

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.<sup>1</sup>

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

Karen Grace

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.

### 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

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**2: Factors affecting stress levels in junior medical officers**

**External stressors**

- Quality and continuity of registrar presence
- Helpfulness of nursing staff
- Nature of the work
- Type of working environment
- Medical knowledge
- Exhaustion — caused by long working hours, intensity of workload, and entry into full-time employment from student lifestyle
- Supportiveness of medical administration

**Internal stressors**

- Anxiety, lack of confidence
- Lack of interpersonal skills (assertion)
- Physical illness
- Psychiatric illness
- Unresolved critical incident stress
- Professional ethics
- Personal, non-work-related problems
- Belief that they have chosen the wrong career

**3: Clinical Learning Contract to document assessment of a JMO's performance**

Clinical learning contract for Dr \_\_\_\_\_  
 Supervising Consultant \_\_\_\_\_ Senior Registrar \_\_\_\_\_

Objectives	Strategies	Date and signature	Review date	Outcomes	Date and signature
1					
2					
3					
4					
5					

concerns. Most alerts are prompted by concerns about clinical performance. However, pastoral concerns are sometimes implicated (Box 1).

**Establishing the drivers of distress**

Following an alert, a wider context needs to be established. There is a need not only to check the information, but also to look beyond the obvious (eg, a seeming inability of the JMO to prioritise may disguise an avoidance issue and a host of other factors). Fact finding may involve talking with other members of the unit, or being aware of a particular unit's history with JMOs, and/or the "track record" of the person who initiated the alert, and of the JMO concerned. Of course, there is a need for discretion, whether enquiries are made directly or at a more casual level. Usually, an informal interview is conducted with the JMO to detail the issues raised and note any additional pertinent information. Once the facts are established and a picture begins to emerge, the underlying issues can be more clearly identified, and then decisions can be made and actions taken. The key drivers of JMO distress that have emerged at NWAHS are listed in Box 2.

Stressors may be external (ie, to do with the outer environment), or internal (ie, to do with inner processes at a personal level). An example of an important external stressor that is crucial to a JMO's experience is the quality and continuity of registrar presence on a unit. For example, how organised is the registrar? Does the registrar involve the JMO in patient management decisions? How willing is the registrar to teach and extend the JMO? How willing is the

registrar to assist and support the JMO during busy periods? And, finally, how available is the registrar when needed? In this regard, the lead-up to physicians' examinations is a particularly stressful time for JMOs.

Other external stressors of note include bullying and harassment, particularly the way in which nursing staff can undermine a JMO (or a student). Once covert, these issues are now beginning to be more openly discussed. Having a supportive medical administration, too, can make a big difference to JMOs' sense of wellbeing. This has been clearly documented by end-of-year intern surveys conducted at NWAHS in 1999 and 2000. Highlighted issues included perceived unfair rostering and leave allocation, general unhelpfulness and discourtesy, and bullying and harassment issues.

One of the internal stressors listed, professional ethics, has emerged from interviews and end-of-year surveys of JMOs. Issues related to the constant pressure for early — sometimes perceived as too-early — discharge of patients; how "not for resuscitation" orders are interpreted by nursing staff on some wards; and, more generally, the way patients are routinely treated by some health professionals. By the end of the year, some JMOs report disillusionment with a system which they perceive is forced to practise "conveyor belt" medicine. Given that many JMOs entered medicine for altruistic reasons, these ethical issues are a source of distress.

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**Assessment of stressors**

Before proceeding directly to an intervention, an assessment of the stressors is useful. The distinction between external and internal stressors clearly indicates different intervention strategies, although the stressors often involve a combination of external and internal factors. Other aspects of the stressors are useful to consider as well. For instance, has the distress been triggered by a critical incident that has gone unrecognised by the unit and so the JMO has not been debriefed and supported? Also, would the stress be classified as short term, medium term or long term? Periods of short-term stress (a few days to perhaps a fortnight) tend to resolve themselves without causing any lasting problems or major performance concerns; medium-term stress, perhaps for the duration of a particular attachment, may require substantial support; and long-term stress demands attention.

