Clinical staging of clinicians

Medical practice weights clinical staging models, so why not a staging model for medical practitioners themselves?

Clinical staging models are relevant to managing many medical conditions and have the potential to determine prognosis and phase-specific interventions. Reflecting this age of personalised medicine, a staging model for personalising clinicians (henceforth, personalised to "you") is now offered.

Stage 0 (stage direction — you are at increased risk of training in medicine)

Factors include familial risk (two medical practitioner parents further increase the risk above an elevated risk of one parent being a medico) and a declared adolescent wish "to find the cure for cancer". Less common factors include a parent effecting a vicarious gratification model (awaiting the day when "my son/daughter the doctor" could be dropped into a conversation) and/or being an only or eldest child.

Prodromal stage (staging post — inhabiting the role of "medical student", with "pre-clinical" and "clinical" substages)

At the pre-clinical stage, first contact with a dead body may shape future career choice. If you dissect with total contentment and detachment while eating your lunch, you will be inclined to choose surgery. If attracted by the smell of formalin, a pathology career beckons.

A key predictor is the ability to immediately understand the Krebs cycle. If so (being left-brain dominant) you will later flower in medical practice domains weighted to logic. If not so able and wondering why it lacks an apostrophe (Kreb's cycle or Krebs' cycle?), you are ordained for a medical domain requiring pattern analytical skills. Cool future clinical judgment is foreshadowed by you working to a model that an exam result of 53% means having studied 3% too hard.

The clinical stage is marked by the wearing of a white coat and an insouciant swinging stethoscope. You purr when someone refers to you as "doctor". As you group with fellow students on the consultant's rounds, your position has prognostic value. Those who offer to be the first to examine the patient are more likely to train in surgery. Further, imagine that the consultant turns on you and states, "Smith. You deserve an HD. (Smirk). 'H' for honest and 'D' for dumb". Deciding whether it is you or the consultant who has a problem predicts your future self-confidence as a practitioner.

If high on agreeableness, you will be a caring doctor. A level of cool detachment will shape a procedural career. A touch of paranoia will assist a research career (where every rejected journal submission or grant application encourages you to "prove the 'bastards' wrong").

This stage is also marked by hypochondriasis. You ask your co-student partner (snuggled beside you) whether they can hear a murmur. Every freckle is a melanoma. When toileting, you resemble a King's Groom of the Stool.

Residency stage (stagehand)

A stage of polar emotions. Stage fright when you walk into the emergency department (ED) and observe six waiting ambulances, and you become aware of your sphincter ani externus for the first time. You have pre-traumatic stress disorder (jumping out of bed to be met by a smiling ED nurse who, noting your pyjamas, encourages a return to bed). Your consultants respond to your clinical formulations as if you are a dunce — agreed, the patient's primary symptom of polyuria did not discount your diagnosis of sarcoid of the hypothalamus.

And a contrasting brashness pole. You are so confident in diagnosing appendicitis that you lay bets as to which direction the hot appendix will be pointing when the abdomen is opened. You are disappointed if you cannot get the valid diagnosis with less than six (closed) questions. And you are delighted when you make a confirmed diagnosis such as pancreatic cancer in a 45-year-old executive, not for a moment contemplating how the patient's life has immediately changed. You are preoccupied with getting the right diagnosis, not considering its impact.

And so many simple pleasures. You can now get a needle into anyone's veins and do single-handed surgical knots with your eyes closed.

Discipline training stage (stage race)

You choose a specialty principally because a consultant within that field was kind to you and praised your skills. Perhaps general practice, being attracted to its variety, seeming independence, and work–life balance. If another specialty, you are now conjoined with peers and the statistics are stark: only 30% of you will clear the exam hurdle. You confer daily with your favoured colleague, enjoying the friendship while fantasising that their *wan mien* might indicate a latent carcinoma. The zero-sum game has started.

You gain knowledge in your field in a linear way (rote learning diagnostic criteria and treatment guidelines). Off-duty you are now settling into a relationship. Either another professional who understands your lengthy work hours or a non-professional with practical skills and a willing "I've got it covered" attitude.

Young clinician stage (stage performance)

You and your successfully examined colleagues are now a happy band of brothers/sisters. You say "my patient"

Gordon B Parker AO

University of New South Wales, Sydney, NSW.

g.parker@unsw.edu.au

doi: 10.5694/mja2.51780

in conversation. But now you have to learn medicine all over again, as your discipline's nuances were never part of the training program. You still employ an explicit diagnostic and prognostic model — weighting facts from the literature and lengthy history taking.

And you become a successful juggler. You have set up your practice, you are in an established relationship, a parent, have a mortgage, and seek to remain fit, while knocking off a bottle of wine each night is readily achieved.

Mature clinician stage (stagecraft)

Your brain is now operating to a Bayesian model, seemingly unconsciously weighting certain probe questions, so that you often appear to intuitively derive the correct diagnosis and prognosis; you now have mastered pattern analysis. You increasingly accept non-clinical roles, finding committee work more intriguing than previously imagined.

Your current perception of doctoring will shape the future. Is it a job, a career, or a calling? If a job, you will retire in your 60s to pursue multiple interests and travel widely, and seek to be an active grandparent, content to have stepped away from medicine.

If a career, you will seek to stay on into your 70s. Now having "seen it all", you are unfazed by what might await you in the waiting room, and respect from your colleagues and patients keeps you keeping on.

If a calling, you have no plans for retiring. You judge that you are at the height of your career, and that you can maintain that peak for decades. You are a "top gun" in your field. Medical students and younger doctors wish to sit at your feet, your curriculum vitae captures multiple roles, empires built, organisational attachments, committees and boards, publications and awards. You weight giving over receiving, evidencing a level of reticence and even simplicity.

Older clinician stage (stage left)

You recognise some physical limitations and even some memory lapses but doubt that anyone else could detect them. You are the Flying Dutchman, always around but favouring inconspicuousness. Colleagues are gentle and kind to you, although they do ask about your health quite a lot.

Retirement stage (stage dive)

If a surgeon, age is against you, but you tend to bloody mindedness about retirement. For several years, you have told your junior colleagues, "if you notice one mistake, tell me immediately and I'll step down", but when the mistakes start to occur you rationalise them.

There are three substage retirement patterns. One abrupt and complete. You wake up one day and realise that you are you are burnt out (principal driver being the electronic medical record), no longer enjoying practice, and you pull the plug. Prognosis is poor. Your days will be aimless, there being little pleasure in trying to retrain your partner about the best way to organise a shopping list, the things that you were "going to do" now seem trite and unsatisfying, and the days appear endlessly long.

Second, you move to a non-clinical role, perhaps medico-legal work. It may be insufferably boring but you are out of the house, still feel a doctor, and can pretend satisfaction to your bridge partner.

Third, you fade out gently, dropping from 5 days to one day per week and then slide imperceptibly to no medical work. This is the trajectory associated with the least perturbation and distress. Like the Cheshire cat, your body of medicine has faded out and what is most observed now is your smile.

Final stage

Let's skip the post-mortem.

Open access: Open access publishing facilitated by University of New South Wales, as part of the Wiley – University of New South Wales agreement via the Council of Australian University Librarians.

Competing interests: No relevant disclosures.

Provenance: Not commissioned; not externally peer reviewed. ■

© 2022 The Author. *Medical Journal of Australia* published by John Wiley & Sons Australia, Ltd on behalf of AMPCo Pty Ltd.

This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.