Chapter 2: Medical Student Self-Care and Culture

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Introduction

The health and well-being of medical students matter. The development of their professional identity matters, as does their learning and work culture. Why? Because as educators we owe a duty of care to our students as well as a responsibility to improve and shape future medical culture, which lies in their hands (Selvaraj and John, 2020). In this chapter, we explore the nature and determinants of medical student distress and impairment, and the evolution of professional identity, its interaction with student culture and the wider medical culture. Finally, we provide a brief guide to the Australian Health Practitioner Regulation Agency (AHPRA) regulatory processes and the National Law in relation to students and provide a guide to available resources to support students. We aim to raise awareness of these issues amongst students and educators alike while debunking the myth of omnipotence and shame associated with mental disorder that seems to start early in a medical career.

As will be seen below, much of our understanding of the Australian medical student comes from the largest Australian survey of its type, the National Mental Health Survey of Doctors and Medical Students reported in 2013 and updated in

2019. The sample comprised 6,658 medical students: the final response rate being 27% yielding 1,811 respondents (National Mental Health Survey of Doctors and Students, 2019). Similar insights can also be found in the United Kingdom (UK) General Medical Council (GMC) review of the experience of medical students working and learning within the UK's healthcare systems (West and Coia, 2019).

Distress and Burnout

The stressors facing medical students are well-known. Beyond the obvious examination stresses, there is also perceived mistreatment by consultant staff, financial and family issues (Gaughran et al., 1997; Tennant, 2002). Focus groups with UK medical students identified generic factors shared by all students including the transition from home and school to university life; the lack of a support network (family, friends); fear of disclosing mental health issues; competition with peers reinforced by social media; and self-care issues (e.g., with nutrition or sleep). These are compounded by stressors specific to the medical student's experience such as witnessing ill or dying patients; being part of a serious untoward incident or mistreatment by supervising doctors (West and Coia, 2019).

These issues are even more keenly experienced by the international medical student, who often faces isolation from family while at the same time trying to meet family expectations and aspirations, as well as difficulties with social acculturation in the hegemonic culture both at university and socially. International medical students report more stress symptoms, achieve poorer results in written, oral, and practical exams, have extended study duration and higher dropout rates (Huhn and Nikendei, 2018).

Although the concept of burnout is often associated with practising doctors, burnout can begin in the early years of medical training. A systematic review of literature on burnout in the United Sates showed that at least half of all medical students experienced burnout (IsHak et al., 2013). These results have been echoed in the Beyond Blue National Mental Health Survey of Doctors and Medical Students which found that students reported high rates of burnout and emotional exhaustion (National Mental Health Survey of Doctors and Students, 2019). Such burnout has practice implications, even in students, in its association with both unprofessional conduct and less altruistic attitudes regarding physicians' responsibility to society (Dyrbye et al., 2010).

Impairment

This distress frequently reaches levels of frank disorder. The National Mental Health Survey showed that levels of very high psychological distress were

substantially higher in medical students than in the general population (9.2% and 3.1% respectively). Rates of current (8.1%) and lifetime depression (18.1%) were substantially higher in medical students compared with the general population (12-month prevalence 6.2%, lifetime prevalence 15.0%). Similar patterns were found for anxiety, although it was noted that these prevalence rates for anxiety and depression were shared by all university students. In contrast, while male students showed higher levels of moderate and high-risk drinking behaviour than female students, medical students have lower levels of harmful drinking (4%) in comparison to the general student population. Moreover, a decline in moderate drinking with age suggests that these behaviours may improve over time (Said et al., 2013). Most sobering is that approximately 20% of medical students have had thoughts of suicide in the previous 12 months, a rate substantially higher than that observed in the general population (National Mental Health Survey of Doctors and Students, 2019).

