and 39% were overdue for some aspects of their preventive healthcare.

Conclusions and recommendations

Young doctors give their own healthcare a low priority. They feel great pressure not to miss shifts due to ill-health — as if this were not a valid reason. They have to be sure they are really sick enough before they would consider asking for help. This attitude to healthcare means that it is even more difficult for young doctors to seek help for a stress-related illness, a mental health issue or for substance misuse, as these are not seen as "real" illnesses.

Some of the recommendations that have come from this research may help to overcome these barriers to appropriate healthcare. For example, 82% of respondents felt that hospital administrations should allow doctors time to have an annual checkup, while 42% of respondents agreed that it would make it easier for them if the checkup was compulsory. Certainly, the information we have indicates that hospitals should be actively encouraging their medical staff to have regular medical checkups. This would act as a reminder, create an environment in which medical checkups were seen as the norm and not requiring a reason, and perhaps set up life-long patterns of behaviour.

Rates of self-prescribing and prescribing for colleagues among 158 junior medical staff

	Have prescribed or would prescribe	
Drug class	**For self**	**For a colleague**
Antibiotics	81%	78%
Sleeping tablets	38%	36%
Antihypertensives	15%	22%
Antidepressants	7%	14%
Narcotic analgesics	7%	18%

Summary

This short overview of our project does not include the data from the General Health Questionnaire. However, notable links with levels of stress in particular groups of doctors have emerged.

This preliminary research indicates that patterns of inappropriate healthcare behaviours develop very early in doctors' careers. We have a responsibility to care for JMOs, who appear to be more vulnerable to stress and its consequences. While we have focused on this group, our results can clearly be extrapolated to the medical profession as a whole. Perhaps the culture of poor self-care that appears to be ingrained in the medical profession comes from within.

Acknowledgement

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References

1. Lawrence J. The tragedy of doctor suicide. *Journal of the Queensland Branch of the Australian Medical Association* 1997; 12-13.
2. Schlicht SM, Gordon IR, Richard J, Christie GS. Suicide and related deaths in Victorian doctors. *Med J Aust* 1990; 153: 518-521.
3. Raphael B, Hugh G. Doctors and depression — the clinical viewpoint. *NSW Doctor,* July 1997; 13.
4. Pullen D, Lonie C, Lyle D, et al. The medical care of doctors. *Med J Aust* 1995; 162: 481-482.
5. Goldberg D. The General Health Questionnaire. East Windsor (UK): NFER Publishing Company, 1978. ❑

The junior doctor in distress: the role of a medical education officer at the systems level

Anne A Martin

> The training of junior doctors requires a delicate balance between "on the job" experience and quality training. . . . The preregistration year is a time in which training, skills and working role are consolidated under supervision, and it has been suggested that it may be the most stressful period in medical practice.[1]

IN SOUTH AUSTRALIAN TEACHING HOSPITALS, the education and training of doctors in their prevocational years is currently the domain of a team comprising a Director of Clinical Training (DCT) and a Medical Education Officer (MEO), in conjunction with a general clinical training committee. The overarching aim of the DCT–MEO team is to ensure high-quality patient care by guiding and supporting the developing junior doctor. To achieve this, the team works both in and on the system of the public teaching hospital.

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The DCT–MEO team

The DCT and the MEO have different, but complementary, roles. The DCT is a senior practising clinician and mentor, whose involvement is of necessity part-time, because of clinical responsibilities within and outside the teaching hospital (Box).[2] The MEO, on the other hand, can be more

focused on prevocational medical education and, especially if full-time, can provide a consistent presence in the hospital for junior medical officers (JMOs) during their training. The MEO has a range of skills in healthcare education, evaluation and counselling, and gives educational credibility to the team (Box). This team is more effective than each individual acting alone.

The MEO in South Australia

In mid-1999, MEO positions were established at each teaching hospital by the South Australian Council for Early Postgraduate Training. This model was adapted from one previously developed in Queensland by the Queensland Medical Education Centre with Queensland Health. At this time, the five foundation South Australian MEOs undertook informal needs analyses at the hospitals to gain objective insights into the local system. We asked the questions *"What is happening now for JMO education and training?"* and *"What needs to be done?"*. From the results of these analyses, we could tailor appropriate strategies for quality improvement of education and training in response to the particular and current needs of the JMOs at individual hospitals.

Quality management and evaluation of JMO education and training

Quality-monitoring and improvement systems are vital in a structure which is responsible for staff development, as the teaching hospitals are for JMO education and training. Quality management is an important role for the MEO with educational evaluation experience.

MEOs adopt a wide range of evaluation strategies, including questionnaires, interviews and participant observation, resulting in both quantitative and qualitative data. The MEO encourages and coordinates assessment and feedback from supervisory staff on, for example, JMOs' clinical competence, but also vice versa from JMOs about their supervisors on individual term rotations. The gathering of evaluative data about the individual terms, and on the hospital's education and training program as a whole, is essential for quality improvement.

Evaluation must be a continuous process

Evaluation must be part of a continuously cycling process that can be managed by an MEO to ensure rapid responses to needs as they arise in a changing environment. All aspects of JMO education and training programs, and the context in which they operate, need to be monitored. De-identified data are then fed back to the program coordinators, and used to inform the process of implementing change, which, in turn, must also be evaluated. The continual gathering of data can provide evidence of systemic problems which could cause excessive workloads, dissatisfaction with rosters, and reduced training opportunities, all of which may affect JMO development and performance.[3]

The complementary skills and roles of members of the early postgraduate medical education and training team

Director of Clinical Training	Medical Education Officer
Multifaceted role	Focused role
Part-time	Full-time
Clinical insights	Educational insights
Patient care expertise	Evaluation expertise
Clinical teaching	Quality monitoring
Career advice	Counselling skills

Evaluation must result in outcomes

Evaluation undertaken because it seems to be "the thing to do" is doomed to failure. People will not engage in evaluations if they never see any results, and failure to demonstrate outcomes will lead to lack of trust in the evaluators.

