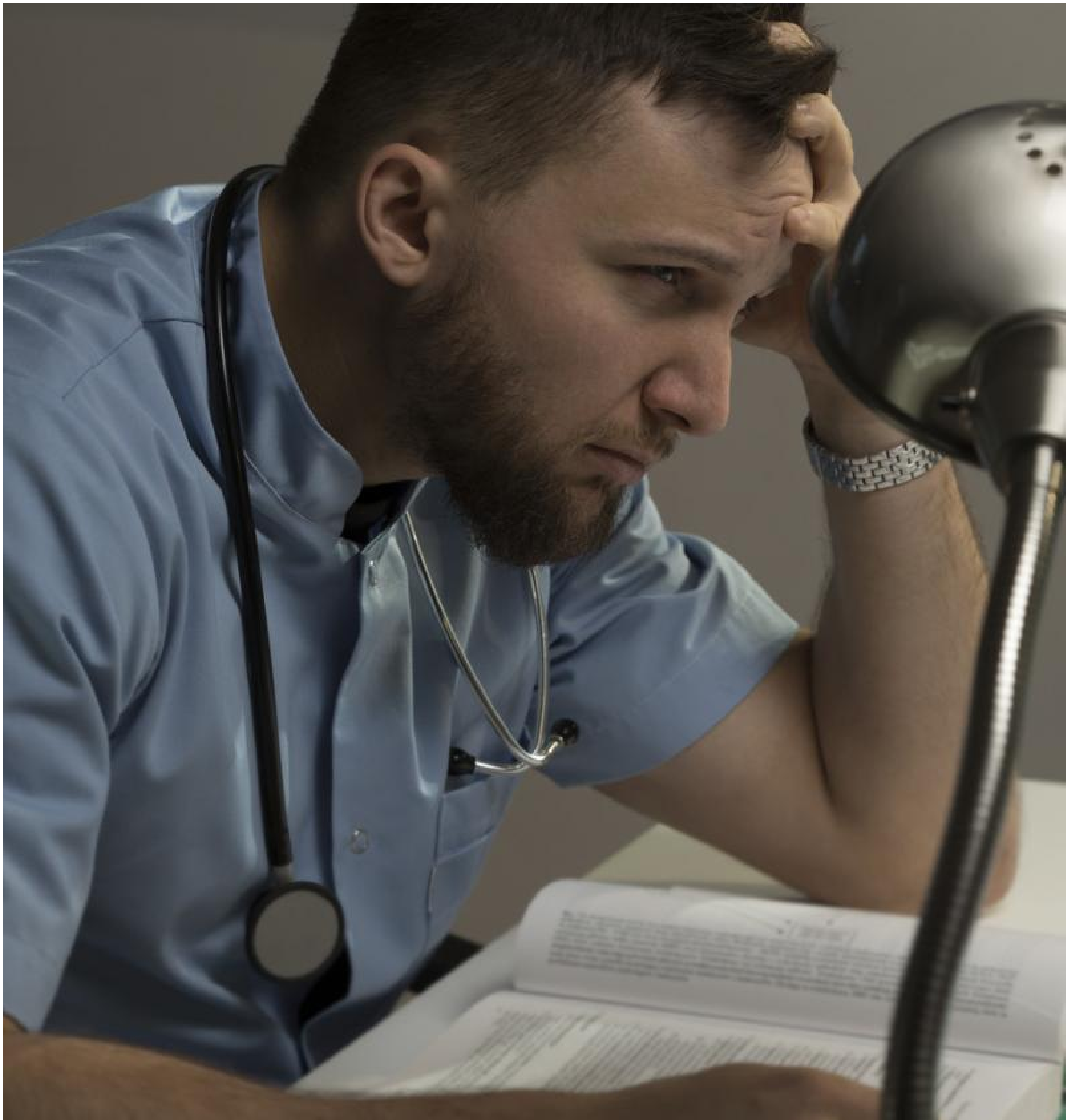
What do high rates of medical student depression say about our health system?

December 20 2016, by Richard Gunderman



Medical student. Credit: www.shuttterstock.com

A recent study in the Journal of the American Medical Association concludes that 27 percent of medical students around the world exhibit symptoms of depression and 11 percent have thought of taking their own lives. Equally troubling is the fact that, among students experiencing depressive symptoms, only 16 percent seek psychiatric treatment.

Other studies have suggested that the prevalence of depression in medical students may be as much as five times higher than among age-matched controls, and anxiety disorders are as much as eight times more common. Many do not seek professional help for fear the stigma of mental illness will undermine their careers.

And depression doesn't stop in medical school. The lifetime rate of depression among U.S. physicians is approximately 13 percent among men and 20 percent among women.

As a physician and educator at a large academic medical center who interacts daily with medical students and patients, I can offer some insights into this study. It raises important questions about both medical education and the way medicine is practiced today, particularly the many non-patient-care-related demands on a physician's attention.

