The Making & Unmaking of a Doctor

Negotiating identity throughout medical training in Australia

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identity

\ ī-ˈden-tə-tē

noun

1. the distinguishing character or personality of an individual.

"I think my job gives me a sense of **identity**."

(Merriam-Webster, n.d.)

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Abstract

A recent string of suicides amongst junior doctors in Australia has once again brought both public and government attention to their mental health and wellbeing. Current research suggests that training doctors have 'significantly higher levels of distress' than doctors at later stages of their careers due in part to bullying, harassment in the workplace, and an ever-increasing workload. Yet, these young doctors are also individuals with a life outside of work and face external pressures associated with the life stage of 'emerging adulthood' (ages 18-30). Doctoring is more than a job; it is a way of life. Being a doctor becomes an individual's primary identity, and often, their only identity, which influences their ability to cope in circumstances such as negative interactions with colleagues. The one identity they have developed for themselves during their emerging adult life is targeted, and they have no alternative identities to fall back on. A significant part of the problem not yet addressed organisationally is that we have framed these issues in individual terms, such as through the promotion of self-directed learning, how individuals can prevent bullying and harassment, or even how they might develop alternate identities to build resilience to protect themselves against difficult scenarios they may face throughout their careers. This thesis outlines the trajectory of training doctors in the Australian medical education context through the exploration of the lived experiences of fifty informants. These experiences demonstrate the complexity of becoming a doctor within the Australian health care system. They highlight that a combination of educational and work-related issues as well as challenges faced in life outside of work make it difficult for junior doctors to navigate this period of their lives.

Statement of Originality

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

The ethical aspects of this research have been approved by the Macquarie University Human Research Ethics Committee (Human Sciences & Humanities)—Reference No: 5201800092.

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For Rachel

Introduction

"I think medicine can be very much a bubble," Bishan explained during our conversation. I had travelled to a small town on the outskirts of Melbourne on a beautiful day in the Australian Spring of 2017 to meet with him over coffee.[1] Bishan was in his second year out of medical school and working as a resident at the local hospital. He had a keen interest in pursuing a career in surgery, but also tried his best to keep up with some commitments and community-related activities outside of work which he felt were important for his well-being. Becoming a doctor, and in particular, a surgeon, was a way of life for Bishan. "On a good week," he said, "it's very easy to embrace [surgery as a career and lifestyle choice] because it's a very satisfying profession. I think tangibly you feel like you contribute. You see someone, you fix their problem, and send them home."

However, when work becomes difficult, Bishan told me that it can be hard to "distance himself" from the situation as he is "so invested in [surgery]." This investment is very personal as it has significant emotional consequences in addition to the resources spent as they slowly make their way through their training. Whilst most junior doctors like Bishan have invested a considerable amount of time and money in the pursuit of a career in medicine, the most substantial result is to their own identity. These doctors first and foremost describe themselves as doctors. Doctoring is not just what they do for a living; it is, in fact, who they are. The passion for their vocation that comes with the embodiment of doctoring makes Bishan and his peers excellent clinicians. It drives them to be the best doctors they can be which, in turn, benefits both the individual patients who they treat and the broader health care system. Yet, when an individual has one sole identity—in this case, being a doctor—they cannot fall back on alternate identities when faced

[1] To differentiate between my own interview data and citations from other published research, I utilise double quotation marks for quotes from informants and inverted commas for direct quotations from literature throughout this thesis.

with a difficult or distressing situation either at work or in life outside of work. Bishan suggested that this identity trait was particular to doctors. “All my friends that are engineers and lawyers and dentists, [they] don't seem to [link] so closely, like, their identity with their work,” he explained. Doctors work hard, and this inevitably impacts on their individual well-being; but in fact, identifying so strongly with their role within the medical field takes doctoring well beyond merely a “lifestyle”. When one’s identity is so intrinsically linked to and dependant on being a doctor, the risk for personal and psychological ruin is much higher.

Aim

This thesis outlines the trajectory of training doctors in the Australian medical education context through the exploration of the lived experiences of fifty informants. These experiences demonstrate the complexity of becoming a doctor. They highlight that a combination of work-related issues and challenges faced in life outside of work make it difficult for junior doctors to navigate this period of their lives. These narratives concur with results of the 2013 Beyond Blue National Mental Health Survey of Doctors and Medical Students, which was updated and re-released in 2019, that suggests that the most common source of stress reported by junior doctors relates to ‘the need to balance work and personal responsibilities’ (p. 4). Doctors pursue medicine, not just as their profession, but also as, in many cases, their sole identity. The medical identity is so prominent that alternate identities are not developed enough, if at all, to provide an appropriate degree of resilience to support an individual following such a demanding career path.

Following a string of suicides amongst young doctors in New South Wales, *The Daily Telegraph* published an article in April 2017 headlined, “Junior doctors being driven to suicide by a grinding workload”. The article claimed that fear of accessing existing support networks prevented young doctors from seeking help for mental health issues. Published merely months

later, Paul Hayes wrote a piece entitled, 'Workplace Scars', in the August 2017 issue of *Good Practice* magazine about the mental health issues concerning doctors. 'An alarming rash of suicides within the [medical] profession in recent months,' Hayes wrote, 'has highlighted the fact that many doctors are not only struggling to cope with the burdens of their vocation, but also with how they can even acknowledge the issue and ask for help' (2017, para. 4).

Doctors, in general, have higher rates of psychological distress and attempted suicide compared to the general population and those in other professional fields (Grassi & Magnani, 2000; Wall et al., 1997). Beyond Blue is an Australian organisation which works to 'raise awareness of depression, anxiety and suicide prevention' and provides services to support individuals seeking help with mental health (Beyond Blue, 2020). A 2013 report based on the findings of research conducted by Beyond Blue found that 2% of doctors surveyed had attempted suicide and that suicide ideation was higher amongst doctors than in the general Australian population. These findings resulted in an increased focus by employers and medical colleges on the mental health and wellbeing of doctors broadly, and junior doctors more specifically (NSW Health, 2017).