Gender Differences in Impairment

The National Mental Health Survey (National Mental Health Survey of Doctors and Students, 2019) has revealed a number of concerning gender differences in mental health amongst Australian medical students. For example, with regards to burnout, females reported a slightly higher rate of burnout in all three domains (emotional exhaustion: 57.1%, cynicism: 26.4%, low professional efficacy: 31.2%) compared to male students (emotional exhaustion: 44.2%, cynicism: 24.4%, low professional efficacy: 25.6%). Female students have higher levels of psychological distress and minor psychiatric disorders and report more specific mental health diagnoses than male students. Female students show higher levels of distress than male students (26% and 18.2% reported high or very high distress respectively). Most troubling of all is that female students were more likely than male students to have had suicidal thoughts in the previous 12 months (20.5% vs. 17.1%) and prior to the previous 12 months (34.3% vs. 27.3%) (National Mental Health Survey of Doctors and Students, 2019).

These gender differences have been replicated elsewhere (Dahlin et al., 2005; Said et al., 2013) and the causes can be thought of as falling into three broad groups: gender differences in the population at large, differences in relation to the experience of medical training, and measurement error or bias. With regard to the population at large, the Australian Bureau of Statistics National Health and Wellbeing Survey (2007) showed that for lifetime prevalence of anxiety disorders (32% female vs 20% male) and affective disorders (18% female vs 12% male), there was a marked female predominance. Without a non-medical control group for the Beyond Blue survey, it is difficult to know how much of the gender differences could be accounted for by these differences.

Various hypotheses have been put forward to account for differences specific to medical students including: a greater expectation on women to manage domestic duties, perceptions of guilt and institutional disincentives around pregnancy and maternity leave, some ongoing disparities in the presence of female role models in positions of power, and exposure to harassment. Some of these indicators are rapidly changing with improving gender balance in medical schools both amongst students and teaching staff. Females comprised 51.3% of all medical students in Australia and New Zealand in 2019-20 (Medical Deans Australia and New Zealand Inc, 2020). Nevertheless, in certain specialties the gender difference remains profound. For example, of all medical practitioners working in the fields of General Surgery, Orthopaedic Surgery and Neurosurgery the proportion of females were 11.6%, 3% and 10.9% respectively (Walton, 2015). In a study of women surgeons 87% experienced gender-based discrimination in medical school. Notably, 40% of these discriminatory events came from other women (Bruce et al., 2015) suggestive of a "transgenerational" transmission of adverse medical culture, which isn't simply addressed by greater female representation.

A longstanding issue of bias remains unresolved in the collection of many of these statistics however, and that is that females may be reporting their distress in greater numbers. It may also be that the expressions of distress that are being measured (e.g. depression, anxiety) are more in line with the ways that females are socialised to express their distress in comparison to other predominantly male ways (antisocial behaviour, substance use). Looking further back, socialisation in early family life may encourage more affiliative orientations in females and more self-made independent orientations in males. This could create some discrepancies in perceptions of role performance and self-efficacy in females while also enabling them to seek help and voice their emotional struggles more openly (Richman and Flaherty, 1990).

LGBTIQA+ Issues

The vast majority of LGBTIQA+ (Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/questioning, Asexual and other minority gender identities and sexualities not explicitly included within the term) people in Australia live healthy and happy lives. Nevertheless, they are disproportionately impacted by mental ill health when compared to their cisgender peers. LGBTIQA+ young people (16 to 27) are five times more likely to make a suicide attempt than young people in the general population (Robinson et al., 2014). Unfortunately, LGBTIQA+ populations were not assessed separately in The National Mental Health Survey (National Mental Health Survey of Doctors and Students, 2019) and statistics around the mental health outcomes of this group amongst medical students are largely unknown.

Given the long history of homophobia in our society, it is difficult to know what proportion of Australian students or doctors identify as LGBTIQA+. There has been a revolution in the institutions of medicine and in society at large, which started with the removal of homosexuality as a DSM diagnosis in 1973. LGBTIQA+ doctors and students come from every ethnic and religious group and many still face discrimination from their own communities over and above what they experience in medicine (Myers and Gabbard, 2008). The ongoing barriers faced include the lack of access to healthcare due to perceived and real stigma; harassment in the workplace by colleagues, superiors and patients; and a lack of data which leads to difficulties making evidenced-based arguments for change.

