A crisis brewing for the healthcare system and a crisis already happening for our students

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Working in medicine has always been a stressful job for a number of reasons. Long hours, dealing with life and death situations day and night, lack of time to build personal relationships and stressors related to work-life balance contribute to personal stress. This is compounded by putting oneself second to the needs of others combined with changes in practice of medicine, technical advances and changing patient expectations among other factors. Furthermore, organisational and institutional pressures and structures can add to the burden of practising medicine. Medical students (doctors-in-training) carry with them a number of stress-inducing factors. First and foremost, they are in that vulnerable age group where two thirds of psychiatric disorders begin. Secondly, stressors of all types can contribute to the development of mental ill-health. The history of medicine tells us that doctors would often work hard and in relative isolation, but enjoyed extremely high social status and other rewards. This social contract with medicine has shifted significantly over recent decades, with doctors almost ubiquitously working in teams with other doctors, nurses, social workers and others. Indeed, healthcare overall is becoming much more collaborative and patients themselves are increasingly seen as a crucial part of the overall team in their care. This is undoubtedly welcome. At the same time, societal and financial rewards for doctors have lessened in many places alongside marked changes in patient expectations and changes in laws with clear emphasis on health as a commodity which can be bought and sold and patients being consumers who have greater understanding and can communicate widely using social media and other methods.

The practice of medicine itself has also become more transactional and less holistic with increased specialisation and technologization of care. This has led to much ‘silo practice’ and often patients find it difficult to navigate care systems and meet the criteria of various specialised teams. This may be less so in primary care but with super-specialisation in mental health care often doctors and trainees flounder and get stressed out traversing the boundaries. Long term relationships with patients and families are much less common than previously, with managing episodes of care being the usual approach internationally. It could be argued that this is one of the main reasons for the change in both medical care, the satisfaction clinicians derive from it, and the value attached to it by society, with doctors often seen as mere technicians, albeit highly skilled and authoritative ones.

Over recent years, much more attention and recognition has been given to the wellbeing of doctors for a variety of reasons, including their well-known high suicide rates and their need to be able to work under pressure to deliver the best patient outcomes in an era of changed patient expectations and increased scrutiny of clinical decision making by the media and other stakeholders. Reported stress levels have been increasing and support services for practicing doctors are now ubiquitous in high-income countries and available in some lower and middle too.

Unfortunately, the same degree of attention has not been paid to the mental health and wellbeing of medical students (the future workforce). Over recent years it has become evident that students also have high rates of burnout and low levels of wellbeing as measured on reliable and valid instruments. This should be no surprise to us as the life of medical students is stressful, both in terms of the work required and in terms of various aspects of personal life such as leaving one’s home area, relationships, housing, and finance.

Burnout is a term often used and is defined as having three components of feeling emotionally exhausted (‘spent’), displaying a detached attitude towards others (depersonalisation and cynicism), and a low sense of work efficacy (diminished or reduced personal accomplishment) (Brotheridge & Grandey, 2002). The opposite of burnout is engagement, often described as a state of mind which is typified by vigour, dedication and absorption (Bargagliotti, 2012; Spence Laschinger, Wilk, Cho, & Greco, 2009). There is no doubt that these feelings can be affected by various personal, social and/or professional factors. Individuals can be content with the (good) quality of work they do and thus may not feel exhausted. If people feel engaged then rates of burnout are likely to be low. Burnout is said to be related inversely to empathy (Wilkinson, Whittington, Perry, & Eames, 2017) which confirms the paradox that medical students face regularly. On the one hand they are expected to be empathic and on the other they are supposed to be professional, keeping their distance from...
their patients. The high rates of burnout in many countries described in this volume indicate that the medical profession needs to look at training at undergraduate level in a more sensible and holistic manner. Furthermore, we also need to explore the true meaning of burnout. In anonymous surveys rates are high and this may be due to respondents replacing anxiety or depression with burnout as it is seen as less stigmatising. There is no doubt that clinicians experiencing burnout will be working at a sub-optimal level and may have a higher than expected level of critical incidents. It has been argued that patients may not notice any difference in care provided to them (Castaneda & Scanlan, 2014). It can be argued that alienation (estrangement from patient care) is linked with burnout; in particular in the UK this has been associated with bureaucratic drive and demand. Rather than using the term burnout, some authors prefer moral distress meaning that individuals feel distressed that they are not able to perform their duties to the best of their abilities but feel stuck and trapped (Dzeng & Curtis, 2018).

