

## A student mental health and welfare program in a medical faculty

Chris C Tennant

IT HAS BEEN LONG RECOGNISED that the practice of medicine is stressful and that doctors are prone to anxiety, depression, drug and alcohol problems, and even suicide.<sup>1,2</sup> Similarly, the process of medical education is stressful and medical students, too, are at risk of psychological problems.<sup>3</sup>

In New South Wales, in 1997, after a report on doctors' mental health, the NSW Medical Board convened an independent *Doctors' Mental Health Implementation Committee*, with wide-ranging representation from the profession. This Committee produced the NSW Doctors' Mental Health Policy to provide a framework for the NSW Doctors' Mental Health Program.<sup>4</sup> Separate policies were developed for rural practitioners, area health services, specialist medical colleges, and for medical schools.

### Mental health policies for medical schools

The policies for medical schools included:

- promoting the importance of mental health — by embedding it in the curriculum;
- encouraging a caring culture within the medical school;
- identifying suitable personnel to provide assistance to students with social and psychological problems; and
- assisting students to obtain good medical and psychological care.

Many factors may contribute to stress and distress in medical students. These include not only the intrinsic stressors within medical education, but also significant changes and conflicts in lifestyle. For example, students in graduate programs, who are often older and married with young children, may have great financial pressures placed upon them.

### Implementing the policies at Sydney University

The policies were implemented primarily in two ways:

- by incorporating the theme "Personal and Professional Development and Ethics" in the curricula; and
- by establishing a Student Welfare Committee.

**Personal and Professional Development and Ethics** is one of the four teaching themes in the graduate medical program, which are integrated both vertically and horizontally. The others are Basic and Clinical Sciences (pre-clinical sciences), Patient-Doctor (diagnostic and clinical skills) and Community-Doctor (epidemiology and social medicine).

The Personal and Professional Development and Ethics theme is integrated into all aspects of the students' learning program, which is centred around "problem-based learning" in small groups meeting twice weekly. These groups focus each week on a specific clinical problem. The students are encouraged to develop good listening and communication skills and to be aware of the functioning of the group. In the context of these clinical problems, they are exposed both to the multiple roles of doctors — as clinicians, educators, supervisors, and patient advocates — and to the professional and ethical issues in the clinical case.

Larger lecture or seminar teaching sessions cover healthy lifestyle, stress and stress management, anxiety and depression, and substance misuse. Other sessions deal specifically with mental illness and stigma in mental health, and students are encouraged to understand the political, financial, legal, and ethical impacts of these disorders. In addition, they understand the duty of care in relation to mental health problems in their colleagues and their own mental health. The Personal and Professional Development and Ethics theme is assessed at several points during the medical course, in both a formative and summative manner. (A formative assessment does not involve a pass or fail, but, if unsatisfactory, may require some remediation. A summative assessment is a pass/fail assessment).

**A Student Welfare Committee** was established with basic principles of confidentiality regarding student information, a duty of care to students, and, in some instances, a duty of care to hospital staff and to patients.

The Committee comprises the coordinators for the first two, non-clinical years of the medical course and the Associate Deans of the teaching hospital clinical schools, with the chair being a psychiatrist on the university staff. If appropriate, a member of the Medical Board is invited to attend. Information about individual students discussed in the committee is de-identified. The importance of collecting detailed information about problems has been emphasised, particularly as the Medical Board requires detailed information to be able to make the most appropriate decisions if and when students are referred.

The Committee has established appropriate processes for referring students to appropriate clinicians — counsellors, psychologists and psychiatrists — outside the faculty. Other options available are referral to the Medical Board, for establishing and maintaining psychological care for the student, for placing specific requirements on the student for registration, or for deregistration. (In New South Wales, medical students are registered in a similar way to medical graduates.)

Students with problems tend to come to the Committee's attention in two ways. Firstly, students may self-present to the year coordinator or to the Associate Dean's office with

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either social or psychological problems. Initially, a supportive identified member of that office screens the problem. The matter can then be referred to the Associate Dean or the year coordinator and discussed at the Student Welfare Committee meeting. Appropriate documentation is kept. Secondly, students may be reported to the Associate Dean by other concerned students or staff, usually when they appear quite psychologically disturbed or have significant behavioural problems.

In the early days of this Committee, there were often differences of opinion, particularly in considering, firstly, duty of care to patients and other staff, and, secondly, confidentiality within the faculty. For example, should relevant university staff be notified of a student who was distressed or not coping so they could be of support and assistance in the student's next rotation? As the committee progressed, these issues were largely resolved. It was agreed that one key staff member in a rotation would be made aware of a student needing support.

## Stress in a graduate medical degree

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**MEDICAL COURSES** are inherently stressful because of the nature of the course, the workload and, for some students, financial issues. These stressors can lead to impaired judgement, reduced concentration and self-esteem, and increased anxiety, manifesting in turn in depression and even suicide.

In 1997, as a first-year medical student of the graduate program at Sydney University, I attended the conference of the Australian and New Zealand Association of Medical Education. The conference explored facets of stress for medical students and found that medical students were indeed stressed. However, the causes of the stress were not explored, and neither were the ways of managing this stress. I decided to examine the level of stress in students in my year.

There are fundamental differences between the undergraduate and graduate medical courses and in the type of students enrolled. As opposed to the predominantly lecture-based, didactic undergraduate courses, the graduate course emphasises self-directed learning in problem-based, small-group tutorials. Graduate students have an advantage in that they have had previous experience of university education. In 1997 the average age of the students in my year was 24.5 years. They therefore had different life experiences to younger undergraduate students.

## Conclusions

The pressures placed on medical students during their education, which can lead to significant psychological problems, are increasingly being recognised. The consequences for the student — in distress caused, and in interruption to their education — are considerable. The problems may also adversely affect others. Medical faculties need to be aware of these problems and identify and deal with them as soon as possible. Structures should be in place to accomplish this.

## References

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I hypothesised that stress in the first year of the graduate course would reflect financial, personal and living issues; time management problems; the new format of the course and the problem-based learning structure; using computers; and, for some students, the requirement to move residence to study. Examination pressures were not applicable in the first year.

## The study

A study was devised to assess overall stress and the effect of these eight potential stressors.

## Methods

Each parameter of stress was assessed by a retrospective questionnaire, using a four-point scale ("stressed", "very stressed", "unstressed", and "very unstressed"). Students were assessed twice in their first year, at enrolment and six months later. Stress at these two time points in first-year students in 1997 was compared with that in first-year students in the two subsequent years, when an intrafaculty support network, the "Buddy Program", had been established. For this program, the medical faculty encouraged students to be involved, and supported the development of this student support network. Students finishing first year were asked to volunteer to take part in peer support — to be a "buddy" for the next year's first-year students. Volunteers were introduced to two or three students at an informal morning tea. Contact between the buddy and first-year students was maintained using the tutorial rooms, telephone

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