be present when students are selected for medical school but only later manifested as sustained abnormalities of social behaviour – unmasked perhaps by the absence of structure in comparison with life at school or in the parental home, rather than by any direct stress of university life. It is true that prospective medical students are subjected to a variety of selection procedures but most medical schools around the world offer little in the way of screening for significant personality and behavioural problems. It is therefore possible, and indeed probable, that vocational medical courses accept young students who may not have developed sufficient personal maturity or strength to deal with the rigours of medical training. It is also true that trainee doctors may have to take on considerable responsibility at a comparatively young age and that many find this difficult.

In recent years there has been a growing emphasis on the importance of doctors having good communication skills and this is now addressed within the medical school curriculum. This is important in terms of communicating not only with patients but also with colleagues. A stressful working environment combined with a communication style that others find difficult frequently leads to problematic working relationships that contribute to impaired performance. Often the individual concerned lacks insight and while colleagues may recognise that someone is difficult to work with they may not be able to pinpoint the specific underlying problem. It is only when an adverse event occurs that everyone acknowledges that damaging interpersonal behaviours may have played a major role. However, for the sake of patient safety, such issues should not be allowed to smoulder indefinitely.

The General Medical Council's guidance *Good Medical Practice* (2001) states that 'all patients are entitled to good standards of practice and care from their doctors. Essential elements of this care are professional competence; good relationships with patients and colleagues; and observance of professional ethical obligations'. In *Good Psychiatric Practice*, the Royal College of Psychiatrists (2004) identified a number of core attributes for practitioners, including 'a critical self-awareness of emotional responses to clinical situations' and 'being aware of the power inherent in the role of doctors and its potentially destructive influence on relationships with colleagues in other disciplines, with patients and with carers, and respecting boundaries'.

It follows that, if there are serious concerns about a doctor's competence and behaviour, there need to be clear routes for assessment. Early recognition of patterns of behaviour which may indicate that a doctor is struggling in work is of paramount importance. However, a strategic approach to prevention will also be important. In a study of over 50 cases referred for poor performance, the National Clinical Assessment Authority (2004) in the UK identified wider, systems issues. These included undergraduate and postgraduate training, workload, team function and handling stress. Studies of this type are invaluable in identifying what contributes to a competent and well performing doctor being derailed from good practice and good delivery of care.

Early recognition of patterns of behaviour which may indicate that a doctor is struggling in work is of paramount importance.

References

Firth-Cozens, J. (1992) The role of early family experience in the perception of organisation stress: fusing clinical and organisation perspectives. *Journal of Occupational and Organisational Psychology*, **65**, 61–75.

Firth-Cozens, J. (1995) Sources of stress in junior doctors and general practitioners. *Yorkshire Medicine*, **7**, 10–13.

General Medical Council (2001) *Good Medical Practice*. London: GMC.

Graske, J. (2003) Improving the mental health of doctors. *BMJ*, **327**, s188.

Morgan, M., White, C., Fenwick, N., *et al* (1999) *An Evaluation of the General Medical Council's Health Procedures*. Department of Public Health Sciences, King's College, London, and Nuffield Institute for Health, University of Leeds.

National Clinical Assessment Authority (2004) *Understanding Performance Difficulties in Doctors*. London: NCAA. Available at http://www.ncaa.nhs.uk/site/media/documents/930_1.pdf. Last accessed 26 August 2005.

Paice, E. (2000) Early identification, diagnosis and response. In *Doctors and Their Health* (eds H. Ghodse, S. Mann & P. Johnson), pp. 21–29. Sutton: Reed Healthcare Limited.

Royal College of Psychiatrists (2004) *Good Psychiatric Practice*. London: Royal College of Psychiatrists.

Vaillant, G., Brighton, J. & McArthur, C. (1970) Physicians' use of mood-altering drugs: a 20-year follow-up report. *New England Journal of Medicine*, **282**, 365–370.

