

The student and junior doctor in distress

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A RECENT ARTICLE noting that “unhappy doctors are a worldwide phenomenon” imputes this to ongoing changes in relationships with patients and society.¹ Despite this phenomenon, many young people, for a variety of reasons, still wish to study medicine. The reasons include:

- parental pressure — “you’ve got the marks” . . . “it’s a secure income” . . . “doctors are well respected” . . . “you can always sing/write later”;
 - the challenge — both academic and personal; and
 - the wish to help people — “to do something meaningful”.
- Here, I outline some of the issues in the student and early postgraduate years which may influence performance, summarise the effects of recent changes in medical practice, and, finally, explore impairment issues as they affect medical students and doctors.

The student years

Selection bias

Whatever the prerequisites for medical school entry, there is a selection bias towards those who are conscientious, intelligent, able to delay gratification, and have high levels of personal drive and demands on self. But they may also be unassertive and fairly compliant. Another, frequently overlooked, group entering medical school are multitalented and curious (“they could have done anything”). This latter group may be restless and impatient with others less gifted. The interaction between these character traits and student expectations will affect medical students’ performance, career choice and impairment.

Changes in curricula

In the past, despite the apparent academic nature of medicine, the old model of medical education (ie, preclinical “chalk and talk” followed by a clinical apprenticeship) relied heavily on rote learning. The newer medical curricula put greater emphasis on adult learning techniques and the acquisition of life skills. This is a welcome change² and should challenge all students and lead to greater awareness of communication skills.

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Educational philosophy

The philosophy underlying medical education is an important factor affecting student selection as well as distress and impairment. There are two different views:

1. *Medical education can be seen as a right — a broad education for those interested in health issues, which is open to anyone who can gain entry.*

In this paradigm, medical education is not linked to ability or fitness to practise medicine, and the role of universities is to produce graduates with a sound knowledge and appropriate basic skills, but they have little or no responsibility for their clinical conduct after graduation.

2. *The role of medical education is to maintain a flow of well qualified doctors, with education linked to workforce requirements.*

Here we need to consider whether the goal is to produce potential interns, general practitioners, or specialists. Each of these goals implies different training needs and priorities:

- if the aim is to produce junior doctors, this paradigm acknowledges the significant subsidy by the taxpayer and the physically demanding nature of the work, requiring fitness standards akin to those of airline pilots; or
- if the aim is to produce doctors who become specialists (in primary or secondary care), then the course is pitched beyond the first few years, with an assumption that the Postgraduate Medical Council will be responsible for early training issues.

Both of these views are valid — the choice of goals with their differing underlying philosophies will influence selection and “goodness of fit” of the student with the paradigm, and will indirectly affect stress and impairment issues.

Ethical pressures

A recent study³ has explored the ethical pressures on final-year medical students, and noted three main types of ethical problems:

- conflict between requirements of medical education and patient care;
- responsibility exceeding student’s capabilities; and
- involvement in communication or procedures with patients that were deemed to be substandard.

These issues are important in themselves, but the authors also noted that the areas of conflict between medical education and patient care are rarely discussed.

Student concerns

Against a backdrop of upheaval in the health system, expectations of patients, their families and society in general, there is a need to identify the concerns of students and junior doctors and to keep them motivated and inspired. Box 1 lists the concerns identified by a recent survey of

1: Responding to medical students' concerns at the University of New South Wales

Concerns

- the need to earn money;
- the requirement to travel between campuses;
- the lack of understanding by friends and family of the pressures involved;
- communication difficulties (especially for those from a non-English-speaking background); and
- the lack of an identifiable referral network for students with problems.
- The concerns of older students (who, with the advent of postgraduate courses, are now becoming more common) are slightly different — they may have taken a drop in income to study and already have families and mortgages.

Responses

Some of the responses to these concerns have included

- a decision to establish scholarships for those who are financially burdened (so that they can study *and* have a balanced lifestyle);
- encouraging students to have their own general practitioner; and
- the appointment of a Student Support Officer (who is a working general practitioner)
 - to improve liaison for those students in distress,
 - to improve the referral network for those in need, and
 - to coordinate services for those requiring remediation and counselling.

There has also been an initiative involving mentor groups (students in Year 3 mentoring those in Year 1, and students in Year 6 mentoring those in Year 4) which has been very successful. Finally, medical students in New South Wales are registered with the Medical Board and paths for referral and review have been improved.

medical students at the University of New South Wales by our Student Support Working Party, and some of the responses to these concerns.

The early postgraduate years

Rites of passage

The first two postgraduate years have traditionally been seen as a rite of passage, and a time to assimilate with the culture of “*the harder I work, the better doctor I am*”. The system seems to reward self-sacrifice and “driving yourself into the ground”, and to discourage time for self-reflection or self-care. We know we must tell patients about the need to exercise, to reduce stress, to have a balanced lifestyle and good, restful sleep, but doctors are presumably different from everyone else!