Young doctor suicides are not a recent phenomenon, despite global media outlets increasingly reporting these cases. In 2015, the Australian Broadcasting Corporation's *Four Corners* featured an investigation, entitled 'At Their Mercy', into the suicides of four junior doctors and attributed these deaths to severe bullying and harassment in the medical profession as well as unsuitable working conditions and burnout. In 2002, Tyssen and Vaglum reviewed the previous 20 years of literature on mental health concerns amongst young doctors and reported that a significant number of studies found that the highest rates of mental health problems existed amongst doctors in their first postgraduate year. The doctors who faced mental health issues, particularly depression, were more likely to abuse drugs or suicide. Distress could also lead to broken relationships (Colford, 1989) and a decline in both physical and mental health due in part to poor self-care with a lack of exercise and a poor diet (Ball & Bax, 2002; Gutgesell et al., 1999).

NSW Health is the administrative body that comprises the public health services for the Australian state of New South Wales. In their *JMO [Junior Medical Officer] Wellbeing and Support Plan*, published in November 2017, NSW Health state that 'calls for wide-scale system and cultural change were amplified after a number of junior doctors took their own lives in NSW' (NSW Health 2017, p. 9). They note that this push for change occurred 'not only at the State level', but also across Australia (2017, p. 9). NSW Health recognise that, whilst discussion around mental health is becoming more common in all areas of society, junior doctors face 'specific pressures related to their professional stage and development' that place them at higher risk of suffering from mental health and wellbeing issues than the average doctor (Australian Medical Association, 2011) and than the average Australian who is not in the medical profession. The 2013 Beyond Blue report concluded that 'trainee doctors (pre-vocational and vocational) had significantly higher levels of distress compared to doctors in later stages of their careers' (2013, p. 23).

Junior doctors face significant challenges relating to their mental health, the causes of which are numerous. Burnout, stressful working conditions, and bullying and harassment are contributing factors to the mental health issues of young doctors. Likewise, Rich and colleagues (2016) argue that when training doctors move workplaces, and often cities, regularly (a requirement of training in Australia and the UK), the disruption to their personal lives can make it difficult to cope with both work-related and personal pressures. They may lack the social support they would have if at home, and this geographic isolation can significantly affect morale and well-being. Research conducted by NSW Health (2017, p. 12) also suggests that 'exposure to trauma', 'personality factors such as a high level of perfectionism', 'a reluctance to seek help due to the strong social stigma attached to mental health issues in the medical profession', and the knowledge of how to kill oneself with easy access to the prescription medication are additional contributing factors to poor wellbeing, mental health issues, and ultimately elevated suicide rates amongst junior doctors.

Doctoring is more than a job; it is a way of life. Being a doctor becomes an individual's primary identity, and in many cases, their only identity, which influences an individual's ability to cope in circumstances such as negative interactions with colleagues. That is, the one identity that they have developed for themselves over the course of their emerging adult life is targeted, and they have no alternative identities to fall back on. These young clinicians do not just call themselves doctors. They embody the act of doctoring so much so that they often struggle to separate their professional self from the person they are outside of work.

Methodology

The research for this project was conducted predominantly in Sydney, Australia, between April and December 2018. I also undertook participant observation and interviews in Melbourne, Victoria, and in parts of regional New South Wales including Wagga Wagga, a city in the Riverina region, Wollongong, on the south coast, and Gosford and Newcastle on the central coast. Several training doctors elected to participate in an interview over the phone or on Skype due to either work placing restraints on their availability or because they resided in a location to which I could not easily travel throughout the fieldwork period. These interviewees lived in the centre of the Australian outback, in tropical east Queensland, in-land New South Wales, Tasmania—an island off the south eastern coast of Australia--, and in a small town on the outskirts of Melbourne, Victoria.

The fieldwork involved one-on-one interviews and participant observation. Interviews were conducted with individuals who expressed interest as a result of the recruitment notice approved by the Macquarie University Human Research Ethics Committee (see Appendix 3). In order to recruit individuals, I wrote to the Health Education and Training Institute in NSW in the early phases of the project to request their assistance in disseminating the project's recruitment notice to which they agreed. I also distributed the notice amongst my

own personal networks. From these campaigns, I received an overwhelming response of more than 90 training doctors and consultants or administrative/pastoral care staff who wanted to be involved in some way in the project. These led me to conduct a total of 55 interviews. 50 of these interviews were transcribed and have been used in analysis for this thesis. Unfortunately, five of the original interviews either did not properly or clearly record, or participants did not sufficiently fill out the Participant Information and Consent Form (see Appendix 4). To protect the identity of my informants, I use pseudonyms throughout the thesis when referring to these individuals and their experiences. Some informants also requested during their interview that I do not include detailed information regarding their workplace in this thesis to further safeguard them.

I initially set out to interview training doctors between the ages of 18 and 30 years. I did this in order to consider the influence of this life phase, namely 'emerging adulthood', on their wellbeing (Arnett, 2000). However, throughout the course of the fieldwork, I realised that, in fact, training doctors do not reach the end of emerging adulthood until well into their thirties. That is, these doctors are not 'adults' by the Western social definition (which usually includes marriage and children, when people do have them) until they are nearing the end of their training around age 35. In the current study, some doctors delayed their 'adult' milestones, prioritising the completion of their training program first, while others combined such milestones, such as getting married and having children over the period they were junior doctors. As I will discuss later on, those who did marry and have children often found that they needed to reduce their workload to part time for some or all of the remainder of their training. The time it took for these people to complete their training, and so become fully qualified consultants, was therefore extended significantly, which has its own set of consequences for their mental health and wellbeing.

I thus decided, relatively early in the fieldwork, that age would not be an excluding factor when recruiting participants. Including training doctors of all ages, I believed, would help me to better understand how the training pathway plays out now that medical training continues on for so many years post university. Having said this, all interviewees were required to be at least 18 years old and were asked to give informed consent prior to the interview taking place (see Participant Information and Consent Form in Appendix 4).

My participants included interns, residents, senior resident medical officers (SRMOs), registrars (both provisional and advanced trainees), and consultants (see the Map of the Australian Medical Training Pathway in Chapter 1 for further information and definitions of these training levels). I also interviewed a senior midwife who has worked with training doctors throughout her career and several individuals involved in the pastoral care and administrative sides of medical education and training. I excluded several groups in particular from this project in order to outline the scope definitively. These included medical students, training doctors who are not working within the Australian public health system, and retired physicians.

