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The medicalisation of medical students

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It has almost turned into folklore that medical students become convinced they have whatever dreadful illness they happen to be studying at that time. Yet, there is a more serious side to this phenomenon: when doctors become convinced that medical students are sick when in fact they're just students. Like much of medicine, it can be hard to get this right.

There are two powerful counteracting forces at work in this medicalisation of medical students. On the one hand there is the problem where students may be tempted to seek corridor consultations with the risk of the ensuing over-investigation, jumping to conclusions, and failure to take the usual steps to reach a diagnosis.

Diagnostic error can easily occur in consultations when medical students are patients, as they can when practising doctors are patients. The more these doctors-as-patients can be treated just like any other patients, the less likely it is for these problems to occur. This is why we try to teach our medical students and doctors how important it is for every doctor to have their own General Practitioner and how corridor consultations breach all kinds of boundaries.

The other powerful force at work however is how good we can all be at denial. Doctors may be less likely to seek help, more likely to self-diagnose and more likely to suffer the adverse consequences as result. It's tricky being a patient as a health professional. It's tricky being a patient as a medical student too. It may be even trickier not being a patient.

Doctors wear many "hats". We are familiar with the usual hats of professional life versus personal life. Can we keep these separate, are we ever off duty, do patients have priority over family? Sometimes doctors are asked to be judges—is this patient telling the truth? Does he deserve a sickness benefit? Is she safe to drive? These are conflicts in roles that we often face.

Put medical education in the mix, and it can get even more complicated. Here doctors have to be teachers, judges, mentors, role models, and examiners. It would be surprising if sometimes we failed to keep these roles completely separate from each other. Did this student not do so well on my assessment because my teaching wasn't up to scratch? Or was it just that the student didn't put in the work? Another of the challenges we face therefore can be when we think their learning isn't up to scratch because they're sick.

Did she fall asleep in that tutorial because I was boring, because she's burning the candle at both ends or because she has sleep apnoea? Was that other student lacking motivation because he found my area of medical practice less interesting or is he depressed? It can be so easy to merge our roles and suddenly find we want to "diagnose" our students' illnesses.

This is not helped by learning that medical students find some aspects of their course to be distressing,[1] nor by learning that problems with progressing in a course can be a marker of illness.[2] But are medical students more prone to depression than other students; are they more likely to be stressed? This is where evidence can sometimes help.

The paper by Samaranayake and Fernando in this issue of the *NZMJ* has relevance to some of these dilemmas.[3] In their paper, the authors surveyed Auckland students from medicine, nursing, health science and architecture to determine the prevalence of anxiety, depression and satisfaction with life. Contrary to what many may claim, it would seem that medical students aren't more stressed than other students, aren't more likely to be depressed and actually are happier with their lot. It's refreshing news. Capable students who have got where they want to be, are doing a course that interests them and have a reasonably certain career structure ahead of them after graduation mostly seem quite happy with life.

There are however some cautions to be taken alongside this conclusion. The medical students who were surveyed were only in their third year. There's still time in years 4–6 for it all to go downhill. However, a similar study has been conducted in Australia[4] finding a similar result. In that survey students from all 6 years of an undergraduate medical course were compared with students from Psychology, Law and Mechanical Engineering courses. The non-health discipline students were significantly more distressed than the health discipline students. Distress levels were statistically equivalent across all 6 years of the medical degree.

The other caution to be taken is that, in Samaranayake and Fernando's study, there was quite a high prevalence of depressive symptoms—16.9%. Although this was less than the 23.6% in the non-medical students, this could still mean that their depression is being under-diagnosed and, to a pharmaceutical company's delight, possibly even undertreated. Like a lot of medicine, it can be hard to get this right too.

The good news is that those of us involved in teaching students needn't feel the burden of getting that bit right. Diagnosing illness in medical students should be left to the students' doctors, not their teachers. Of course, we can be alert to alarming symptoms, should help point students in the direction of help and can encourage them to have their concerns addressed.

But medicalising medical students shouldn't be part of a teacher's job. Respecting boundaries begins at home.

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References:

1. Wilkinson TJ, Gill DJ, Fitzjohn J, Palmer CL, Mulder RT. The impact on students of adverse experiences during medical school. Medical Teacher. 2006;28(2):129–35.

2. Wilkinson TJ, Tweed M, Egan T, et al. Joining the dots: Conditional pass and programmatic assessment enhances recognition of problems with professionalism and factors hampering student progress. BMC Medical Education. 2011;11(1):29.
3. Samaranayake CB, Fernando AT. Satisfaction with life and depression among medical students in Auckland, New Zealand. N Z Med J. 2011;124(1341). http://www.nzma.org.nz/journal/124-1341/4838
4. Leahy CM, Peterson RF, Wilson IG, et al. Distress levels and self-reported treatment rates for medicine, law, psychology and mechanical engineering tertiary students: cross-sectional study. Australian and New Zealand Journal of Psychiatry. 2010;44(7):608–15.