Thus, in the past, the intern year provided a significant barrier — the assumption being that, if junior doctors are emotionally and physically resilient enough to complete the early postgraduate years, then they have “earned their stripes” and are able to continue. For the survivors, again, there used to be significant mentoring and social support through association with a particular hospital.

The first few postgraduate years of a medical career are still just as physically and emotionally demanding. Thus, if the threshold is lowered by making provision for an increas-

ing range of specific impairments in interns, it may be necessary to have other methods of screening physical and emotional resilience — or else to change the prevailing medical culture and public expectations of doctors.

The following questions flow from this philosophy:

- Can people who cannot carry out a physical examination or basic medical procedures work as interns?
- Can they become doctors if they cannot fulfil an internship?
- How should interns who become very distressed by illness or sick people be catered for?

Non-practising doctors?

When these questions are posed, some proffer the idea that there could be special places for doctors who will not practise. This is a matter of whether the taxpayer is prepared to fund places for people who will never be doctors. This may cause considerable difficulties later if those who said they understood the conditions on entry change their minds after graduation. The alternative is to offer different courses, for example in medical ethics, for people who have valuable contributions to make, but cannot physically do the work of a doctor.

Problems of perpetual change

Previously, doctors could expect autonomy, job security, deference and respect, and a reasonable balance between private life and work commitments. There are now growing imperatives towards patient-centred care, greater accountability, evaluation by others and a growing culture of blame.¹ The medical indemnity organisations and the whole medico-legal environment are in a state of flux.

There is also much greater rotation of staff around hospitals, leading to less “bonding” with particular institutions, less camaraderie for interns (who are no longer “residents”), and less access to mentors important for a future career. Overall, there are fewer solo-doctor general practices, and much more emphasis on working with multi-disciplinary teams. There are more female doctors forging substantial careers, more doctors who are working parents, and reports of diminished income in general practice. The impact of corporatisation of medicine is still not clear, while provision of provider numbers means more political involvement in medical workforce issues.

In clinical practice, there is less opportunity for meaningful contact with patients, with shorter hospital stays and less continuity of care. Particularly in emergency departments and with home visits, doctors can face potentially dangerous incidents involving verbal and even physical abuse related to drug misuse. Associated with all of these changes is greater voicing of dissatisfaction from junior doctors. There are also significant changes in the nursing profession, with greater staff turnover in hospitals leading to less continuity, and the newer roles of nurse practitioners and practice nurses, which offer potential but are yet to be fully explored in Australia. The far greater range of paramedical and alternative practitioners may be seen as allies or potential competitors. In

2: Distress and impairment

“Stress” and “distress” are often used interchangeably

- *Stress* results from an event which produces physical or psychological pain.⁵ Stress is also applied to the autonomic arousal associated with such events.
- *Distress* is the external sign that all is not well and assistance is required. It is usually related to specific events or illness, and is understandable and acknowledged as appropriate, or considered inappropriate in the context. It may temporarily affect performance, but should be a signal for action to reverse the cause of the distress.

Impairment

- *Impairment* may be acute, episodic or longstanding — the course is related to the underlying disease, condition or disability. The term implies that performance is affected by the course of the underlying physical or mental condition. An impaired but insightful student or doctor may be able to practise safely under specific conditions.

terms of the broader health system, there is a greater demand for transparency, and, from the general community, rising rates of medical litigation, but also more opportunities for collaboration with “informed consumers”.

Over the past decade, there has been a move away from an emphasis on treating acute illness to managing chronic disease. A recent article, “Are we teaching the wrong things?”,⁴ highlights the growing need for clinicians to promote greater autonomy in their patients with chronic illness, working with them in a collaborative relationship. The authors provide a set of specific interpersonal techniques to help doctors promote effective partnerships, leading to greater mutual satisfaction. This new paradigm contains the seeds of the answers to many of the problems facing both doctors and patients.

In the next decade, new ethical issues confronting medical students and young doctors will concern the Human Genome Project, the impact of pollution, the increasing burden of chronic illness and an ageing population (within the constraints of a shrinking health budget), and the prospect of an increasing role for doctors (particularly general practitioners) as budget holders and “gatekeepers”. In coping with these issues, informed consumers may prove to be welcome allies.

Impairment issues

Stress, distress and impairment are defined in Box 2. Distress, while not necessarily linked to academic failure, is often associated with a fall in academic performance. Impairment implies some effect on performance. Many students or doctors may have short periods of distress, but they are usually not impaired. The distress is often related to some identifiable cause that can be dealt with by holiday leave, or personal or administrative change. Others may be impaired, but not distressed.