Participant observation involved attending wellbeing days held for training doctors and volunteering at teaching days for JMOs after which I often had the opportunity to socialise with these doctors. I also conducted 'in-action' research in the form of delivering several workshops on balance and mindfulness in medicine at clinical teaching conferences for doctors training to be emergency medicine physicians. This additional interaction gave me some greater insight in a group context as to how these individuals implement strategies to deal with burnout, stress, and anxiety in the workplace. Finally, I have worked in a support role for the delivery of educational events for emergency medicine trainees since 2014, a role which, despite preceding this research project, has undoubtably given me an insider's

view of how education and training are delivered in a more formal capacity in New South Wales. I draw upon all of these experiences to inform the analysis of my interview data.

Both my interviews of training doctors and participant observation in a range of different environments gave me an otherwise unattainable exposure to what it is and what it takes to become a doctor for someone who does not actually get trained. I neither entered medical school and became a doctor myself, nor did I follow doctors around on shift (although I considered these research methods at times throughout the course of the project). However, these methods would have not given me the understanding that I instead gained through the techniques I used. I befriended and developed excellent rapport with over 50 young doctors across many different specialties. That is, over 50 diverse, first-hand experiences of the Australian health care system—their unique accounts of what is involved in becoming a doctor. These doctors experienced training in countless hospitals across the country, a feat I could have never achieved by myself. My approach favoured broader information gathering over focused attention to a smaller set of cases.

This research highlighted the individual's lived experience by taking a phenomenological approach. In order to best understand the mental health issues facing junior doctors and how emerging adulthood has impacted upon these, we should respect that the reality of these young people, and anyone for that matter, is constructed through individual experiences and 'we must, therefore, pay careful attention to an individual's account of their reality to begin to understand it' (Reeves, 2013, p. 68). Much of the current literature relating to the workplace experience of junior doctors and trainees takes a quantitative approach, focusing predominantly on surveys to collect statistical data. These data play a very important role in understanding the issues faced by these individuals; however, a quantitative approach does not collective individual narratives which might provide an understanding of the lived experience of being a training doctor. Caroline Elton's 2018

publication, *Also Human*, which considers the histories of training doctors in the United Kingdom, provides an example of the profound value brought by a qualitative analysis of this group of subjects. Thus, this project aims to provide a more in-depth appreciation of the lived experiences of the individuals who sit in the roles of 'junior doctor' and 'trainee' in Australian hospitals.

I also note that my research, in part, falls into both the *cultural interpretive model* of medical anthropology as well as within *critical medical anthropology*. According to Baer, Singer and Susser (2013), in the cultural interpretive approach, disease is understood only through the 'interaction of biology, social practices, and culturally constituted frames of meaning' (p. 25). In the same vein, following from the cultural interpretive model, the meaning of doctoring and of becoming a doctor is understood largely within the culturally established setting. In contrast, *critical medical anthropology* emphasises that 'the dominant ideological and social patterns in medical care are intimately related to hegemonic ideologies and patterns outside of biomedicine' (Baer et al., 2013, p. 26). This framework critically highlights the institutional, economic, and power-related implications implicit in medical interaction. The focus in this thesis on the way that patterns of neo-liberalism have influenced medical education clearly borrow from critical approaches to medical education. However, this thesis presents an ethnography of becoming a doctor and of the Australian health care system more broadly, and so my work sits between the fields of medical anthropology and the anthropology of 'medicine'. I study the way those within the system are organised, how they organise themselves, and how individuals practice medicine rather than considering cultural perspectives of disease, for example.

A significant portion of the literature to which I refer throughout the course of this thesis regarding the experience of junior doctors and trainees derives from the industrialised West. More specifically, based on the significance of sociocultural influences on an individual's

experience of emerging adulthood, this project also reflects on research conducted in other Western countries, including the United States, United Kingdom, and some parts of Europe, where some aspects of medical education are similar to the training programs in Australia. Countries outside the industrialised West may well be facing similar issues; however, these were excluded from the study to appropriately limit its scope.

The Ethnography of Becoming a Doctor

Ethnography is a method of social research common in the discipline of anthropology in which the researcher experiences the culture and way of life of the research participants before any explanations are derived about their practices (Leung, 2002). Rena Lederman (2006, p. 485) defines ethnographic research as the 'systematic openness to contingency.' That is, whilst ethnographic researchers may enter the field with a plan or research methodology, they cannot predict with any certainty how the set of circumstances may play out. Lederman suggests that 'the specific complementary value of participant observation in relation to other research practices… is its interest in exploring unexpected entailments of informant-generated constraints' (p. 485). Ethnography usually comes about through long-term fieldwork in a single setting and is characterised predominantly by participant observation and interviews (Goodson & Vassar, 2011). Ethnography does not constitute a 'single strategy of data collection, nor a strategy of data analysis' (Atkinson & Pugsley, 2005, p. 228); instead, it involves a more general approach to better understand and explore social processes.

Rice and Ezzy (1999) argue that ethnography is beneficial in that it helps us to better understand diverse groups and why they behave as they do. Or rather, ethnography helps us to place ourselves into another's shoes and learn of his or her experience or view of the world. Ethnography has the potential to be particularly useful in the field of medicine where

quantitative approaches are more common (Wade et al., 1997; Murray et al., 1998). The clinical setting 'lends [itself] well to be analysed in a more open-ended approach' (Goodson & Vassar, 2011, p. 3) demonstrated by the works of influential medical anthropologist, Byron J. Good (1993), and prominent American surgeon and author, Atul Gawande (2002, 2014). Ethnography can improve our understanding of the dynamics of interpersonal relationships inherent in the clinical setting—aspects largely missing from surveys or archival sources. In the case of this project, ethnography can provide us with a more complete account of how training doctors experience their day-to-day life in a way that statistics or Key Performance Indicators cannot.

Ethnography is traditionally conducted by researchers who go to a specific location (a city, town, or community group, for example) and live with the people, observing, participating, and immersing themselves in their culture. George W. Stocking Jr. (1992) provides an in-depth analysis of how this 'tradition' within the discipline of anthropology was constituted in particular colonial moments. Bronislaw Malinowski, for example, like many other European and American anthropologists, focused his ethnographic fieldwork on 'exotic non-Western societies' (Lassiter, 2014, p. 73) and suggested that the aim of ethnography is 'to grasp the native's point of view, his relation to life, to realize *his* vision of *his* world' (Malinowski, 1922, p. 25). In order to do this, the anthropologist might adopt the language and become involved in important social rituals, and through this familiarity, she develops a deep understanding of the experiences of those individuals.

