# Surviving transition from student to doctor: reflections from a life in medicine

A doctor's commitment to caring for patients is his/her greatest source of satisfaction – but is also often stressful. Here are some suggestions to cope with it.

Medical student? Recently qualified medical practitioner? The transition is brief, the difference profound. After years spent acquiring knowledge and familiarizing yourself by applying it within protected circumstances, you acquire that magic title, 'doctor'. With it you inherit instant trust, respect – and the sudden weight of personal responsibility. The leap fundamentally changes your focus from examinations to patients.

I believe you will have a life of vast medical change. For many centuries advances were halting. Since the end of the Second World War the pace has quickened, often in an unpredicted manner. It will probably continue to accelerate. One characteristic has remained unchanged so far – doctors' commitment to the personal care of their patients. Concentrate on this. It is your guiding beacon and the source of greatest fulfilment.

## The old way

In 1948, following an 18-month basic sciences course, I entered the hospital wards as a clinical student. It was a momentous year, not just for me. On 5 July Britain inaugurated the world's first national health service, centrally funded, available to all and free at the point of need. On 10 December the Universal Declaration of Human Rights was proclaimed by the United Nations. Their effects were then not immediately evident.

We were taught exclusively by clinicians or their assistants on patients admitted under their care or via casualty (the accident and emergency department). There was no written syllabus. Throughout our training we never visited a general practice. Astonishingly, newly qualified doctors could immediately embark on singlehanded practice. We were given no guidance on our interpersonal relations with patients and other aspects of conduct, it being assumed that we would learn 'on the job'. Most of our role models were admirable but others behaved abominably – and were unchallenged. Class discrimination was still prevalent and patients were often treated as supplicants.

I was then, as now, impressed that students straight from school adapted to the new relationships while they were still in the throes of maturing and establishing their own personalities. They were confronted by patients ranging from infancy to old age, and including their contemporaries of both sexes, struggling with issues paralleling their own. They had to ask questions and receive answers that would be considered scurrilous within normal society. Naked bodies were inspected and examined. I do not recall any advice on chaperonage. As an ex-service veteran I felt sanguine in my maturity, but my first encounter with a young female patient demonstrated the fragility of that self-assurance. Fortunately I was able to call upon a female student (my future wife) to accompany me.

In the absence of a curriculum, final examinations were a lottery. Qualification signalled the descent of punishingly heavy and often unsupported responsibility. House appointments were resident, providing sympathetic friends to hand. We worked within discrete teams ('firms'), responsible for individual patients from entry to discharge, enabling us to assess the outcomes. There were many outstanding units created by committed leaders, identifiable by their queue of aspiring trainees and the high morale of their team. We learned by direct experience, aware of our sole responsibility; the lessons of which were deeply engraved in our memories. Too often they were from revealed mistakes, acknowledged in the mantra: 'Try not to repeat your errors'. There was no system of protocols, guidelines or audit.

## Lessons from this career

I hope you can perceive vast changes that have occurred since the start of my career. Many were intended to correct the defects and improve the standards of training. I know from personal experience that patients are now greeted in an atmosphere of respect, dignity and openness. The tolerance with which young doctors treat elderly and infirm patients makes me ashamed as I recall that this was not always so. It is an encouraging confirmation of the intentions implicit in the declaration of human rights.

Newly qualified medical practitioners should feel more securely prepared than were their predecessors. During training you will have had discussions and simulated encounters on communication with patients, appreciation of relations with colleagues, social awareness, team-working, management skills and ethical practice. Preliminary introduction of procedural skills using models and virtual reality are demonstrably better than exposing patients and novice students to the stress of first encounters in real life. Uptake may be tested using objective structured clinical examinations and communication assessment and skill building exercise. They incompletely reproduce human reality but students study only what will be subjected to examination: 'The prospect of assessment drives learning'. Thus you can have a preliminary exposure to most of your likely future encounters, including shadowing of qualified predecessors. The vital importance of carrying out complex procedures in the correct sequence is inculcated during step by step instruction. You have the safeguards of information on evidence-based practice, continuing medical education and periodic reassessments intended to prevent or correct fallacious practices.

Do not expect a serene progression through to your retirement. In a nationally funded service the economic state is crucial to maintaining standards and introducing improvements. Medical service funding has

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to compete with many other needs and may be cut. If the esprit de corps is high within the community, problems can be overcome with minimal dissension. Reorganizations introduced at times when morale is low create resentment and conflict. Morale is raised if direction is perceived as efficient and sympathetically driven. It is eroded by incompetent leadership and duplicity.