Following on from the initial project conducted by the British Medical Association (Bhugra et al., 2011), we decided to focus on medical students as the workforce and health leaders of the future and approached colleagues in several countries. Thousands of students responded and completed the same questionnaire anonymously online, allowing direct comparison across many countries at the same time point - a first. What we found saddened but did not surprise us. There were very high rates of burnout, both disengagement and exhaustion, across all countries surveyed. Well over two thirds of most samples scored as cases in these regards, a worrying result and a real concern for later stages of these predominantly young people's careers. Using measures of substance misuse, we found levels of problem alcohol and drug use at least equal to the population level in each country and in many cases much higher. This despite the students being in the best possible place to understand and indeed be faced by the consequences of such use in others - the physical, mental, and societal damage caused. At the same time, we also found low rates of wellbeing and high reporting of symptoms of poor mental health, again higher than in those around them - whether that be other students or the general population. Reported causes of stress did differ between countries as one might expect, as different systems and cultures bring differing pressures. Notable were financial pressures in many high-income countries and the reporting of family pressures in others such as India. Nowhere was without pressures of some type and many students reported multiple stressors across different domains of life. These obviously need to be teased out further to understand the causation and develop appropriate interventions.

On a more positive note, many medical schools report an increasing focus on wellbeing awareness through their curricula and ease of access to services and the introduction of measures to provide emotional and practical support. This is crucial as our survey showed that both are important and often come together to cause stress and reduce wellbeing. We found everything from debt advice to sessions of yoga, mindfulness, and even stroking and playing with puppies (!) in order to reduce stress. The needs of medical students are in many ways the same as those of others and we must remember that all students are considered a high-risk group and many of the general population work in intense and difficult roles. We know that many psychiatric disorders in adulthood start around the vulnerable age of these students.

We are necessarily being narrow here but there is one crucial difference; medical students are to some extent 'in our care' and compared to other students are usually away from home much more and have significantly less flexibility in schedules to attend leisure or family activities or indeed to take part in wellbeing activities. We are therefore beholden to ensure that support and treatment (if it comes to that, and in many it does) are readily available to mitigate these issues.

While we do not exactly know how major changes such as artificial intelligence, machine learning, and digital technology will change our profession, we can be sure that doctors will always be needed and likely will remain in short supply, especially if current rates of attrition at all stages continue. Though new technologies will undoubtedly replace some traditional 'medical activity', our ageing world population and our ability to do ever more to create and prolong life (and our continued drive to do so) will ensure the need for high functioning and motivated healthcare staff of all types. It is therefore important that as well as protecting the health of medical students for their own sake we must do so for the health of us all. It is inconceivable to think of healthcare without humans. To be able to care for vulnerable people humanely and efficiently, all those involved need to have reasonable levels of wellbeing and substantially lower levels of burnout than we have found. In addition, we need to think carefully about how we train medical students with focussed rather than generic curricula.

There can be no doubt now that we need to act globally on this issue for several reasons. Doctors will move around for personal and professional reasons and may well choose to work in a different country rather than the one they have trained in, raising specific issues related to stress and alienation and lack of social support. The key question is how we support these young students and doctors of the future. There are examples of excellent support services and initiatives that we can all learn from but we need to go further back at the same time and discover why so many of our medical students are so burnt out and unhappy and what we can do to alter courses, living arrangements, and the overall
structure of this crucial stage of life to make things better, or at least less bad.

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References


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