Anthropology, and as such, ethnography, however, now focuses on both Western and non-Western culture. My research did not involve entering medical school and progressing through the ranks in a hospital as a fellow doctor. Although I pondered how *not* doing this might impede my results, I strongly believe that, despite not undergoing the same training, I found an alternative way of immersing myself in the lives of these doctors. For a start, I am the daughter of two doctors working in regional New South Wales—an orthopaedic surgeon and an

emergency physician. I spent my childhood in surgeries and hospitals, drawing pictures at the nurses' station whilst my father saw to patients he had been called in to examine, following my mother on her weekend ward rounds, and filing patient notes in her practice during my school holidays. I volunteered as a patient actor at trauma teaching days, and I spent weekend evenings celebrating with my parents and their students when they finished a term or rotation. I went on to work with emergency training doctors, with whom I continue to work today, running teaching programs and training days.

I have interacted with these doctors in an immersive sense since before I can remember. My analysis of the lived experiences of training doctors comes from the perspective of someone who has lived with and amongst training doctors both before and throughout the course of this research. My close friends are training doctors. My colleagues are training doctors. Short of becoming a doctor myself, I have developed a deep understanding of what it is to be a junior doctor or trainee in Australia. However, the fact that I am *not* a doctor myself makes me an outsider. That is, although I am a trusted confidante to these training doctors, I bring a third-party perspective which allows me to analyse what might otherwise be largely accepted ideas and philosophies within the training doctor cohort. Training doctors must adopt community understandings in order to get through their arduous education; I am at liberty to observe, consult, and criticise the practices they must endure and accept.

This project takes an ethnographic approach in its methodology to consider the lived experience of training doctors. I define training doctors in this context as those who have finished medical school and thus are working within Australian hospitals but who have not yet completed their specialty training (or general practice training for those who chose that path). I reflect upon existing ethnographies which describe one's journey to becoming a doctor. Byron Good and Mary-Jo Del Vecchio Good (1989) wrote of the experience of first- and second-year medical students at Harvard Medical School. They collected narratives and stories of what is involved in

medical training and found that medical students struggled to balance the notion of 'competence' with that of 'caring'. That is, the trainees knew they had to possess enough clinical, scientific knowledge, but were concerned that increasing their clinical expertise would reduce their ability to show compassion to their patients. Despite being almost 30 years old, the results of this study are arguably still just as relevant, particularly when considering the role ethnography plays in the medical education space. This ethnography provides insight into the ways that these students change throughout their training—an understanding that we may not otherwise have. Ethnography can be used to demonstrate how a young, idealistic medical student can, over time, become cynical, overworked, and less concerned for his or her patients and more focused on the biology of the injury or illness at hand.

Rachel Clarke, in her 2017 book entitled, *Your Life in my Hands: A Junior Doctor's Story*, describes significant issues like understaffing (a major feature of both the UK's National Health Service [NHS] and the Australian health care system) as 'at best exhausting, [and] at worst soul-destroying' (2017, p. xxi). Clarke wrote about being left to do the job of two doctors, which is arguably dangerous for both doctor and patient. She also argues that 'a further casualty of doctor overstretch' is kindness. Kindness, or a sense of caring for one's patients, is central to many individuals' motivation to pursue a career in medicine in the first place. Without it, can a young doctor, or any doctor for that matter, really be expected to find satisfaction in the daily (and nightly) grind of hospital medicine? My participants overwhelmingly felt that they have become more cynical, less tolerant, and less caring over time. This growing callousness impacts the wellbeing of training doctors significantly. But perhaps even more so, it effects the quality of care that patients receive.

In the medical setting, in particular, ethnography can uncover what has been described as the 'hidden' curriculum (Becker et al., 1961). That is, ethnography can provide access to the skills that doctors require to help themselves get through their training relatively unscathed. In the

same sense, ethnography can unearth the issues—relating to emotional health, for example—faced by training doctors that cannot be properly explored by quantitative research methods. Few accounts of the experience of a junior doctor in Australia exist. Mohamed Khadra (2009), in his book *Making the Cut*, chronicles his experience as an intern in the Australian medical system. Khadra, however, trained in the 1980s, so his experience may differ significantly from that of doctors training today.

My research is very different from ethnography in the traditional sense. I did not become a medical doctor myself in order to immerse myself in the experience of medical training nor did I spend a year living in a community of doctors or shadowing them in a hospital environment. These strategies would have been impractical given both the timeframe of the project and issues relating to bureaucracy in the health system. For example, on a fieldwork trip to Melbourne in 2018, I requested to spend a day with one of my informants at work. The hospital required me to gain approval from several individuals and to then complete a host of paperwork in order to gain access for the day. This process was reasonable given that I had no affiliation with the organisation. However, by the time the approval came through and the documentation was accepted, my trip to Melbourne had passed by several weeks. Perhaps I should have better anticipated how long this process would take; but the outcome demonstrates how unfeasible it would have been to pursue this type of research for this specific project. This example also shows how bureaucracy acts as a way of disguising power within routine, and the role it plays in the relationship between the researcher and the researched.

In addition, a more traditional anthropological approach would not have brought forth the most valuable results for this project. The narratives and experiences I have heard through the course of this research are those of the individuals that have experienced them, and theirs alone. I have come to hear these stories only through their re-telling in a generous and open manner. In addition, my participant observation has allowed me to develop a greater understanding of how

the health system functions and what it is doing as an institution or government structure, and in many situations, as individual departments or communities, to address the issues that junior doctors currently face. I have, therefore, undertaken a phenomenological approach to ethnography. After all, the ethnographic method allows the 'pawns' of larger structural forces to emerge as real human beings who shape their own futures (Bourgois, 2002, p. 17).

Outline

This thesis explores the themes that interviews with informants uncovered. Part One comprises two chapters. The first describes the structure of the Australian health care system and outlines how an individual becomes a doctor in Australia. Chapter Two looks at the neoliberalisation of medicine and medical education, and the implications of College de-accreditation and challenges faced by those within the system who want to make change. It considers the use of 'mindfulness' programs and the 'debrief' as strategies for personal management and discusses the role of collective movement.

