Support for tomorrow’s doctors: getting it right, meeting their needs

The provision of support for medical students is an area of growing concern in the UK and internationally. In spite of the support already provided, there is clear evidence that we are not meeting students’ needs. Medical students have higher incidences of ill-health and, in particular, common mental health problems than other students [1–4]. It is ironic that in training young adults to become guardians of society’s health and well-being, we unwittingly place their own health and well-being at risk. However, how best to provide timely and appropriate support for students who are found to be struggling requires careful consideration.

Training to become a doctor is challenging. To be successful requires resilience, persistence and tenacity. To gain a place at medical school, a student must overcome many hurdles. Once this has been achieved, the pressure continues unabated. For some, this is compounded by parental or family expectations. Educational and clinical demands leave little time for the health and social activities that are central to well-being. Doctors and medical students show well-documented tendencies towards traits like perfectionism and neuroticism [5]. This may be a potent recipe for success. However, for some, this is instead a recipe for silently struggling when things go wrong.

Medical students face specific challenges, and it is these that should shape the principles of support. Undergraduate training is more demanding and longer than most other courses. This brings both financial and social pressures. The impact of ethical conflicts, exposure to death, human suffering and emergency situations on young medical students cannot be underestimated [6,7]. Poor role modelling by senior doctors can lead to confusion, distress and anger in young doctors [8].

The General Medical Council stipulates that medical schools should provide both academic and personal support. In terms of academic support, ‘Students should be able to seek academic advice from identified staff when they are concerned about their own progress’ [9]. Medical schools are also expected to ensure that students have access to personal support through student support services, occupational health and personal tutor systems [9]. The challenge seems to lie in the tension between the students’ own perceptions and expectations of being a medical student, the culture of medicine that they find themselves immersed in and the systems and processes in place that are intended to provide support.

The stigma around mental health is a powerful barrier to students seeking support.

It is well recognized that doctors self-manage, self-treat and enter into corridor conversations about their own and their families’ health needs [10,11]. Like the doctors they observe, students learn to self-manage illness early on [12]. This increases during training with increasing access to medical wards and availability of drugs. Coping responses are exacerbated by both learned behaviours and the hidden curriculum, where ill-health is minimized and resilience an expected outcome [7,13].

In one study, less than a quarter of first and second year medical students who were depressed had used appropriate mental health services [14]. Inappropriate responses to anxiety and stress are evident. Medical students’ alcohol consumption regularly exceeds recommended levels, and increased use of illicit drugs has also been reported [15–17].

Barriers also exist due to the systems that identify and provide access to support. Those providing the gateway to support often have conflicting roles, which can inhibit disclosure. Boundaries are often blurred between those that teach, examine and provide personal support. In many cases, personal tutors are also academic tutors and may also be examiners or hold other senior positions within the medical school. An academic tutor may be well placed to identify that a problems exists, but they are not always best placed to manage those problems. The interface between policing performance and providing sensitive, confidential support is often not clear or explicit. The role of personal support lacks definition. Some see personal support as a coaching and mentoring role, others as assessment and development, and some move into a therapeutic counselling role with students. Given these uncertainties and unclear boundaries, it is not surprising that a student may falter in seeking support. Issues of confidentiality and note keeping compound the problem. Processes and procedures around confidentiality lack transparency and leave students wary of disclosure. Our unpublished research indicates that when information is stored, where it is held and who has access to the information are major issues of concern for students.
That medical students will require some kind of support during their training seems obvious, but at present, it seems that our systems often fail them. So what can we learn from the wider literature on health and work? Common health and social problems prevail in any working population. The biopsychosocial model is well established as the most effective model for providing support. In many work settings, line managers are now being trained to understand that an issue with performance may reflect hidden health, personal or social issues, and the boundaries in which they should work [18,19]. Clear pathways and processes for support have been developed and have shown to be effective [20]. There are many excellent examples of where the culture and stigma of mental ill-health in the workplace has been turned around by an open and well-managed system of respecting health and valuing employees [21]. Early intervention is important.

Having considered the challenges and barriers medical students face, what lessons can be learned? For medical schools, academic and personal support should have clearer boundaries. Training for those providing academic or personal support should be mandatory. Systems and processes for providing support should be open and transparent. Ensuring students have access to clear pathways of personal support is crucial. Expecting students to provide intimate details about their personal life to a tutor who later they face in an exam is not appropriate. Separating personal and academic support and the pathways to accessing help not only will provide students with clarity and more confidence about disclosure but also will hopefully engender the principles of appropriate self-care when they later move into the world of work.

Responding to a student’s need, so-called ‘reactive support’, should be clearly signposted, providing timely access to appropriate health, personal and social interventions. Personal support should also be proactive. This should be built into the curriculum to give the subject matter importance. It should provide students with strategies and skills to help maintain their own mental health and well-being. Both individual and small-group sessions are effective for academic and personal support. Group support is powerful, particularly when discussion around shared experiences is encouraged [22,23]. The strength of near peer or buddy support cannot be underestimated.

Perhaps, this is the time to move away from the language and need for a compulsory personal tutoring system and to embrace other models of delivery. Why should personal support be compulsory and from one named individual only? Language is all important. Tutoring suggests directing and informing students about their progress. Models of medical education and personal development today suggest mentoring and guiding as a more appropriate method for doctors and medical students to follow [24,25]. A mentee will move from one mentor to another as they outgrow each other. This would seem appropriate as a student grows and develops their particular areas of interest. So we should start to embed this method of guidance, support and development from the start of training.

Medical schools in the UK are developing more bespoke services for students, but they have much to learn from wider knowledge and experiences from occupational settings. It is clear that any support system must be transparent and explicit in its process and delivery. Confidentiality and consistency must be central to its activities. It must be flexible and able to respond appropriately to demand and student need. It should have multiple modes of delivery and provide both reactive and proactive support mechanisms. Good communication between students, tutors and the medical school is the key to success. Schools should focus on the learning environment alongside personal and social support.

This is not just about medical education, this is about professional practice. We have a duty of care. Embedding the biopsychosocial approach and allowing its principles to guide models of personal and academic support can only benefit medical students, their educators and ultimately patients.

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