For impaired doctors and students, the impact of a disorder can vary with the age of onset relative to the stage in a medical career, and may present different issues for junior doctors and for students in undergraduate and

postgraduate medical courses. For many psychiatric disorders, the age of onset is in the late teens and early 20s–30s (eg, psychotic illnesses and eating disorders tend to present in late teens and early 20s, while anxiety disorders and bipolar disorders tend to present in the 20s and 30s). Furthermore, by virtue of their personality styles, their expectations of themselves and others, as well as sleep deprivation and the responsibility and nature of their work, medical students and young doctors constitute a vulnerable group for depression. There is a need for doctors involved with medical boards to have an understanding of current management of psychiatric disorders, and there may be a role for ongoing involvement of impaired doctors who have frequent relapses or severe impairment with medical board impairment programs. This in an acknowledgement that some disorders (such as bipolar disorder) may require long term, less intense monitoring during times of improvement.

Medical students

For medical students in New South Wales, the criterion for NSW Medical Board involvement is impairment which impacts on patient welfare. Our Medical Board has developed a short, structured referral form for universities, and we are also having regular meetings with the universities to identify clear goals and feedback mechanisms. We also encourage early referral to ensure the smoothest possible arrangements for internship. The most difficult impairments to manage include intermittent psychosis, severe personality disorder and addiction. Moreover, these impairments may not be evident at a selection interview. It is also important to note that a few people will not be able to practise medicine because of their impairment. If so, there needs to be discussion about the acceptability of having these students continue in the medical course.

This argument goes back to the underlying philosophy of medical education and whether it is ethical to allow someone to make the significant investment required in a medical course, knowing that they will not be able to practise medicine and that the course may not equip them for much else. If it is not considered ethical, such students should be encouraged to make other career choices and helped to do so. Using the airline pilot analogy, they would be counselled about their lack of suitability. If, on the other hand, these students are allowed to enrol in medicine and continue studying, despite significant impairment inconsistent with practising medicine, it is not sufficient to assume they will find a place in medical research — there needs to be more consideration of what appropriate, non-clinical career choices are available.

Doctors

The NSW Medical Board has recently developed a working definition of impaired doctors (Dr A Reid, Medical Board of NSW, Medical Director, personal communication). Impaired doctors are defined as those who “suffer from any physical or mental illness, disability, condition or disorder (including the misuse of drugs or alcohol) that detrimentally

3: Questions for the Conference to address

- Do the universities need a statement about their goals for provision of medical education and preparation for a medical career?
- Should medical students be made aware of these goals at entry into medical studies? Should they be required to declare any problems in meeting the requirements?
- What is the purpose of identifying students in distress or with impairments? What can we offer them? Are these goals being realised? Can we provide transparent, supportive, proactive processes for those who are impaired?
- Is medical training consistent with current medical workforce requirements?
- Are we doing enough to emphasise positive functioning (at all stages of a medical career)?
- How much impairment will society tolerate in doctors? How much will the profession tolerate?
- What are the workforce implications of impairment?
- What is role of the Medical Registration Boards? Should boards deal with only the most impaired doctors or should they be more proactive?
- Can we produce some acceptable Australian policy and good documentation on proactive strategies for dealing with stress and

affects their physical or mental capacity to practise medicine, and results in risk or potential risk to the public that is not adequately managed by treatment or practice modification". The Medical Board's main interests lie in the maintenance of good standards and patient safety. A longitudinal assessment of possible impairment is important, with an accent on ability to communicate with patients and others, periods of absence from studies or work, degree of social support, and the amount of insight and personal responsibility taken by the impaired person.

A recent article⁶ discussed the need for simple, well publicised access to a program for impaired doctors, which should include some crisis intervention. It also stressed the importance of peer support, ongoing supervision and monitoring for five subsequent years, together with frank discussions about future prescribing. An example would be doctors who have had problems with analgesic dependence, who might be required to demonstrate that they are better informed about prescribing. The NSW Medical Board requires such doctors to undergo education about pain management as part of their rehabilitation.

A suggestion has been made that impaired doctors should be matched with other doctors with similar illnesses or impairments, who can assist them from their own experience.⁷ Other possible solutions for doctors with a chronic illness include proactive career counselling and guidance,

secured funding for retraining doctors who can no longer practise, and ensuring attitudinal change as part of medical training.⁸

Positive trends

We have the prospect of new graduates being a cohort of bright, interested young people with a much broader ethnic mix. They may be better placed in assisting those in distress, with more specific training, greater awareness of the stresses pre- and postgraduation and greater access to effective psychological management strategies. An article entitled "Promoting well being among doctors" has advocated moving from a disease model to focus on positive functioning.⁹ The authors advocate use of techniques from the growing field of positive psychology which aim to promote self-care, encourage peer support, challenge self-critical thoughts and foster optimism. This theme is also pursued in the "Career Focus" section of the *British Medical Journal*, with articles on looking after yourself and evaluating life roles.^{10,11} The goals are to help doctors influence their work environment and increase feelings of self-worth and effectiveness. Self-care techniques, combined with work practices, ensuring a balanced lifestyle and a growing focus on a more collaborative approach, both in the doctor-patient relationship and in clinical teamwork, have the potential to increase job satisfaction and resilience in doctors.

Finally, I would like to pose a series of questions for us to answer at this Conference (Box 3).

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