Early in my active career the administration of hospitals was dominated by voluntary committees of senior clinicians. In 1975 the government attempted to halt rising costs by introducing a system of professional governance. At that time British commercial management was widely regarded as pitiable. The cost of introducing innumerable undertrained managers was widely perceived as wasting resources urgently required for patient care. The resulting conflict had parallels with some of the present reactions to the proposed revision of junior doctors' contracts. Discord arising in these and other circumstances can be avoided only by compromise reached after reasoned, unhurried, civilized discussions. It is aptly called 'negotiation', from the Latin 'not leisure'. Do not allow these episodic conflicts to disillusion you from your vocational commitment to serve needful patients with skilful care.

Strive to avoid anxieties, as these impair your effectiveness. There are many causes but the commonest is sheer overload, often compounded by attempts at 'multi-tasking'. You have already been introduced to the concept of triage (Old French 'to pick') – evaluating the degree of urgency for required action. Apply the same discipline every time you encounter a new demand. Stop. Review and re-arrange your priorities to incorporate it. If you cannot do so, briefly explain why you must defer it. If you do not, you will rapidly lose your reputation for reliability.

Among a plethora of other factors, a potent cause for disaffection is interpersonal conflict. I had learned the value of comradeship during my war service but it was deepened during my ensuing medical career. Comradeship embraces everyone with whom we come in contact. It is not limited to status; no one is above or below inclusion. Develop and maintain close relationships with your colleagues. They are your best protection against becoming isolated if you are overstressed by anxiety, remorse, overwork and conflict. The intervention by friends often prevents you from inflating a problem into an obsession. You earn friendship and trust by being supportive, tolerant, reliable and honest to others.

I regret occasionally undertaking activities without first carefully assessing the difficulties and the likelihood of success (Kahneman, 2011*). By the time the project began to appear increasingly unpromising, my accumulated efforts had acquired a spurious value which resisted abandonment. On other occasions I also neglected to devote serious thought to potential opportunities revealed within the rich flood of emerging innovations. In so doing I robbed myself of the chance to make fresh contributions. I should have asked myself the question: 'How can this be applied more widely or effectively?'

## A privileged position

Never disregard the privilege of being a physician. Stating your occupation brings almost universal respect as a caring professional devoted to the wellbeing of patients. Compare the fulfilment and security of your career with the precariousness facing actors, musicians, artists, sports(wo)men and politicians. They compete for every opportunity to perform and have no security. Provided you retain your competence, you need never be unemployed. There is one further, often overlooked benefit. Medicine provides an almost limitless array of different areas of interest. Whatever your aspiration, there is a niche awaiting you. Moreover, if your desires change you can usually take your acquired skills into a different area or benefit from further training; home or abroad, acute or elective and ranging through clinical, manipulative, psychological, research, administrative and political.

At the beginning I mentioned that our commitment to our patients has so far remained unchanged. We are already well aware of seeking services through the internet and being asked to choose from menus. The emerging power of artificial intelligence may unburden doctors from many tiresome bureaucratic chores – but will undoubtedly intervene into the doctor–patient relationship. How deeply will it erode the rapport between two sentient humans? There will be many other developments that we cannot predict or imagine. You have joined a challenging profession.

A medical qualification is a membership certificate to a select club. Your patients are a cross-section of the whole of mankind who open their lives and private thoughts to you. The privilege of being instantly welcomed, respected and trusted by most people imposes on you the absolute responsibility to honour their trust. If you dishonour it you desecrate the whole profession.

I have learned:

- I cannot contemplate any other career that is so capable of offering such a wide range of job challenges within employment security
- Cherish all those with whom you work. They are your support and loyal colleagues in adversity. Do not isolate yourself
- Do not thoughtlessly waste your energy. There is no intrinsic merit in effort; ensure that it is profitably directed
- Be open to advances that have the potential to advance your special interest
- The practice of medicine is challenging, not placid. Episodic stresses are inevitable. Do not allow them to sour your career – they will pass
- Retain your humility. Practising medicine is a privilege.

## Conclusions

Doctor: your ultimate examiner is not the formally appointed adjudicator who approved your registration. It is the patient confronting you, searching your face for reassurance. BJHM

### KEY POINTS

- You cannot cure everyone you see – but try to give everyone the comfort of genuine concern and support.
- Your career will not remain static as you continue your education in a changing world.
- Maintaining harmonious relations with all your colleagues is a powerful antidote to stress.

* I wish that I had had access to the wisdom contained within this small book at the beginning, not the end of my career. Do not fail to read it.

Kahneman D (2011) *Thinking, slow and fast.* Farrar, Straus and Giroux, USA