculum design, planning and consideration for nations that have formal family medicine residency programmes.

Identifying burnout

Resilience training could be general or be targeted to those most in need by identifying burnout. The most commonly used burnout inventory is the Maslach Burnout Inventory (MBI) and then the Burnout Measure (BM). The burnout measure defines burnout as being "a state of physical, emotional and mental exhaustion caused by long term involvement in situations that are emotionally demanding" [8].

Family Medicine trainees and Family Medicine Physicians are often in situations that are physically and mentally exhausting and hence are at a high risk of burnout and hence awareness of burnout and increasing resilience of trainees should be an important part of the curriculum.

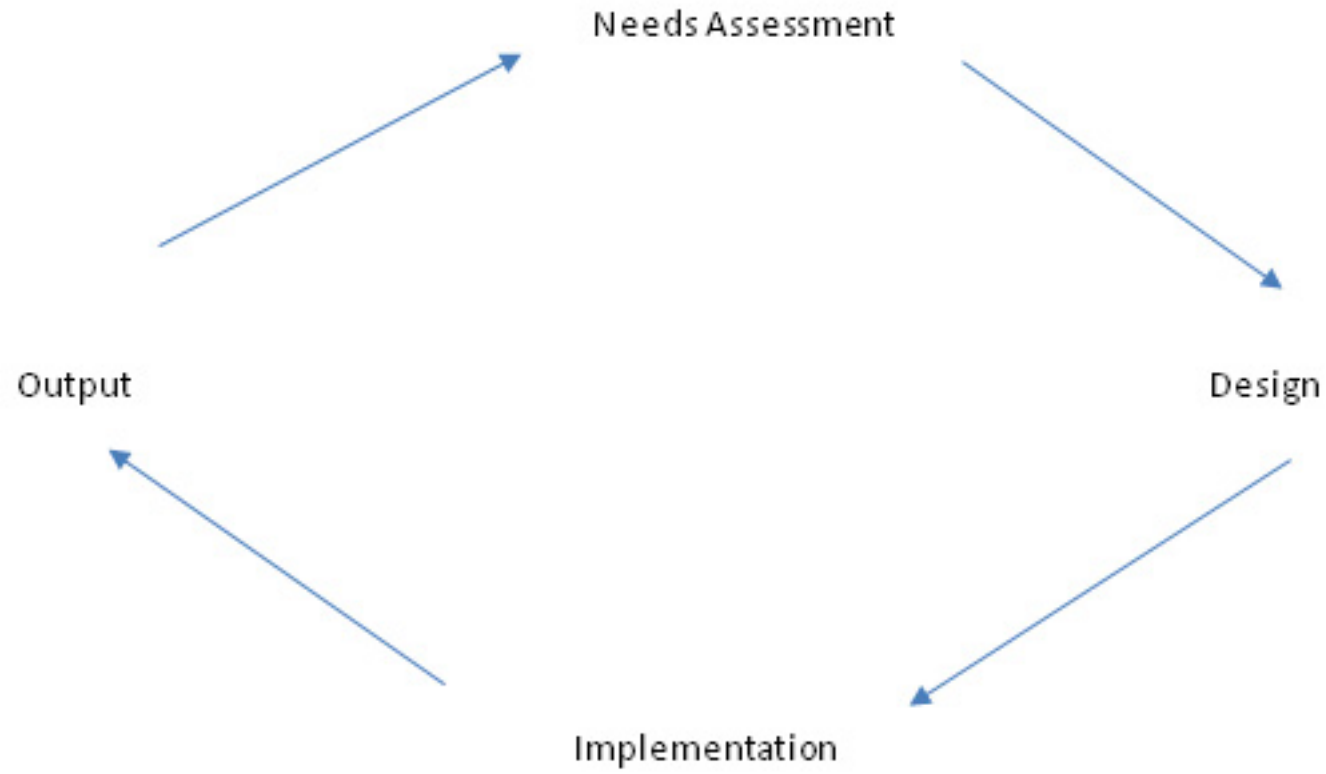
A systematic review examined numerous studies searched for on a definition of resilience and came across a multitude of interpretations. One of the studies mentioned the definition of resilience as being "able to moderate the negative effects of stress" whilst another suggested it was "a dynamic evolving process of positive attitudes and effective strategies" [9]. Dr King who is a psychiatrist wrote in a recent blog on the General Medical Council UK website [10] that resilience is "not only the ability to cope with stress but being able to thrive and flourish in difficult circumstances. It is not about asking doctors to grin and bear it and handle intolerable organisational pressures or excessive workloads. Neither is it about naming and shaming of the 'weak' doctor" [10].

A recent article by a GP educationalist implored medical educators to consider resilience as an 'emotional competence' and a "behaviour that can be acquired through training"[11]. It is more difficult to plan for emotional or behavioural competencies and perhaps this is why educators may be less keen to consider them in curriculum design.

Curriculum Planning Cycle

Peyton and Peyton suggest a curriculum planning cycle outlined in Figure 1 [12]. We applied the cycle to reflect on the possibility of enhancing an existing curriculum. The needs assessment has been done in that there is ample evidence of burnout amongst GPs, so doing something to prevent this will help in theory. The output would be trainees that are more emotionally resilient and less likely to burn out. The Design and Implementation is what I would like to focus on in this essay.