Possible explanations

There are at least two ways to explain the high rates of depression among medical students. One focuses on the people who are attracted to careers in medicine. Perhaps medical students are more perfectionistic than

others and more liable to become discouraged when they make mistakes.

It is also possible that medical students are especially compassionate and more liable to become depressed by frequent contact with suffering.

Is medical school inherently depressing?

If these explanations were correct, the medical profession could respond by administering psychological tests to medical school applicants and screening out those who appear predisposed to depression. Of course, this might weed out compassionate people who would make especially good physicians. They could also identify such students at an early stage in training and offer services to help them cope more effectively with life in medical school.

It is also possible that medical students are no more predisposed to depression than anyone else, and that there is something inherently depressing about medical school. The study of medicine is certainly rigorous, requiring long hours of study, intense encounters with illness, dying and death, and sacrifices in other areas of life.

To some degree, such burdens are unavoidable. It is not easy to grasp the structure, function and diseases of different organs and organ systems, the role of the history, physical examination and a wide array of test options in the diagnosis of disease, and the vast array of treatments from which contemporary physicians need to choose.

Of course, the learning challenges with which students are presented are not purely scientific and technical. There is also much to learn about human relationships. Medical students need to become more caring and trustworthy, share bad news with patients and connect with as many as dozens of different patients on a daily basis.

More than a mental health problem

But depression among medical students is not inevitable, and some medical schools are not doing all they could to help their students maintain their mental health and become more resilient and hopeful over the course of their studies. To rectify this, many schools need to devote more resources to protecting and promoting student mental health.

Yet it would be a mistake for the medical profession to address these findings as simply a mental health problem. For every medical student who is experiencing depressive symptoms, there is likely another, or perhaps even several, who are finding aspects of their studies discouraging and whose entry into medicine is taking a substantial personal toll.

A good part of the blame may lie with changes in the profession of medicine that are making work more burdensome and ultimately less fulfilling for physicians. Recent studies have suggested that nearly half of U.S. physicians are experiencing burnout. It is only natural that medical students who see their teachers and role models struggling are likely to become discouraged.

Today's physicians are being asked to practice medicine faster than ever before, which limits their ability to get to know and connect with their patients. Moreover, an increasing proportion of the physician's time is devoted to record-keeping, to the point that many feel the doctor looks more at computer screens than at the patient.

At issue is our very notion of what constitutes good medical care. On the one side are financial metrics such as patient throughput and revenue, which dictate that physicians move from patient to patient quickly and spend much of their time collecting the information hospitals and health systems need to code and bill for the work they do, ensuring that no

money is left "on the table."

A related issue is the evolving notion of quality in health care, which is increasingly dominated by systematic definitions that put clinical algorithms and guidelines at the forefront. Such approaches measure quality by the degree to which physicians have adhered to guidelines for the type of patient they are seeing – for example, a diabetic – but not their knowledge of each particular patient.

Consider an elderly diabetic patient who was experiencing fainting spells. A consulting physician realized her blood sugars were being kept under such tight control that they were occasionally falling too low. He relaxed her blood sugar control and the fainting spells ceased. However, the physician was penalized, because her blood sugars were rising somewhat higher.

When the practice of medicine is organized along such lines, relationships between patients and physicians take a back seat to compliance with standards. The physician knows more about each patient than the designers of such systems, but this knowledge is more difficult to come by and counts for less than many physicians believe is appropriate.

Putting the human being first

A similar point applies to medical education. We live in an era when the organizations that accredit medical schools, residency programs, and hospitals and health systems are all placing increasing emphasis on standardization. The implicit assumption is that excellence is defined by conformity to a guideline, from which every deviation becomes defined as an error.

Giancarlo, a 26-year-old fourth-year medical student of mine, sees this

way of thinking at work even before students are admitted to medical school. Grades and standardized test scores often determine who gets selected, yet he says, "Students are much more than mere numbers. Just looking at the numbers may streamline the candidate selection process, but schools often neglect getting to know candidates as whole human beings."

I cannot count the number of times I have heard medical students describe their education as an assembly line. If the education of physicians and the practice of medicine were fundamentally the same as the mass production of widgets, such a metaphor would make sense. But medical students are not all cut from the same cloth, and neither are the patients they are learning to care for.

Giancarlo puts it this way: "Good doctors care for the person, not the disease, and the same thing needs to happen in medical education. We need to stop treating students like living computer algorithms and teach them how to work humanely."

When medical education performs at its best, it does not make students feel as though they must all fit into the same mold, each becoming a clone of the others. Quite the reverse, medical education should encourage students to draw on and develop fully their own distinctive life experiences, interests and abilities.

Says Giancarlo, "The world is filled with variety – therefore it is imperative that the medical profession train a wide array of physicians with different personalities and experiences, to be able to meet each and every patient's needs. To help students avoid depression, what we need is not more standardization but more self-growth."

When we recognize that good medicine means putting the patient at the center, we lay the groundwork for a more humane approach to medical

education, one that encourages students to become the best human beings they can be. Only when we see medical education in these terms will we be in a position to rein in the epidemic of depression among medical students.

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