Emerging adulthood, the time between adolescence and full-blown adulthood, has an impact on the wellbeing of individuals and so Chapter Three, the first of two chapters that make up Part Two, investigates the lived experience of this developmental stage. I present three outlying cases which illustrate the importance of alternate identities in navigating a sustainable medical career. The fourth chapter draws on informants' concerns around uncertainty, a concept that I unpack to consider how expectations of medicine and individual motivation play into a delay in emerging adulthood, or a shift in the ultimate markers of adulthood.

Part Three includes the final two chapters of the thesis. The first, Chapter Five, explores social and expertise hierarchy within medicine, which I propose persists because those who struggle with the hierarchy when they are at the bottom end up becoming beneficiaries of hierarchical

progression later on. I then discuss bullying and harassment, which has a traditional standing in the medical industry. This section touches on issues in surgery around what my informants, and others, describe as the "boys' club", as well as workplace bullying, the notion of 'teaching by humiliation,' and how the current structure of medical education, at least in the earlier years, tends not to encourage an investment in the individual trainee by those who supervise him or her. Finally, Chapter Six delves into the problem of "burnout". Junior doctors use metaphor to express their lived experience of burnout, a concept which has held several different culturally influenced meanings over time. "Burnout" is neither a clinically recognised condition, nor a mental health diagnosis and thus it is useful for talking about conditions that the junior doctors are reluctant to consider either. Here, I also consider how the burnout experience for women has additional characteristics to the broader experience.

Part One

Chapter 1: "It feels like you're being churned through a machine..."

Bree was a young doctor working in a remote Australian hospital. She was in her fifth year out of medical school when I interviewed her over the phone in the winter of 2018 and had just started her general practice training as a junior registrar. Bree explained to me that she had gone to university as a rural bonded medical student, which meant that in exchange for enrolment in the degree, on graduating, she was required to work a number of years in a rural hospital or general practice. The bonded position's requirements suited her, she explained. "A really big driver for me was the aim to commit to somewhere for a long period of time, in an effort to have that continuity [for the patients] and make sure I was feeding back into one community in one place in an area of workforce need." Not long after starting her internship in the remote hospital in which she still worked, Bree bought a house with the intention of undertaking "a good ten-year stint" in that particular area during her training.

After completing her first and second years of general practice training rurally, Bree moved back to her hometown on the outskirts of Sydney for various family-related reasons. She had hoped she could fulfil some of her training requirements for general practice during this time, but after receiving mixed advice from the College, she decided to take a year out of training and reapply the following year. Issues continued to arise over time relating to getting a supervisor at the rural hospital at which she was based and being given a job that would comply with the obligations of her bonded scholarship and training program. These issues resulted in a two-year delay in starting her general practice training, which Bree found extremely disheartening and frustrating. The confusing information that she had received, combined with moving and trying to accommodate her family's needs, left Bree with few job options. Bree explained that she had "spent two months thinking [she] wouldn't be able to get a job anywhere in Australia", which seemed nonsensical "as an Australian citizen who had trained in medicine and was under the Medical Rural Bonded Scholarship", which meant that she was required by contract to work

within Australia. Bree eventually took a resident position in a regional Intensive Care Unit (ICU) in New South Wales—primarily, so she was not left unemployed. The panel assured her at the interview that she would be well-supervised by a consultant. Bree arrived for her first shift and was met with a surprise. "So, I got there, and it was chaotic," she said, "which is not a good way to describe an ICU." Adequate supervision and staffing levels were just two of the major problems that this particular department faced, placing Bree in a confronting and difficult situation.

Bree's experience of the Australian medical system as a doctor is not unusual and demonstrates its precarity. She described going unpaid for the overtime she had worked, being unsupported due to staffing shortages, and working shifts of up to 23 hours, which is not permitted under current industrial agreements because of concerns about patients and doctors' safety. Bree explained that in many situations throughout her career to date, she has felt taken advantage of by her colleagues and the organisations to which they report. This particular situation did not come about as a result of any one individual's mistreatment of Bree but as the consequence of a system that has not responded to the ever-increasing burden it faces. "It feels like you're being churned through a machine," Bree told me, "where they hack and chew you up and spit you out. If you don't survive it, it doesn't matter. As a junior, in the current way of running hospitals, it feels like you're just a cog in the whole thing. Quite dispensable."

To better understand Bree's experience of becoming a doctor in Australia, and those of my other informants, this chapter outlines the structure of the Australian health care system and the steps that a person would take on graduating medical school to become a fully qualified consultant in their medical specialty of choice. The chapter explains the difference between pursuing a medical degree at a graduate level as opposed to as an undergraduate student, aspects of the internship and residency years, how these opportunities are allocated, and the role of an

unaccredited trainee. Finally, the chapter reflects on my informants' experiences of being accepted into their preferred training programs at their respective medical College.

The Australian Health Care System

In the most basic sense, the Australian health care system comprises private and public services. The public Medicare system, the Whitlam government's equivalent to Britain's National Health Service (NHS), started as *Medibank* in 1975 and changed to its current structure under the Hawke government in 1984 (Duckett & Willcox, 2015). Medicare is a universal health care system that gives all Australians access to high quality medical and allied health services (Willis et al., 2016). Service is made available through a series of Commonwealth government payments to public hospitals (through the state governments) and private medical and healthcare providers. Patients may be required to contribute co-payments for treatment. In addition, the Commonwealth government subsidises private health insurance. The private system is available to those with private health insurance or those willing to pay directly. The health insurance market in Australia is 'highly regulated and highly subsidised', according to Duckett and Willcox (2015, p. 51), despite only counting for 8% of the almost $150 billion government spending on health services.

