

Distress and career regret in doctors: are we really that different to other professions?

Health departments should support the professional training they require and show that their employees are valued

[Authors: Editorial authors are invited to supply head-only photographs (JPG or TIFF: MINIMUM 300dpi resolution, 1000x1000 pixel) to accompany their article. They can [uploaded to Scholar One](#) or [forwarded directly to pfoley@mja.com.au.](#)].

The COVID-19 pandemic has again focused attention on the mental health and wellbeing of doctors, particularly those in training. An earlier meta-analysis (54 studies during 1963–2015 that included a total of 17 560 trainee doctors) found that 21–43% (pooled estimate: 28.8%) had symptoms of depression during residency.¹ The cross-sectional online survey of Australian orthopaedic trainees in late 2021 reported by Author and colleagues in this issue of the *MJA*² found even higher rates of distress and burnout: 39 of 88 respondents (44%) met the Physician Well-Being Index criterion for distress (a short 7-item measure); 55 (63%) had experienced burnout during the preceding 30 days. Those who reported distress were more likely to regret having chosen medicine as their career.²

How concerning are these findings? Survey rates of various indicators of poor wellbeing (distress, depression, burnout) derived from nationally representative population-based surveys are generally 30–50% lower than reported for doctors³, leading to the conclusion that poorer wellbeing is more frequent among doctors than other adults. However, there are reasons why junior doctors should have better mental health than other workers,³ including the fact that they are often socio-economically advantaged,⁴ are by definition well educated, have successfully negotiated early adulthood (when most chronic mental illness emerges), and have a vocation with purpose and minimal likelihood of unemployment. [Author: The overall effect of the initial question and what follows in this paragraph might suggest that the findings in ref. 2 are not very concerning. Is this intended?]

One explanation for the discrepancy is that single occupation surveys have important limitations. Most surveys have relatively low response rates (38% in the study by Author and colleagues²), raising the problem of respondent bias producing a “grumpy worker effect”. A United Kingdom meta-analysis covering a broad range of professions found rates of distress in single occupational studies to be fairly consistent at one-quarter to one-third of respondents, significantly higher than rates for the general adult population.⁵ The authors concluded that being recruited to “stress surveys” may lead to selection bias or over-reporting, and that this problem is shared by many occupations.⁵ When we examined rates for various professions derived from repeated national representative surveys in Australia with very high response rates (greater than 90%), the prevalence rates of mental ill-health were in the range 4–22% in 2019, and 8–22% in 2020⁶; [Author: OK? To match Table 1.] the prevalence was lowest for doctors, with higher rates of pay and of life satisfaction, than for the other professions examined (lawyers, engineers, accountants, nurses and midwives, and teachers).⁶ Over the past few years, even before COVID-19, professional bodies in Australia have reported similarly low morale, burnout, and job dissatisfaction among emergency service workers,⁷ architects,⁸ and teachers.⁹

So are doctors any different to other professionals? We do differ in two key ways: the length and depth of our apprenticeship, and who pays for our professional training. Medical schools in Australia have changed radically in recent decades: thirteen of twenty-one [Author: On re-examination, I think your original number of 21 is correct] medical programs are now graduate entry degrees, often providing accelerated four-year, instead of five- or six-year, programs. To compete internationally, most graduate programs provide MD qualifications, cramming into these shorter courses a research project that once

required an extra year. Recording “learning experiences” and continuing workplace assessment fill students’ days, while professionalism, communication, and ethics courses compete for time with pre-clinical and ward-based learning, with (at my university, at least) extensive attendance requirements. As a result, medical students are older when they graduate and have acquired more debt than earlier generations;¹⁰ more have competing family and parental responsibilities than younger undergraduate medical students, and with less of the downtime many older clinicians had when they were studying. The number of medical graduates in Australia increased from 2733 in 2010 to 3637 in 2019 [Author: OK, to match reference?] (33% over nine years);¹¹ and career progression in many specialities is slowed by bottlenecks, while other areas, including general practice and psychiatry, struggle to fill training roles. Nevertheless, in 2019 more final year students wanted to pursue surgery as a career than any other speciality except “adult medicine”, and only one final year student wanted to work in addiction medicine!¹¹

After graduation, junior doctors face a mixture of excessive and conflicting demands. The social connections and support that help deal with long and stressful work hours are undermined by training rotations to far-flung hospitals and frequent early year job changes. We do not know the ages of the surgical trainees in the survey by Author and colleagues,² but most were probably in their thirties. Career regret and jealous glances at schoolfriends in professional careers, often fully qualified and many earning six figure salaries in their late 20s, paying their personal trainers more per hour than a junior doctor receives, are understandable.

Given the similar rates in other professions, distress and career regret are likely to affect a minority of trainees. However, the authors of a new meta-analysis of longitudinal studies¹² suggested that increasing resources and reducing work demands for junior doctors would improve their work engagement and clinical care. The same may be true for students, who may also need guidance about career pathways and community needs. After demanding weeks in hospitals, junior doctor’s weekends are regularly spent preparing for expensive exams (and paying HECS debts), unlike most other young professionals who have had protected study leave and for whom exams are paid. Surely it is time that health departments act like good employers, and fund and support the professional training they require and show that their employees are valued?

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