Figure 1: Peyton and Peyton 1998



The SPICES Model

The SPICES Model [13] outlines some educational strategies to consider when developing curriculum with each of these six issues presented as a spectrum with two opposing positions as outlined in Figure 2.

Figure 2: The SPICES Model

1.	Student Centred	Teacher Centred
2.	Problem based	Information Gathering
3.	Integrated	Discipline Based
4.	Community based	Hospital Based
5.	Elective	Standard Programme
6.	Systematic	Apprenticeship or opportunistic

Considering these curriculum strategies in relation to incorporating resilience development into an existing curriculum was helpful. It is thought those curricula that are to the left side of Figure 2 are innovative whilst the right side is more traditional. The curriculum enhancement we are suggesting would have to be student centred although in post graduate terms it would be trainee centred rather than teacher or trainer centred. There seems to be little scope for a teacher telling someone how to be resilient but one could be 'coached' or guided to being more resilient.

An example of this could be helping a trainee learn how to say 'no' or learning how to delegate to manage workload better and hence increase emotional resilience. You could leave a trainee to be on call with various requests from all the community allied health professionals and requests from secondary care colleagues for months and they may be drowning in the workload, using the 'problem based learning' approach to come up with solutions. Or the trainer could guide the trainee to advise them to use community resources such the emergency care practitioner who could potentially do some of their home visits and reduce the workload.

This strand of the curriculum would have to be integrated as it transcends disciplines and could be both community based and hospital based. Resilience can be developed for the Family Medicine trainee who is doing 12 days in a row during his Emergency department rotation or the paediatric trainee who is doing the night shifts looking after unwell neonates. It would have to be part of the standard programme as it is not a skill or piece of knowledge, but attitude or behaviour that is being developed and cannot be confined to an elective block.

One day Workshops and Integration

During a recent GP training event in South Yorkshire there was thought given to resilience training as 'resilience' is the new buzz word in medical training given the current NHS crisis and low junior doctor morale amidst contract disputes and ever increasing workload. A one-day conference was organised at a local football stadium and workshops were organised around resilience. The most notable workshop was by a company called 'Chimp management' [14]. This workshop was on mind management and controlling the 'inner chimp' as a way of increasing emotional wellbeing and resilience. It offered strategies of how to put certain emotions into a 'box' when dealing with work related stress. It was useful to reflect on ones 'inner chimp' and how to deal with negative primate emotions in the face of adversity.

However, resilience training should be built into the curriculum in an integrated fashion rather than a one off study day.

Integration in medical education terms refers to whether curriculums are compartmentalised into different disciplines or integrated so teaching is interdisciplinary [15]. Horizontal integration refers to multiple disciplines being taught together perhaps around cases or problems, whereas vertical integration refers to integrating what was traditionally thought of as the distinction between pre clinical and clinical years. The spiral model of curriculum design has "clinical placements interspersed with content based learning, emphasising reinforcement, structured repetition and application of learning to clinical medicine" [16].

Most GPs or clinicians will be delivering a part of a curriculum and those who are Training programme directors (TPDs) will be planning the delivery of the curriculum during the 3 year training programme. I would recommend vertical integration of resilience training so that it is introduced gradually from Year one specialist trainees to final year Family Medicine trainees. Naturally, things will get more difficult as work load pressures increase for final year trainees and professional exams approach so resilience sessions will become increasingly important and relevant.

Outcome Based Curriculum

A recent trend in medical education is to move towards an outcome focussed curriculum [17, 18] where outcomes are defined which then informs curriculum design. In this case, an outcome that could be added would be that GP trainees must demonstrate personal and professional resilience. However, the assessment of this would have to be done via work placed based assessment and commented on by clinical supervisors. This assessment must be formative and can take the shape of discussions in one on one tutorials on development of professional and personal resilience. One of the reasons formative assessment would be important would be so that trainees are not discouraged from seeking help if they were struggling and fearing that would be deemed as not having resilience.

Implementation

In terms of actually incorporating this topic into the 3 year family medicine programme we would propose input from the local training progamme director to ensure some of the weekly half day VTS teaching sessions are devoted to personal and professional resilience. The tutorial sessions can focus on more hands on advice to trainees about how trainees are managing with certain tasks. They can focus on issues specific to the trainee and perhaps create learning opportunities tailor made to the trainees needs. For example, if one trainee is struggling with dealing with patients with multiple issues in ten minute consultations and hence is struggling with their resilience then sessions can be directed at this issue, whereas if another trainee is struggling with burnout due to the heavy workload whilst on call then this can be the focus of a particular tutorial.

Conclusion

Current Family Medicine trainee programmes can be enhanced by including resilience as an emotional competence and having a stated curriculum outcome focussed on personal and professional resilience.

Learner centred, integrated and problem based curriculum design features can be used to plan to include resilience training throughout the 3 year Family Medicine training programme to promote trainee well-being. Assessment of this competence should be formative rather than summative and struggling trainees can be given additional support tailored to their particular needs.

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