Junior doctors generally undertake their training in the public hospital system, although this does not apply to general practice training, which takes place within general practice clinics themselves. Upon completing their training program, they can then choose to work in the private, the public, or both systems. Depending on their specialty, many consultants will go into private practice and see or operate on patients in public hospitals either regularly or on occasion. General practitioners differ in that, whilst they work in private practice, they will usually bulk bill some, if not all, their patients. This decision is entirely up to the doctors themselves. Some practices place patients into categories to more clearly define those who will

pay privately (a portion of which they receive back through reimbursement through Medicare) and those who are entitled to bulk billing.[2]

All the doctors I spoke to during my fieldwork worked in Australian public hospitals or were undertaking training in Australian general practices. Some senior doctors had their own private practices and undertook work in private hospitals. Still, as the project considers their work with training doctors, my discussions with these consultants focussed primarily on their work in the public system.[3]

Both the Australian health care system's public and private sectors pride themselves on providing high-quality patient care. Duckett and Willcox (2015) argue that hospitals' internal processes have been structured to benefit those who work within them rather than the patients themselves. Health services such as NSW Health pride themselves on focussing on good quality patient care as one of their core values as an organisation. At the same time, it makes sense that employees are a prime focus of the system's structure, as they are primary stakeholders who have arguably the most significant influence over how hospitals are run in day-to-day terms. A best-case scenario would mean employees have the most time and energy available to shape the institution in which they work to ensure output is productive and of high quality. And yet, staff who work for these institutions, particularly doctors in training, suffer from very high levels of stress, outlined by Beyond Blue in their 2013 *National Mental Health Survey of Doctors*. The

[2] 'Bulk billing' refers to a payment option covered by Medicare at the discretion of the health service provider. It means that the patient pays nothing out-of-pocket for the health service they have received, and instead, the service is paid for by the government. The service provider receives a fixed amount, and under the bulk billing scheme, a co-payment is not permitted.

[3] Some of these consultants also held positions outside the scope of their clinical work, such as teaching positions with hospitals or universities, pastoral care-type positions, and administrative roles that included roster writing.

2013 report compared earlier statistics from the 2007 National Survey of Mental Health and Wellbeing (Australian Bureau of Statistics, 2008):

> the level of very high psychological distress was significantly greater in doctors in comparison to the general population and other professionals (3.4% vs. 2.6% vs. 0.7%). In particular, the high psychological distress levels in doctors aged 30 years and below is significantly higher than individuals aged 30 years and under in the Australian population and other professionals (5.9% vs. 2.5% vs. 0.5%). (Beyond Blue, 2013, p. 2)

Even if hospital structures are intended to support those who work within them, trainees are stressed, which is not ideal in a role that is meant to provide care to other people.

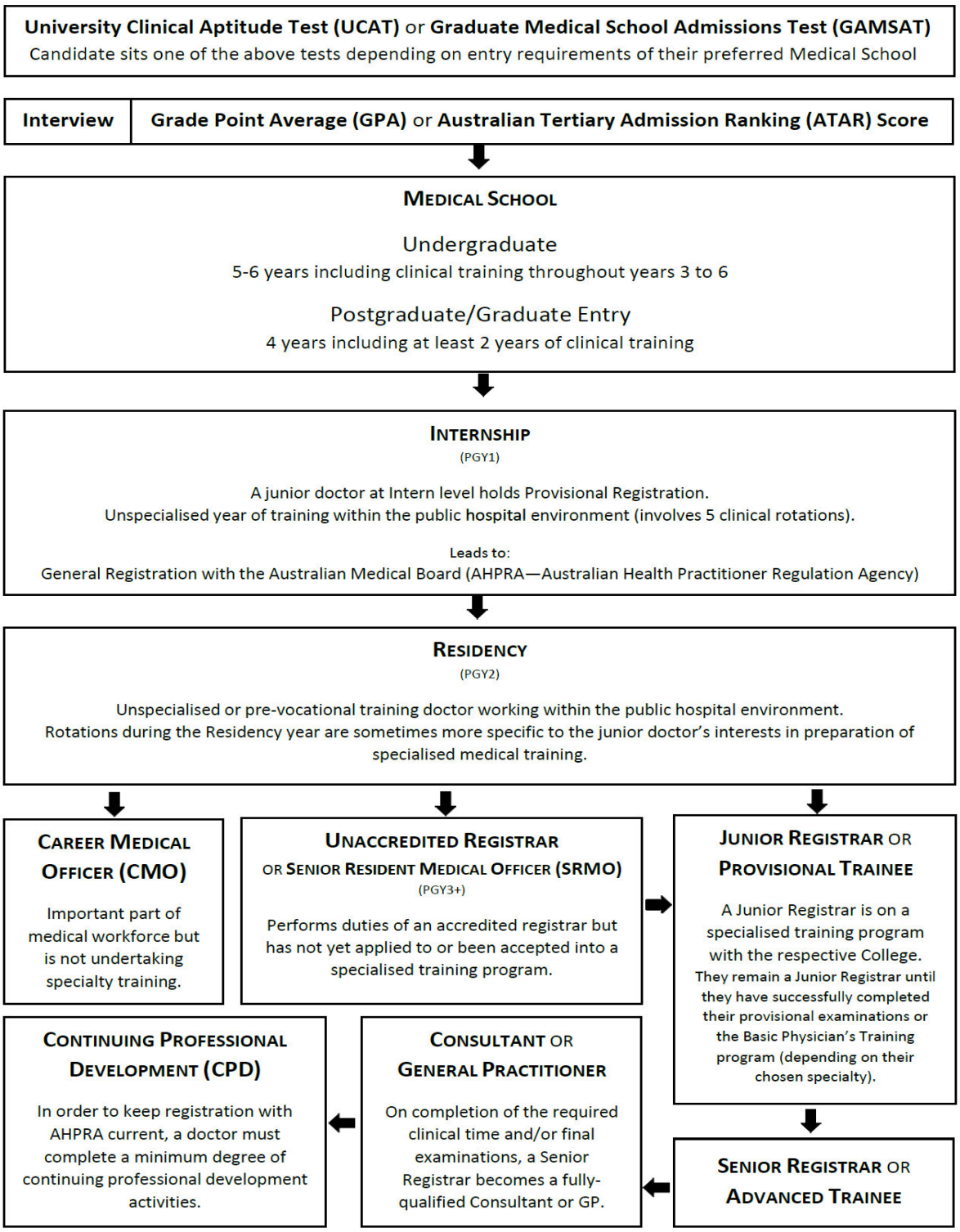
Many of the issues that junior doctors and trainees face result from an increasingly neoliberal medical education system. As was the case in Bree's experience, a lack of funding, an inability to recruit to certain positions, and the many layers of bureaucracy are just some of the immediate driving factors that lead to junior doctors being overworked, underpaid, and not adequately cared for in a system which fails, perhaps inadvertently, to support its workforce. Whilst the system has tried to implement support, the strategies that have been put in place to date are either wrongly directed or insufficient. To better understand the complexity of these issues, this section provides an overview of the medical education trajectory for a training doctor within the Australian context. This background will lay the foundations for the second chapter of this thesis, which considers the implicit role of neoliberal management and economic trends both within the Australian health care system and on individual subjects themselves.