Australian Aboriginal and Torres Strait Islander Issues

Australian Aboriginal and Torres Strait Islander participation in professional life and medicine is on the rise, albeit with challenges. However, data that speaks to the experience is still lacking. In the National Mental Health Survey of Doctors and Students (2019) approximately 0.2% of doctors and 1.2% of students responding identified as being of Australian Aboriginal and Torres Strait Islander background. The sample sizes were small and comparisons with the non-Aboriginal and Torres Strait Islander group were necessarily cautious. Yet among the Aboriginal and Torres Strait Islander Australian student group 73% were classified as having a high likelihood of a minor psychiatric disorder, a much higher proportion than the non-Aboriginal and Torres Strait Islander Australian group (43%). Very high psychological distress was reported in 27% versus 9% in the non-Aboriginal and Torres Strait Islander Australian group. Although the small sample made it harder to be clear about depression and anxiety levels in doctors and students, suicidal ideation in this group of students was high with 45% reporting suicidal ideation in the previous year. Substance use was however low in the Aboriginal and Torres Strait Islander population.

With respect to burnout Aboriginal and Torres Strait Islander Australian doctors reported similar levels to the general doctors' group, but the student group reported high levels of emotional exhaustion (59.1%). In terms of sources of stress, 21.7% were very stressed by bullying, a higher level than the general doctors' population. In line with other work on Aboriginal and Torres Strait Islander Australian health, more Aboriginal and Torres Strait Islander Australian students reported experiencing a broad range of stressful events (all of those listed in the survey) compared with non-Aboriginal and Torres Strait Islander Australian students. Cumulative trauma and loss are important in this group (see Chapter 23 Australian Aboriginal and Torres Strait Islander Psychiatry), with the most commonly reported event being the death of a family member or friend. There is much that could be said about the historical, cultural, traumatic and bereavement

issues at play in this group, where the concept of saturation with trauma and loss is relevant (Atkinson, 2002) but good data-gathering and collaborative approaches to research and service remain essential to moving forward together to enable equity and well-being in our First Nation peoples.

Regulatory Responses to Student Impairment

We discuss regulation not to incite fear but to educate and raise awareness. A triad of weighty issues are at stake here, recognised by the Tribunals in their responses to medical student impairment. Firstly, the safety of the public is at stake and remains a relevant and primary consideration even for medical students. Secondly, there is recognition of both the onerous path to medical school and the enormous emotional and financial investment in a medical education, not to be thrown away easily. Thirdly, there is the potential consequences of future practice on an impaired practitioner (Peisah and Haysom, 2021).

Health practitioners supervising students in clinical training must be mindful of obligations under the Health Practitioner Regulation National Law (National Law) for mandatory reporting which explicitly include students. However, the threshold for reporting is very high for the specific purpose of ensuring that students get help and are not frightened of accessing such due to fear of notification. The circumstances for mandatory reporting under the National Laws 141 are that if a registered health practitioner who, in the course of practising their profession, forms a reasonable belief that a student has an impairment that, in the course of the student undertaking clinical training, may place the public at substantial risk of harm, they must, as soon as practicable after forming the reasonable belief, notify the Australian Health Practitioner Regulation Agency (AHPRA) of the student's impairment, unless they know or reasonably believe, that AHPRA has already been notified (e.g. by the university, who have equal obligations under the Act).

This 'reasonable belief' must be based on direct knowledge or observation, or report from a reliable source (who might consider making a mandatory notification themselves) about the incident or behaviour that led to the concern. The "reasonable belief" should not be based on suspicion, speculation, gossip or rumours (Australian Health Practitioner Regulation Agency (AHPRA), 2020). There is protection from civil, criminal and administrative liability for persons who, in good faith, make a notification under this Law. Conversely, while failure to notify does not constitute an offence it may constitute behaviour for which action may be taken (Australian Health Practitioner Regulation Agency (AHPRA), 2020).

An important distinction to make here is that in this section we are referring to big "I" Impairment, i.e., legal Impairment. Impairment for students is also defined separately under section 5 of the Health Practitioner Regulation National Law, namely:

A physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect a student, the student's capacity to undertake clinical training—
(i) as part of the approved program of study in which the student is enrolled; or
(ii) arranged by an education provider.

