Conference overview: a duty of care

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AT THE 3RD AND 4TH NATIONAL FORUMS on Prevocational Medical Education, held in 1998 and 1999, it was realised that the issues surrounding students and junior doctors who are distressed warranted further attention. As a consequence, this Conference, *The student and junior doctor in distress — "our duty of care"*, was arranged with the aim of formulating recommendations to educational bodies, health departments and medical boards.

More than 100 delegates representing the diversity of stakeholders were involved in stimulating discussions over the two days of the Conference in July 2001. We were fortunate to have talented speakers and participants to address the issues involved, which pose many challenges to educational and health institutions, as well as to the health professions and workplaces.

The transition from university to workplace is inherently stressful for medical students and junior doctors. However, changes in the workplace and society are making it even more stressful than in the past. The stressors include the rapid pace of change in the health system and spiralling healthcare costs, as well as the demanding nature of the job, with long working hours and heavy responsibilities. Also, there is often conflict between educational and workplace imperatives.

The working environment is not always as supportive as it could be, and the traditional culture of the medical profession and its workplaces has not fostered an environment where distressed students and junior doctors are able to acknowledge their need for help. Nor does the system always make it easy for them to find appropriate help.

Drug and alcohol abuse and mental illness can also affect the ability of students and junior doctors to do their job. It is not only the health and the future of young doctors that are at stake; problems which impair their performance in the workplace may also jeopardise patient safety and wellbeing.

Students and young doctors who may be at particular risk include those from non-English-speaking backgrounds and those who are socially and professionally isolated. They were described by one Conference participant as "the lurkers" — those who sit at the back in lectures, do not participate in discussion and do not engage with their peers.

Several case studies explored at the Conference illustrated that, with appropriate intervention and support, students and doctors in distress can be helped and can return to productive careers. However, for this to happen expeditiously and extensively requires a cultural change, so that doctors in universities and hospitals are more aware of their duty of care to colleagues and prepared to identify those in distress and help ensure that they receive appropriate care. There is also a need to encourage better self-care and systems of peer support.

It was noted that medical boards can play an important role in helping students and doctors resolve serious problems and return to practice, but the widespread misperception — that the boards' roles are mainly punitive — can discourage approaches to these bodies.

An important unresolved issue was whether universities should pass on information to hospitals and other employers about students who have had problems. This raises sensitive privacy and legal issues that warrant further exploration.

Repeated emphasis was given to the importance of maintaining confidentiality, wherever possible, when managing the problems of students and junior doctors in distress. Fear about the career consequences of being labelled with a particular problem is a major barrier to identifying students and junior doctors in distress.

Finally, the importance of using appropriate language was also stressed. It was noted that the term "impaired doctor", although enshrined in legislation, has negative connotations that could be counterproductive. It implies that a doctor is damaged, when the reality is that some doctors have health problems or other troubles that can often be resolved or managed so that they are able to maintain an appropriate practice.

The issues are so complex and sensitive that it was not possible to arrive at detailed, consensus-based recommendations. Rather, the Conference participants developed broad principles, which hopefully will provide the basis for further dialogue and development into detailed strategies that can be implemented at a national, State, institutional and professional level.

This report provides a summary of selected presentations at the Conference, and draws together the important themes into a broad overview of the issues.

My sincere thanks go to all who took part in the Conference and helped make it such a success. I would like to particularly thank the organising committee, the South Australian Minister for Human Services for opening the Conference, and all the speakers. Thanks also for the support provided by United Medical Protection.

A special tribute should be paid to the Commonwealth Department of Health and Aged Care, which, through the Medical Training Review Panel, provided much support to early postgraduate training in Australia, and not only strongly supported this Conference and the publication of these Proceedings, but also funded medical students and junior medical officers from all States and Territories to attend.

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Conference recommendations

Recommendation 1

The medical profession has a duty of care to colleagues. There is a need to promote significant cultural change within the medical and other professions, and within workplaces, to encourage an improved acceptance and management of doctors and students in distress. This change needs to heighten the awareness of stressors in the medical profession and workplace. It also needs to encourage a sympathetic and caring approach to the person involved and to deal with the issues in a non-punitive manner.

- Everyone has a responsibility to identify and assist the student and doctor in distress.

Recommendation 2

For people involved in managing students or doctors in distress

- Each institution should have a clearly identified person as the point of contact, who ideally should be independent of the student or doctor's career and studies.
- Further consultations with other people or bodies, such as the Director of Clinical Training, supervisors, peers, and medical administration, should be on a "need to know" basis. They should occur only with the individual's consent, unless patient or colleague safety is at risk. The importance of timely, regular and positive feedback for students, junior doctors, teachers and supervisors is paramount.
- When there is concern about patient safety, the Medical Board should be informed.
- The person who made the initial identification should be informed that the matter is being managed.

Recommendation 3

Strategies for preventing distress in students and doctors should be implemented nationally, and should include:

- An emphasis in the student curriculum on maintaining health and wellbeing.
- The education of the profession and students about behaviour patterns and warning signs, especially in "at-risk" groups.
- A comprehensive orientation of students, junior medical officers and registrars, with clear definition of the roles and responsibilities of each.
- The Medical Education Officer and Director of Clinical Training actively seeking to recognise the character of the individual units in all training locations, including community placements.
- Effective performance appraisals of junior doctors, and feedback incorporating registrar and/or nursing perspectives where appropriate.
- Adequate support and provision of resources for junior medical officers (JMOs) including:
  - adequate staffing to cover annual and sick leave;
  - continuing education, particularly in areas of stress management and time management;
  - dedicated weekday time to allow an annual visit to a general practitioner;
  - appropriate location and pager-free time for junior doctors to meet; and
  - provision for national meetings between State and Territory JMOs and students.

Recommendation 4

There is a need for further consultation between relevant bodies regarding the transfer of information about distressed students between university and hospitals. This issue needs to be further explored with discussions by all parties involved — the universities, hospital administration and medical staff, postgraduate councils and medical boards.

Recommendation 5

That the management of students or doctors in distress be:

- confidential;
- independent of training or studies;
- clear and well defined in all medical schools and hospitals in Australia;
- continually re-evaluated by all parties involved; and
- structured to include career counselling, if appropriate.