**Tailoring individual interventions**

These assessments will influence decisions on how to tailor individual interventions to best manage each situation.

#### 4: First-line counselling strategies

##### Non-professional counselling

- Listening, giving emotional support and clarifying issues.
- Providing a confidential opportunity for pressure release — “gripe dumping”.
- Reality checks — checking that perceptions are valid.
- Reframing – reorienting a skewed perception to a more positive perspective.
- Encouraging the JMO to ask for help and having him or her rehearse doing so confidently.

##### Professional counselling

- Using problem-solving strategies and skills from a variety of psychological frameworks.
- Building centring and anchoring triggers which help to maintain confidence and a calm demeanour.
- Self-awareness and skills coaching in responsible assertion.
- Self-awareness and skills coaching in anger management.

Listed below are some of the strategies that have been implemented at NWAHS.

##### **Clinical learning contract (Box 3)**

When a JMO's difficulties are related to personal performance, it is most important that this is identified within the first month of an attachment. This allows time for the problems to be discussed by all concerned, a plan of remediation to be constructed, and a performance review to take place before the final assessment. Those involved include the supervising consultant and unit registrar, together with the JMO, and, at times, the MEO or DCT acting in a facilitating and supportive role. The clinical learning contract forms the basis for this process and serves as a simple, documented record of the JMO's progress.

##### **Focused coaching**

If the medical knowledge base of a JMO is considered inadequate, research registrars can be recruited and paid to provide one-on-one tutoring.

##### **Defusing and debriefing after critical incidents**

Critical-incident stress is far more prevalent among JMOs than is commonly realised. New doctors may be more affected than their more senior colleagues by the painful events they experience. Their colleagues, who may have become inured to this aspect of the profession, may fail to acknowledge this stress and give adequate support to junior doctors at these times. Often there is a delayed response. A distressing event will occur, and then perhaps a subsequent, relatively minor event will unexpectedly trigger an overwhelming stress reaction. Besides the need for professional intervention at the individual level, this also shows the need

to heighten awareness at a systems level and implement training for registrars and supervising clinicians in critical incident defusing and debriefing.

##### **Panic prompts**

Some JMOs temporarily freeze when confronted with an unexpected clinical emergency. I have coined the term “panic prompts” for a small card carried by these JMOs which has a checklist of basic procedures that a JMO would be expected to have worked through before seeking registrar assistance and back-up. At a minimum, this means anticipating the basic information that a registrar would demand.

##### **Crisis intervention**

At times, MEOs feel like they are operating as a mobile triage service. A JMO may be in such distress that immediate crisis intervention is required. For example, a JMO may need to be taken off duty at once, and the MEO must ascertain whether outside support is available within a short time span, and whether the JMO is able to drive safely or if a taxi may be required. To date there have been four such occurrences at NWAHS.

##### **First-line counselling strategies**

Some of the first-line counselling strategies are listed in Box 4. The first few relate to general skills that are available to most mature and reasonably sensitive people willing to spend time with another person in distress. The second group applies to people trained in counselling.

##### **Conclusion**

Integral to the whole process, and the real strength of MEOs, is their independence from medical power structures and from direct involvement in JMOs' evaluation. The MEO, however, should be able to “network” and access hospital and medical authorities. To this extent, the trust placed in MEOs by all concerned (junior doctors, registrars, senior clinicians, and administrators), and the need for confidentiality and discretion, are complex and crucial factors. Professional integrity on the part of the MEO is paramount.

The Conference has focused on students and junior doctors in distress. However, it is artificial to consider the problems of students and JMOs in isolation from senior practising clinicians. To what extent are senior clinicians' performances and sense of wellbeing also affected by varying levels of distress; and of course this begs the question — does their distress have an impact on medical students' and junior doctors' wellbeing? We need answers to these questions. □