THEMATIC PAPERS – INTRODUCTION

Recruitment into psychiatry: a medical student perspective

David Skuse

Behavioural and Brain Sciences Unit, Institute of Child Health, London WC1 1EH, UK,
email: d.skuse@ich.ucl.ac.uk

To ensure a successful future for our profession, we have to attract young enthusiastic doctors to take up residencies in psychiatry, but there have been murmurings of disquiet in recent years that we are not being as successful as we might, or as we should. We have taken soundings for the theme of this issue: why do too many medical students not consider psychiatry as a career choice? We bring

https://doi.org/10.1192/S1749367600007438 Published online by Cambridge University Press

together perspectives from around the globe: from Israel we have a contribution from Moshe Abramowitz and Daphne Bentov-Gofrit; from Guillem Pailhez and her colleagues we learn of a comparison between Spanish and US students; and from Australia we hear from Bruce Tonge.

The contribution from Israel is full of intriguing detail, concerning as it does heterogeneous populations of medical students with different cultural attitudes to psychiatry. We learn that psychiatry is certainly an attractive option to students in their preclinical years, but the further they are in their training the less appealing the specialty appears. This may reflect the initial intellectual curiosity engendered by disorders of mind, which gradually evolves into cynicism and a belief that there is really no great potential to improve people's lives compared with many other branches of medical practice.

In the United States there seems to have been a small increase in the proportion of freshmen nominating psychiatry as a potential career within the past 5 years or so. Pailhez *et al* consider the quality of medical education and the experience of students in their clinical training to be critical factors. However, we have to make sure that the placements in which they encounter psychiatric patients are optimal, in terms of the care given, the attitudes of the staff, and the general sense that these are people who can be helped and rehabilitated. It is disturbing to discover in a survey of Spanish students that their teachers were apologetic when teaching psychiatry, and that in general the specialty had low social prestige.

Australia too suffers from low recruitment into the specialty and experiences difficulty in filling training places. Bruce Tonge also draws direct parallels with studies in the United States. Among medical students the specialty was associated with low job satisfaction and was seen as having a very weak scientific foundation – reminiscent of the finding of Pailhez *et al* that many students regard psychiatrists as non-logical thinkers.

Where do these attitudes come from? Do students enter medical school with such prejudices and, if so, how do we change their attitudes? Or is there a perception which grows during training that psychiatrists sit low in the pecking order of medical specialties in academic and therapeutic prestige? We have an enormous amount of work to do to reverse these worrying trends. Let us hope the College can offer guidance.

We learn that psychiatry is certainly an attractive option to students in their preclinical years, but the further they are in their training the less appealing the specialty appears.

The making of a psychiatrist: an Israeli perspective

Moshe Z. Abramowitz[1] and Daphne Bentov-Gofrit[2]

[1]Deputy Medical Director, Eitanim Psychiatric Hospital, Jerusalem Mental Health Center, Doar-Na Tzefon Yehuda, 90972, Israel, email: mosheabramowitz@yahoo.com; moshe.abramowitz@moh.health.gov.il

[2]Senior Psychiatrist, West Jerusalem Community Mental Health Clinic, Jerusalem Mental Health Center, Israel

When medical school educators – polished veteran doctors – review data on their students' attitudes towards residencies, they remember their own long days in the anatomy dissection room. They recall treating their first teenage patient and comforting a patient seeking solace while succumbing to a fatal illness. They think about why they made their important career choice. Thus the glory days of medical school become a defining and shaping experience for physicians, similar to boot camp for veteran paratroopers.

While cultures differ, medical education seems to differ less, as all doctors have to examine, diagnose and treat. Within this context, the popularity of specific specialties may be based on several factors with local influences. There have been efforts in recent years to quantify the attitudes of medical students using standard questionnaires (Nielsen & Eaton, 1981; Burra *et al*, 1982; Feifel *et al*, 1999). Below we describe the profile of the potential psychiatrist among Israeli medical students and compare our results with the findings of studies using similar research methods from Western countries with different traditions of psychiatry and medical education.

Is there no balm in Gilead; is there no physician there?
(Jeremiah, 8.22)

Medical education in Israel

In Israel there are four medical schools. Approximately 300 medical students are accepted a year. Medical education is heavily subsidised by the government, so the total number of medical students is regulated. Many of those who are not accepted locally choose to study abroad. Those fortunate enough to be accepted in Israel are 2–3 years older on average than their counterparts in the United States, since most men and some women at the age of 18 are drafted into military service. Upon their discharge they are eager to start their schooling and make up for time lost. They then embark on a rigorous 6-year journey of intensive studies: 3 years preclinical and the remainder rotating clerkships through medical

https://doi.org/10.1192/S1749367600007438 Published online by Cambridge University Press