The Path to Consultant: how does one become a doctor in Australia?

This section outlines the steps that a candidate takes to become a fully qualified doctor in the Australian healthcare system. It first considers the different paths through medical school,

followed by a look at the junior doctor's first experience working in the hospital system as an intern and resident. The section then examines the position of the unaccredited registrar and the process of being accepted into a training program.

Map of the Australian Medical Training Pathway[4]



[4] Based on Caroline Elton's TRAINING CHART: Simplified Map of Medical Training in the UK from *Also Human* (Elton, 2018, p. 361).

Postgrad*uate* vs. Undergrad*uate* Medicine

Those interested in becoming medical doctors in Australia can choose one of two paths. Undergraduate medicine allows secondary school graduates (amongst others) to go directly into medical school on finishing year twelve. A degree beyond secondary school is not required. Undergraduate medicine usually takes a minimum of five years to complete, after which time graduates can work as interns in the public hospital system.[5]

Graduate-level or postgraduate entry into medicine has become increasingly common in Australia, with a slim majority (ten of nineteen) of Australian medical schools offering this instead of undergraduate medicine (Graduate Entry Medical School Admissions System, 2019). Graduate-level medicine takes approximately four years of full-time study to complete, including two years of clinical training. A previous undergraduate degree is required to enter into these programs with a minimum Grade Point Average (GPA) requirement and a minimum score on the Graduate Australian Medical School Admissions Test (GAMSAT). Some programs may also require an interview or portfolio, or both. This pathway is said to have benefits over entry to undergraduate medicine directly from secondary school. My participants believed that admission to postgraduate medicine was based more heavily on the interview aspect of the selection process, where this was required, and so candidates can be chosen for their suitability for a career in medicine. Informants also believed that postgraduate entrants came into the medical course with a greater maturity level as they tended to be older, having completed another degree. Both entry pathways were represented amongst my informants, and many of those who completed undergraduate training mused about how their experience may have

[5] Unlike in the United States, where medical school graduates are awarded an MD or Doctor of Medicine, until recently in Australia, all medical graduates were awarded an MBBS or Bachelor of Medicine/Bachelor of Surgery. A change is occurring, however, with some universities now awarding an MD to their graduates, particularly when the degree is entered at graduate-level, which may be in part to attract students to the course.

differed if they had done postgraduate medicine. Medical training, however, will inevitably lengthen as the trend toward the graduate school model continues.

Internship

The step following medical school is the internship year, or Postgraduate Year 1 (PGY1)—the first year during which a junior doctor will be paid to work in an Australian hospital. The internship is a year of provisional registration in which practice is limited. The Medical Board of Australia (2020) outlines that interns 'are not permitted to carry out any clinical work outside of their allocated intern position.' In 2016, over 3300 medical school graduates were recruited into intern positions across Australia (AMSA, 2016). Each Australian state has slightly different procedures and systems for the internship and residency years, or rather, for the transition from medical school to the workforce. The majority of my research was undertaken in New South Wales and Victoria, so this thesis focuses primarily on these regions. However, the internship year is the means of gaining full registration with the Medical Board of Australia (MBA) and the Australian Health Practitioner Regulation Agency (AHPRA) regardless of where in Australia one undertakes his or her junior doctor years.[6]

The Australian Medical Council (AMC) allows graduates to work only in accredited intern positions during the twelve months following medical school (Health Education & Training Institute, 2018). This period of approved supervised practice comes under the MBA or AHPRA's provisional registration. Junior doctors are then eligible to apply for general registration, which must be renewed annually. In New South Wales, medical school graduates are given a two-year contract which takes them through both internship and a subsequent year of hospital work referred to as a residency in the same network of hospitals. In contrast, Victorian Junior Medical Officers (JMOs) are given a one-year contract and are then required to apply for residency in

[6] The MBA and AHPRA are organisations which work together to regulate medical doctors in Australia.

their preferred field. So, if a JMO in Victoria wishes to pursue a career in surgery, he or she would apply for a surgical residency year following internship. NSW JMOs have some input into their rotations during residency, but less than those in Victoria, who can choose to complete a more specialised residency year.

The Postgraduate Medical Council of Victoria (PMCV) explains that the skills learned during internship should contribute to acquiring the 'core competencies and capabilities' outlined in the Australian Curriculum Framework for Junior Doctors (2018, p. 2). These core competencies do not differ from state to state. For example, a doctor in NSW must have the same capabilities to be granted registration as a doctor in Victoria. In order to be granted medical registration, a junior doctor must complete at least a term each of emergency medical care, medicine, and surgery, as well as a range of other approved terms to make up twelve months (or at least 47 weeks) (Postgraduate Medical Council of Victoria Inc., 2018). The internship year can be undertaken part-time but must be completed within three years. The overwhelming majority of my participants were completing their training full time, with breaks or periods of part-time work primarily for parental leave and, in some cases, 'burnout.'

Internship Allocation

The Health Education and Training Institute (HETI 2018), the education-specific organisation within NSW Health, has priority levels for applicants to internships (also known as Post Graduate Year 1 [PGY1]). Medical graduates of NSW universities who are Australian or New Zealand citizens or permanent residents are given priority and placed in a 'guaranteed' category; that is, they are guaranteed a PGY1 position in an NSW hospital. A similar system exists in Victoria, preferencing Victorian graduates, and indeed in each state across Australia. HETI states that if 'the number of positions for NSW is less than the number of applicants entitled to a guaranteed offer, [Local Health Districts] will be requested to increase their number of training positions' (2018, p. 5). An audit, entitled the *National Medical Intern Audit*, is also undertaken

'to ensure that all applicants have an equitable and timely opportunity to obtain a PGY1 position in Australia' (2018, p. 6). The government body in each state responsible for allocating internship and residency positions has several strategies in place to ensure that those who train in their state can complete their internship there.