The threshold to make a notification to AHPRA is further determined by risk to the public. This is why early identification and treatment of the struggling student is so important (Australian Health Practitioner Regulation Agency (AHPRA), 2020). As with practising doctors, just having an illness (or small "i" impairment) that does not detrimentally impact on the student's capacity to undertake clinical training, does not constitute Impairment. Even with an Impairment, not all Impairments need to be reported. A student may carry out clinical training with a mental health condition, physical health condition or physical illness, but that is not enough to trigger a mandatory notification. If the student's impairment affects their capacity to carry out clinical training but does not place the public at substantial risk of harm, there is no need to make a mandatory notification. As with practising doctors, effective safeguards to manage the impairment may include treatment, break from study, such as sick leave, modified scope of practice, strategies used to manage impacts of impairment, compliance with monitoring and supervision, or a reasonable belief that AHPRA has already been notified.

Clearly, there are responsibilities of students, supervisors and universities alike under the National Law. However, the intent of the National Law is not to punish students or practitioners for impairment, but to protect the public by ensuring that impairment is managed responsibly. We neither do ourselves nor our students a favour by pretending this Law doesn't exist. Compassionate responses to this issue require bravery and honesty. Implicit in our responsibilities as educators is the early identification of struggling students, both for their own sake to ensure access to treatment, but also with respect to transparency with regards to career trajectory. Honest feedback to students who are struggling emotionally and providing relevant support or even diverting those, who despite maximal treatment are unable to manage training into a more strength-based career direction, is of far more value than propping up, or worse still, turning a blind eye to a persistently impaired student out of misguided compassion (Peisah and Haysom, 2019).

This approach seems to be echoed by the United Kingdom (UK) General Medical Council (GMC):

"We heard that in some circumstances minimum requirements for attendance were too rigid and didn't allow for life events during training. We have also received feedback that, for some students, re-taking a year was in their best interests and meant they were not struggling to keep up going forward. Although students may not be keen to take time out or re-take a year, medical schools should be assisting students to consider what is best and consistent with achieving GMC outcomes and meeting the demands of the course" (West and Coia, 2019).

Student Identity and Professionalism

Montroux and Rees (2017) describe the concept of medical professionalism as comprising personal virtues, professional attributes of competence and knowledge, professional interpersonal practice (including continuous professional development, respect for diversity, ethical values, and safe practice) and wider societal responsibilities. This professional identity starts budding in medical school. In their exposure to the clinical environment, students progressively internalise professional ways, practices and behaviours. This includes how they view the clinical world, including patients, doctors and other health care professionals.

As professionalism (or lack of) in the learning environment is observed and absorbed by students, their responses to such can be consonant (natural or comfortable) or dissonant (unfamiliar, problematic or confronting (Montroux and Rees, 2017). From their extensive research based on medical student narratives, Montroux and Rees (2017) explore the notion of the dissonant experience. This often arises out of identity-related, patient-safety related, and patient-dignity related professional dilemmas, and by witnessing workplace abuse, all of which can be sources of medical student distress. Examples of identity-related dilemmas include students being mistaken for doctors, sometimes used to coerce patient consent for student involvement, and at other times leading to patients seeking advice from students. Patient-safety related, and patient-dignity related professional dilemmas that often result in moral distress for the student include communication failings and asymmetrical power relationships between doctors and patients. Understanding professionalism and its interaction with medical student well-being is now considered a priority in medical education.

Student Culture and the Wider Medical Culture

Medical student culture is individualistic, not collectivist in nature. Henderson et al. (2012) have observed:

"The competitive medical environment reinforces the need for toughness and self-reliance which has become more of a wider cultural phenomenon."

