What needs to happen to build resilience and improve mental health among junior doctors

May 25 2017, by Richard Murray And Brendan Crotty

Credit: Madison Inouye from Pexels

Doctors experience higher levels of suicide and mental distress than their non-medical peers. A review of studies in the area found male doctors had a 26% higher risk of suicide, while female doctors had a 146%

higher risk (more than double) than the general population.

And a recent survey, conducted by the mental health foundation beyondblue, confirmed there were higher rates of suicidal thoughts and psychological distress among doctors and medical students than in the general community.

But beyond the numbers are tragic stories of young individuals who lost their lives to suicide. In recent months, the suicide of four junior doctors in New South Wales has prompted the state government to investigate the issue. News reports have suggested at least 20 doctors took their own lives between 2007 and 2016 in NSW.

Family members have pointed to stress, "brutal expectations" and working hours as having had an impact on the doctors' decisions to end their lives.

Are our medical students and junior doctors overworking? Can we identify underlying causes of mental distress and suicidal thoughts, as well as the warning signs? Can medical schools, hospital employers, supervisors, professional organisations and peers do more to prevent further tragedies?

A host of factors

Various inquiries and reviews have considered the above questions, in Australia and overseas. The conclusion is that it's complex. Behind the phenomenon are a number of interacting factors.

There's a legacy professional culture that can still view any admission of psychological distress as weakness or incompetence.

Doctors face long work hours in a pressured work environment. They

experience anxiety about making mistakes that can have serious consequences.

Workplace bullying and harassment can also contribute. While this has most recently been highlighted among trainee surgeons, it probably extends well beyond surgical training.

And of course doctors have technical knowledge and access to the means to end life.

A lot has already been done to try to improve doctors' mental health. For instance, progress has been made to reduce working hours. Prolonged shifts and continuous on-call rosters have been discontinued in most, if not all, health service rosters. This was at least in part in response to pressure from the Australian Medical Association (AMA) Safe Hours campaign, which outlined the risks to patients and practitioners of excessive hours worked and the need for breaks between shifts.

These recommendations have been incorporated into industrial agreements for hospital medical staff. These stipulate maximum working hours and mandatory periods of time off. However, 14-hour shifts and rosters that include one in three or four weekends without any reduction in weekday hours are not uncommon. There is considerable anecdotal evidence that some junior doctors are working more hours than they are rostered for.

Progress has been made in other areas too. Polices for better orientation of junior doctors in hospitals to explain supervision and avenues for support have been implemented. Other measures adopted include: education and mentoring programs in hospitals; supervisor training; blame-free reporting; assessment by external accreditors of health services' and specialty colleges' reporting and support arrangements; mental health first aid training for students; medical student guides; and

confidential doctors' health services.

But introduction of these initiatives has been patchy. The levels of support available in different hospitals are variable, and too often dependent on a few enthusiastic individuals. A systematic national approach would have much greater impact.

Medical graduates

One source of increasing stress for recent graduates, anecdotally, is the intense competition to get a job that will be their pathway to a specialist qualification. This pressure has its genesis in the dramatic boost to medical graduate numbers over the past 15 years.

Training beyond medical school is an intense period of four to nine years of work, on-the-job learning, study and examinations. By doubling the number of medical schools and almost tripling the number of medical graduates, Australia has severely increased competition in capital-city teaching hospitals (where, unfortunately, most of the training jobs for medical graduates remain based).

Ironically, the main reason for the boost in graduate numbers was the shortage of doctors in regional areas. An increasing number of young doctors (including those who trained in rural clinical schools or regional medical schools) feel that they have little choice but to apply for accredited metropolitan training posts.

They would be better off working and training from a home base in regional Australia, if only the specialist training pathways existed. Australia desperately needs to re-align this phase of medical training to better serve both regional communities and graduates.

Building resilience

There are core professional capabilities that should be taught and modelled throughout medical training. These include managing one's own health needs, dealing with stress and fatigue, recognising and assisting distressed colleagues, and reporting bullying and harassment.

Medical schools and hospital employers could do better in finding ways to communicate with one other to protect more vulnerable graduates as they transition into the workforce.

We should also critically review our approaches to selecting students into medical school. Selection policies that promote greater diversity, place more emphasis on humanistic qualities (qualities that define who we are as human beings such as honesty, integrity, courage, self-awareness and wholeheartedness) rather than examination marks, and that include people with a positive orientation to risk and innovation may help to take the steam out of the pressure cooker. These approaches could also improve workforce outcomes in rural and under-served communities.

Beyond "resilience building", there are important system challenges in how the nature of healthcare needs to be transformed into something that is more integrated, person-centred and community-based. This has particular implications for our larger institutions.

It turns out that finding "joy and meaning" in healthcare work is not only good for doctor well-being, it's also safer for our patients. Teamwork, fun and personal fulfilment in caring for others are the essence of the joy of medicine.

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