Who Will Guard The Guards? – The Mental Health of Medical Students

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"The ability to empathise with patients, be they medical, surgical or psychiatric, is what distinguishes a great doctor from an average one.

Why then can't we empathise **with our own colleagues**?"

Many of us have sat through a psychiatry lecture, heard the symptoms of a condition and thought, "I have that." But how much of this self-diagnosing is accurate? The answer could be surprisingly high. In a 2007 longitudinal study on burnout (defined as adverse reactions to a pressing work environment) among Swedish medical students, 25% of those interviewed had a clinically significant psychiatric diagnosis[1]. Be it depression, anxiety disorder, alcohol abuse or suicidality, the prevalence rates of psychiatric morbidity indicate that statistically at least one student from each year group must be affected. Given that Medicine contains a more homogeneous group of personalities than the general population, its associated predisposing personality types or traits mean that the prevalence of certain psychiatric disorders is unfortunately higher among medical students, even before entering medical school[1]. For any psychiatric disorder, the 3 Ps are examined to identify the predisposing, precipitating and perpetuating factors which contribute to a patient's diagnosis. For a young, perhaps naive and ultimately inexperienced undergraduate, adapting and succeeding at medical school is no mean feat. One's personality traits may be of great help or of great hindrance in surviving the challenges of medical school and coping with the demands of exams, rotations, research and colleagues.

Traditionally, medicine has been known to attract the Type-A personality: organised, stringent and stressed. While most classes thankfully have a more heterogeneous mix of students, HPAT or no HPAT, the demands and ethos of medical school certainly encourage being of this mould in the early days of medical school. However, as the hours lengthen and summers shorten, with more demands being placed on doing rather than learning, the clinical years can be a major stressor for those Type-As. Once at the top of their game, they often find themselves reduced to being the lonely medical student or sole intern of the team. Type-A personality traits and neuroticism have a proven association with the phenomenon of burnout[1].

Medical educators, through planning the workings of a medical school, aim to expose medical students to the life skills, opportunities and challenges faced by qualified doctors working in the medical field. Consequently, the constraints on time, onus of responsibility and demands on maturity are much more than those placed upon fellow undergraduates in other faculties. Five years of back-to-back 9–5 lectures, immediately followed by blocks of 9–5 rotation, served with a selection of exams covering everything from the ubiquitous Reed-Sternberg cell to ramipril, is surely a recipe for anhedonia, fatigue and persistently low mood in anyone of previously good mental health. A 2009 study of TCD & UCD medical students found the prevalence of depression to be over 14%, ranging from mild to moderate to severely depressed, as measured by a self-filled questionnaire[2].

Thankfully for some, this triad of depressive symptoms is usually reactive and can often lift with the onset of the ever-dwindling summer holidays that haven't yet been consumed by the demands of even more electives/rotations. With a little self-medicating at the nearest watering-hole, all stressors are surely forgotten about; the one thing medical students are perhaps more proficient at than doctors: "Let's have a drink." The same study of TCD & UCD medical students found that 15.4% met the criteria for alcohol abuse[2]. This statistic is particularly worrying given that medical classes contain a substantial number of non-EU students who are less likely to abuse alcohol. Of this proportion, consider those for whom alcohol is merely another redundant medication, or for whom acute abuse turns gradually and insidiously to addiction over the long years of NCHD training. A survey on the prevalence of alcoholism at an American teaching hospital found a rate of 4% among medical staff, with a further 10% classed as having possible alcoholism[3]. It is grave to ponder how many of our classmates will develop

the same addiction, just because their coping mechanisms involved the support of alcohol rather than family or friends in those early days of medical school.

Time brings change, and medical school is full of changes, with few constants such as school friends, boy/girlfriends, flatmates and even family being able to weather the five-year marathon. This isolation worsens over the years, as the move from campus lectures to hospital teaching to hospital living often further removes medical students both geographically and socially from the familiarity, supports and distraction of undergraduate life. For those with few outlets or social supports, medical school can turn into a timetabled hamster-wheel routine, which when coupled with dissatisfaction with the course and distancing from university life can lead to an all-too-easy downward spiral into melancholia and isolation.

