

Reports from breakout groups

Simon M Willcock (Chair)

THE FIRST TWO BREAKOUT GROUPS comprised medical students and prevocational trainee doctors, and the third delegates from medical boards, postgraduate councils and hospital administrators. The groups reported back on student issues, prevocational and trainee doctor issues and medical board issues.

This is a condensed summary of the reports from each group.

Student issues

- Identifying the distressed or impaired student is not the problem; peer groups are usually the first to be aware of this, but don't know what to do about it. We need a *"Dummy's guide to helping a mate"* — a simple flowchart outlining who to contact for each particular problem.
- A structured process of identification and notification of distressed or impaired students is needed. All students could be interviewed, perhaps annually, and the same questions asked. If the time can be found to interview recent graduates for selection for hospital placements, then it should be possible to find time to interview students to identify distress.
- An independent body is needed to assist distressed or impaired students at every medical school (an example is the general practitioner program at Melbourne University). This should be completely independent of the assessment process, and should only report back to the Faculty if there is a problem that needs to be addressed.
- Such a GP program would need to be well advertised. The more people who become involved, the less the stigma. Visiting an independent GP is then seen as positive rather than punitive.
- Confidentiality is a major issue. Career prospects should not be endangered.
- Medical schools should develop a database of mentors or people to contact (eg, GPs or social workers who are not members of the academic staff). They should be available at all campuses, hospitals and rotations, and should provide feedback about global issues for the student cohort — not individual students' problems. This would allow for prevention. Students would also need to constantly evaluate such a system. There would be no advantage if the GP appointed was not up to the task.

- Mentoring eases problems during transition periods (eg, going from Year 12 at school to first year at university, and during the final two years of the medical course when clinical work predominates (Years 3 and 4 for graduate courses and Years 5 and 6 for undergraduate courses). There are logistical issues to resolve. If mentoring is voluntary for both mentor and mentoree, the "lurkers" may still miss out.
- Special programs are needed for high-risk groups, including non-English-speaking students. They may need extra courses, but not special courses, as this can be alienating.
- The Personal and Professional Development tool (ie, using course interviews and essays to identify problems) is not the answer if used in isolation.

Prevocational and trainee doctor issues

Who should identify the student and junior doctor in distress?

- Everyone. A cultural change is needed. There is a culture in medicine of not admitting faults, and of weakness being seen as failure. Confidentiality is the key. Reporting systems should be independent of career prospects. Referral can be self-referral, or referral by peers, resident medical officers, registrars, consultants, or nursing staff. There should be a transparent pathway of events and the implications of reporting which is independent of career pathways.

Who should be informed or involved in the management of those in distress?

- Hospitals should have a list of people available for first contact (ie, staff GP, medical education officer, and others). Management could involve the Doctors' Health Advisory Service and the junior doctor's own GP.
- Directors of clinical training or clinical supervisors need to be aware of individual doctors' needs, but do not need to be aware of the problem itself.
- It is important that those providing help are trained and have some background in the kinds of services needed.

What action should be taken?

- **A. Prevention.**
 - First point of contact outside of the medical framework.
 - Independent follow-up.
 - Half a day's paid leave each year for consulting a GP, with consideration given to making it mandatory.
 - Regular pager-free forum for debriefing.
 - Support and resources for JMOs (ie, adequate staffing and cover for leave or sick leave. Others should not have to take up the slack).
 - Education of supervisors, registrars, consultants.
 - Education about junior doctors' responsibilities.
 - Education about time management.

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Comprehensive orientation.

Resources, such as common room and dictating room.

B. Management

Must be confidential, independent of training, and involve a clear pathway of processes to be followed.

Information about students should be transferred from the medical school to the hospital medical administration, but this is complicated by privacy regulations. In response to a question about whether it would be defamatory if universities passed on information which might affect a doctor's career, a medical school dean said the individual student should be involved. It would be easier if the student was aware that the university was going to ask the hospital to give him or her an appropriate internship environment.

Comment was made about the importance of a supportive administration. This support should extend beyond working conditions and rosters to social activities, housing and other matters.

The role of medical boards

Who should identify the student and junior doctor in distress?

- Everyone, but colleagues have a professional responsibility for doing so.

- The medical board's role is not punitive; it must be seen to be supportive.

Who should be informed or involved in the management of those in distress or impaired?

- Medical boards — but only if the student or doctor is impaired. The boards intervene when public safety issues are involved. The matter can usually be resolved at a local level.

What action should be taken?

- There is a huge role for medical boards in promoting a culture change by providing information on the support they provide to impaired doctors, and by influencing employers to provide support and mechanisms for assisting junior doctors. Most of the profession hopes that their only contact with the medical board will be to obtain registration and to pay their annual fee; they hope never to hear from them again. Medical boards need to be more proactive in promoting their image as caring and supportive, not punitive.

- It was pointed out that universities need to be more aware that the faculties of medicine are training people to be doctors, with all the implications of providing safe medical care for the community. Faculties of medicine are not just producing medical graduates.

- With imminent registration of medical students with medical boards in other States besides NSW, there needs to be a dialogue established between medical boards and university councils. □

Conference Participants

Dr Stephen Addis	Ms Eve Hiland	Dr Alison Reid
Ms Anita Alps	Ms Jane Hosking	Prof Geoff Riley
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