Evaluation must be confidential

It is difficult for a busy DCT to undertake comprehensive, continuous and confidential evaluation processes unassisted. By definition, an MEO in South Australia is not medically qualified and is thus perceived to be outside the "medical establishment". This is an advantage, enhancing his or her capacity to obtain free and frank responses to questionnaires and interviews, and increasing response rates and the usefulness of the data. An MEO is well placed to demonstrate and maintain confidentiality in evaluative processes and objectivity in reporting evaluation results to the DCT and the hospital management.

Support systems for JMOs

While formal administrative structures can be designed to facilitate the successful progress of JMOs through their service and training commitments, additional, less formal systems are also necessary. Another role for the MEO is to advocate for, initiate and organise professional, personal and educational support for JMOs. This can include:

- Weekly intern meetings, providing a collegial atmosphere, peer support and debriefing opportunities in a private, relaxed and caring environment;[4]
- A program of intern tutorials specifically for and responsive to the needs of JMOs; and
- A JMO lounge, which is a private space for relaxation, recuperation and meetings with colleagues away from the ward environment.

Provision of a supportive system and atmosphere within the teaching hospital can be facilitated by the DCT–MEO team, giving junior doctors opportunities and encouragement to support each other and themselves.[4]

A wider role for the MEO beyond JMO training

A background in education and training means the MEO can help support not only doctors in training, but also their supervisors. This can be achieved through the quality

improvement process described above, and by offering practical support and advice, providing, for example, skills in *"Teaching-on-the-run"* or *"How to give constructive feedback"*. In South Australia, the MEOs as a group offer a wide range of skills, including expertise in education, counselling, management, project development and research. They are a resource that can be called on across campuses and along the continuum from medical school through to specialty training programs.

Conclusion

Employment of an experienced postgraduate medical educator by a teaching hospital demonstrates a commitment to medical education and training of JMOs. The DCT and MEO can enhance the profile of JMO education and training within the hospital by active engagement in the work of hospital committees, encouraging mutual feedback between management and junior medical staff, advocating for education and training within the hospital environment, and helping to maintain the "delicate balance between 'on-the-job' experience and quality training" to reduce the potential for distress in junior doctors.[1]

References

1. Bogg J, Gibbs T, Bundred P. Training, job demands and mental health of pre-registration house officers. *Med Educ* 2001; 35: 590-595.
2. Schofield K, Saunders NA. Education and training in the early postgraduate years: the NSW experience. *Ann Community-Oriented Educ* 1993; 6: 173-179.
3. Firth-Cozens J. Emotional distress in junior house officers. *BMJ* 1987; 295: 533-536.
4. Davis M. Intern discussion group: a supportive education experience for junior doctors. *Hosp Med* 1999; 60: 435-439. ❑

The junior doctor in distress: the role of a medical education officer at the individual level

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DESPITE OUR BEST EFFORTS to create systems and organisational supports to facilitate optimal development for all junior medical officers (JMOs), some will continue to perform suboptimally and experience distress. It then becomes necessary to take an individualised approach to these JMOs. It must be emphasised that there is a clear distinction between distress and impairment. Distress does not imply impairment, although prolonged and unalleviated distress may eventually lead to impairment.

North Western Adelaide Health Service (NWAHS) allocates about 50 interns (mainly from Adelaide University Medical School and from the graduate-entry program at Flinders University School of Medicine) between two main public teaching hospitals — The Queen Elizabeth Hospital, which serves a predominantly ageing multicultural population in Adelaide's western suburbs, and the Lyell McEwen Health Service, with an expanding, younger client base in the north. These two hospitals are 25 km apart and together serve some of the poorest socioeconomic areas in Adelaide. This, together with the politically uncertain future of The Queen Elizabeth Hospital, puts NWAHS low on the list of preferred placements for newly graduating medical students. (For the Year 2001 intake, only one of the top 90 graduates indicated NWAHS as first preference.) This means that NWAHS, an already stressed system, may receive a disproportionate share of JMOs at risk of poor performance.

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1: What prompts an alert to the Medical Education Officer about a junior medical officer (JMO)?

Performance-related concerns

- Problems with time management (eg, discharge summaries not completed in a timely manner or not adequate; working hours too long; difficulties prioritising).
- Problems in situations when JMOs provide cover for medical and surgical emergencies, such as during change of shift (short calls).
- Problems with clinical competence in a specific setting or situation.
- Interpersonal problems (conflicts and difficulties relating to others).

Pastoral concerns

- Observably high levels of anxiety and tension.
- Inclined to "self put-down".
- Crying episodes.
- Clinical depression.
- Problems with attitude (eg, perceived arrogant and patronising behaviour; short-tempered, impatient outbursts; or shirking a fair share of the workload).

Here, I present a step-by-step overview of the processes and insights gained since the medical education officer (MEO) role was introduced at NWAHS in June 1999.

Who alerts the MEO and what prompts the alert?

Once the support component of the MEO role becomes known, concern about a particular JMO may be raised by the supervising registrars or consultants, the nursing staff, allied health staff, other JMOs, and, at times, a JMO contacts the MEO directly. There is often a sense of relief that there is someone in the system who can deal with these