Yet this is news to very few. We are all aware of the pressures that exist in the medical profession; it is what we signed up to, after all, at the wise old age of 18. Many others have gone through the same system before us, many will do so after us, but getting through and managing well are entirely different things. Every year sees its share of students who have to repeat exams or take a year off, sometimes for known reasons such as bereavement or physical illness. However, more often than not, these are reasons that could be attributed to a debilitating psychiatric diagnosis that the (at times indifferent) world of academia fails to acknowledge or accommodate. We all know of at least one friend or classmate who has struggled with a period of mental health deterioration, yet the subject is rarely directly addressed by lectures and can suffer from the same stigma and silence that psychiatry faces in the public domain. Are medical students supposed to be immune to such disorders? Is psychiatric illness something that only affects people in other courses? Psychiatric training heavily contradicts this notion, but perhaps the physician credo of "first treat thyself" is too heavily ingrained.

There still exists an expectation, a sort of peer pressure, found nowadays perhaps only in the medical profession, for a doctor to perform beyond the average requirement of a public sector worker. Attitudes are slow to change, especially in Ireland, and the old-school ethos of "In my time as an intern, we worked every single day regardless," can still unfortunately be found in certain specialties. Attitudes devoid of empathy such as these pay little heed to the mental health of medical students, and for anyone suffering from depression, whether mild, moderate or severe, it's the last thing they need. Doctors are not superhuman, nor do they need to be – machines were invented for that reason. The ability to empathise with patients, be they medical, surgical or psychiatric, is what distinguishes a great doctor from an average one. Why then can't we empathise with our own colleagues?

Although the notion of peer mentoring and student-delivered counselling is a valued source of support in college, it is often an inadequate intervention for psychiatric illness, be it an anxiety disorder or florid psychosis. With the student counselling service located on campus, and closed outside of medical teaching hours, it is virtually impossible to attend appointments whilst keeping up with academic commitments. In addition, with one psychiatrist for over ten thousand students, appointments for either service can have a waiting time of over a month. This may seem a trivial amount of time to some, but, to a person experiencing a major depressive episode, such a time lapse can potentially be the difference between life and death. A valid counter-argument would be that medical students are surrounded by mental health professionals every day, and should, in theory, have unlimited access to their advice. Few, however, are comfortable with breaching this age-old master-apprentice relationship. The medical student is, hence, incarcerated in a no-man's land, feeling belittled by their supposed mentors and, subsequently, having no-one else to turn to.

It is the authors' belief that any medical school would benefit from assigning each student a tutor who is a member of the hospital teaching staff, and thus more empathetic to the demands of clinical training. This is as opposed to a college academic, remote in every sense, which is the current situation. Despite a history of suicide within our faculty, there is still no teaching time dedicated towards coping with personal or familial mental illness as a medical student. The importance of psychiatry is clearly acknowledged by our college, as evinced by it counting for one quarter of our medicine mark. We can all take an adequate history of a psychotic or depressive episode, yet we receive no advice regarding what to do if we ourselves are plagued by the burden of mental illness. It must be questioned whether this "emphasis on psychiatry" is a genuine attempt to destigmatise and promote the specialty, or a mere campaign to project the image of such. The provision of in-hospital psychological and psychiatric support services for medical students could prove invaluable in treating mental illness at a time in life when they are vulnerable to depression, alcoholism and isolation. The same approach could potentially prevent mental health deterioration amongst junior doctors and then further down the line as senior physicians, if it were to be instated at the level of medical school.

In conclusion, it is clear that medical students are at a disadvantage when it comes to mental health. Training at such a young age to look after others can often mean that we lose the ability to take care of ourselves, letting our own emotions, hardships and fears slip away through the conscious mind to the abyss of the subconscious, where they are suppressed. There needs to be alternative methods for seeking help made available to students for whom the conventional college measures in place are inconvenient and unsuitable. Realistically, of course, if these changes are ever to occur it certainly will not be tomorrow, so let us at least make a start to approach this indescribably serious topic at a peer level. We know to enquire further when Mister Smith on the ward grimaces with his crushing chest pain, and yet why won't we enquire further when we suspect someone is pained by something less objective? The "SOCRATES" approach does not just apply to

physical insult. So perhaps the question we should be asking our classmates and colleagues is not, “How’s it going?” but rather, “How are things, really?” Probe beneath the exterior and you’ll undoubtedly uncover more than on general inspection.

References

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