It is also perfectionistic, and marks are equated with self-worth. There is a fear of failure and of being failed (Peisah, 2017). This paves the way for medical cultures characterised by rigid hierarchies, teaching by humiliation, denial of vulnerability and omnipotence (Peisah, 2020). With a lack of generativity and commitment to teaching in some medical cultures, it is not surprising that medical students frequently perceive their place "at the bottom of the ladder" (West and Coia, 2019) or "in the way." The UK GMC describes the ideal teaching and learning environment as a compassionate culture, one that provides compassionate and inclusive supervision that offers reasonable flexibility for students with mitigating circumstances, and a culture that enables students to speak up about concerns enabling and supportive supervisory support focused on removing the obstacles in the workplace, rather than creating directive, controlling cultures that focus more on blame rather than on learning and accountability (West and Coia, 2019).

Responses to Distress and Impairment: What Are We Doing About These Issues?

General Principles

From around 1997, policies for medical schools developed as part of the NSW Doctors' Mental Health Program have included:

- Promoting importance of mental health by embedding it in the curriculum.
- Encouraging a caring culture within the medical school.
- Identifying suitable staff to provide assistance to students with psychological and social problems; and
- Assisting students to access good medical and psychological care (Tennant, 2002)

It is one thing to offer such services, it is another for students to actually access these. The myth of omnipotence that doctors are "invincible" and the consequent self-stigmatisation associated with illness is well-documented in doctors (Henderson et al., 2012) and equally evident in students. The National Mental Health Survey (National Mental Health Survey of Doctors and Students, 2019) described a range of barriers to students seeking help including embarrassment, impact on registration and right to practice (34.6%) concern about career development/progression (37%); privacy and confidentiality (49.9%) and reliance on self/ don't want help (47.7%). Not surprisingly, only 56% of students who felt

seriously depressed, or had received a diagnosis of depression, and 40% of those who felt seriously anxious or who had been diagnosed with an anxiety disorder sought treatment. Counselling was the most frequently used treatment in younger students, while older students were more likely to be treated with both counselling and medication. The most common sources of support for students with depression and anxiety were general practitioners, family and friends, and the internet. Notably, few students with depression or anxiety seek support from faculty services, attributed to perceptions of stigmatising attitudes or concerns regarding privacy and confidentiality.

Preventative small group work with medical students may address some of these barriers. For example, there are promising findings from an open-label, single-session, cognitive-behavioural intervention for medical students, focused on improving mindfulness, emotional awareness, and cognitive flexibility (Bermudez et al., 2019). Small group prevention work in the form of Reflective Practice groups is currently delivered at the Sydney Medical School through the Psychiatry and Addiction Medicine (PAAM) term in the curriculum (Lele et al., 2023).

If we are going to make a difference, there needs to be change. Henderson and colleagues (Henderson et al., 2012), have advocated for cultural change from medical school onwards to allow emerging doctors to recognise their vulnerabilities to allow them more easily to recognise and manage illness of any kind, to which we are all vulnerable. Understandably and appropriately so, healthcare professionals often feel an extra responsibility to students with health concerns (Fertleman and Carroll, 2013). As educators we have a responsibility to act as "counter-weights" to some of the unhealthy myths that abound in medical culture and model self-care and recognition of this vulnerability. Finally, there is evidence that dealing with mental health problems at an early stage of training can help promote resilience and reduce burnout later (West and Coia, 2019).

Resources

There are a variety of services available to students in need, ranging from university-based to externally provided support services.

Acute Distress

If it is urgent, namely there are concerns of self- harm/suicide or psychosis, students should attend the local Emergency Department (ED), (and), or the local hospital psychiatry services on call. In light of the aforementioned stigma, shame and reluctance to seek help, if a clinician is involved in the referral they should ring ahead to discuss and ensure that the student makes contact in urgent cases. Emergency

departments are understanding of, and compassionate towards, medical students and colleagues who are in distress. The person will be seen in a private area to ensure their confidentiality as best as is possible and consultation liaison psychiatry will often provide advice and support, usually at a senior level. Many students prefer to be seen outside their teaching hospital environment and if this is possible it should be arranged. If it is not urgent, and the person can guarantee their own safety, consider other options such as the individual's private GP.

Further Reading

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Cite as:

Peisah, C., Lele, K., McLean, L. (2024). Medical student self-care and culture. In Boyce, P., Harris, A., and Malhi, G.S. (Eds.), *The Sydney textbook of psychiatry* (pp. 11–21). The University of Sydney.

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