The Australian Medical Students' Association (2016), which advocates on behalf of medical students across the country, highlighted some issues surrounding internship positions for international students who graduated from Australian medical schools. In 2016, these graduates made up 15% of medical school cohorts–an essential revenue source for their universities. AMSA argued that insufficient internship positions were available for these students, citing a shortfall of 234 openings in the 2016 clinical year. Whilst students with Commonwealth-Supported Places[7] are guaranteed an internship (and will automatically go into the allocation pool in their respective states), along with domestic full-fee paying candidates, international students are not guaranteed an internship place, preventing them from getting full registration and practising in Australia in the future. Blocking these graduates from gaining registration becomes a problem later in the career progression of Australian doctors in that a shortage of training doctors across particular specialities exists, particularly in rural or remote regions, and a number of these graduates could fill workforce gaps.

Residency

On completion of the one-year internship, a junior doctor will receive general registration and will move on to complete a year of residency. Residents undertake hospital work to further develop their clinical skills, usually with a view to pursuing specialty training after one or two years as an RMO (resident medical officer) or HMO (hospital medical officer). They may also be

[7] The Australian government subsidises the education of an allocated number of places in Australian Universities each year. These are referred to as "Commonwealth Supported Places," or CSPs. Students without a CSP are referred to as "full-fee paying" students as their education is not subsidised.

referred to as a 'junior' or 'senior house officer' (JHO/SHO). RMO, HMO, JHO and SHO are different official job titles to describe the same training level (i.e. resident) depending on the state in which they work. 'Residency' in Australia has a different meaning to 'residency' in the United States. A 'resident' in the US would be the equivalent of a 'registrar' in Australia—the term used to describe a doctor who has completed their internship and residency and has successfully applied to a specialty training College (junior/provisional or senior/advanced registrar, depending on the specialty) or who is planning to do so (unaccredited registrar). That is, an Australian' resident' is at a less advanced stage of their training than a 'resident' in the United States.

The internship and residency years are prevocational education—that is, at postgraduate years two and three, prior to entry into specialty medical training. My informants suggested that they often had more influence over their residency rotations than those during internship, which allowed them to gain more experience in specific areas of medicine. The Medical Board of Australia does not have any specific requirements for rotations of residents, unlike during the internship year prior to an individual gaining general registration, which may be why junior doctors at this level have greater opportunities to undertake rotations specific to their interest areas. For example, a JMO who hoped to pursue a career as a hand surgeon may have the opportunity to undertake a plastic surgery rotation during their residency year. Opportunities like this specialist training assisted these individuals to decide which specialty training program they would apply for post-residency. Rotation requests depended predominantly on availability within each hospital service and were usually facilitated by the Director of Prevocational Education and Training (DPET), who is a senior doctor in charge of the JMOs clinical training, or the JMO Manager, an administrator in charge of the junior doctors' rosters and rotations.

Unaccredited training (SRMO)

Toward the end of residency, junior doctors begin applying to their preferred training programs. Some JMOs, such as Jason, who wanted to pursue a career in general practice, found this process relatively simple and were pleased to get on to the program at their first application. Others, however, find the process more frustrating. Mia, for example, completed medical school in 2015 and was in her fourth postgraduate year (PGY4) when we met in 2018. Mia had completed both her internship and residency and aspired to become a dermatologist. However, selection for the training program for dermatology is tough:

> I'm applying [to the College of Dermatology] for next year. Chances of getting on are, like, minimal, right? Whereas people apply, like, many times, and then they get on, I'm considered very junior, and there was like one spot in the state in NSW this year… So, everything I'm doing is pretty much aimed at that.

In the meantime, and in order to improve her Curriculum Vitae, Mia, like many aspiring medical specialists, undertook unaccredited training. Unaccredited training involves working for a specific department or in a position for a hospital that is paid but does not contribute to the required training time for a specialty training program. Mia was completing a research fellow year when we met in 2018 and was doing locum work[8] after hours to make enough money to cover her living costs. She hoped to be selected for the dermatology training program in 2019 but said she understood how challenging achieving this was, so her expectations were low.

[8] Some junior doctors choose to work in short contract positions as 'locums' even during their training. These temporary roles tend to be available in specific geographical areas of need, namely regional or rural hospitals where funding might not exist for a full-time trainee (or in the case where a department has not found a full-time trainee to take up an available position). Locum roles pay very well, and many of the junior doctors I interviewed had worked as locums at some point in their training for financial reasons (as locum work does not usually count toward a doctor's training requirements).

Mia is an example of an unaccredited registrar. Whilst working on all the additional degrees, publications, and projects required to be accepted on to a training program, Mia could continue working as a junior doctor in the public health system.[9] This role is known as a 'Senior Resident Medical Officer' (SRMO); most hospitals employ a number of SRMOs to complete staffing of their departments. In NSW, for example, an SRMO would be paid between $79,648 and $107,713, whilst the remuneration for a consultant who has completed their specialty training would be between $162,432 and $219,452 (Australian Salaried Medical Officers Federation, 2017). This arrangement represents financial savings for the health care system employing SRMOs or unaccredited registrars to meet workforce needs. These doctors are not replacing consultants, of course, as they do not have the expertise to do so, and some doctors may argue that this arrangement is a more efficient way to staff the hospital system as it is more cost-effective. The comparison does not take into account other benefits that the health service gains by employing training doctors who, willingly or not, work unpaid overtime and invest so much of themselves into their work in order to prove themselves to their seniors who may, in future, provide a reference for specialty training programs or have influence over whether or not they will be employed in a more senior position. These junior doctors are not just cheaper to employ, but they are also more vulnerable to exploitation in non-wage ways.

Junior doctors can work as SRMOs for as long as a job is available, and they continue to satisfy their employer—often for several years. Trainees often use the SRMO role as a transient position until they finally get on to a training program. Tim Lindsay (2019), who has written for the Medical Journal of Australia's InSight+ forum on the problems facing unaccredited registrars in the Australian medical education model, suggests that some doctors work as SRMOs for five to six years before commencing specialty training. These years as an SRMO, or unaccredited

[9] Junior doctors often need to undertake additional study to be competitive in their application for specialty training.

registrar, in fact, lengthen the 'training' process from what may seem like a six-year course post-medical school to one that takes more than 13 years to complete if internship and residency are included.

Doctors who decide not to move on to a training program and continue working in the SRMO role become CMOs or Career Medical Officers. CMOs play a crucial role in the public health system. A 2005 review of emergency medicine training in NSW found that of the 145 emergency departments across the state, only 40 were staffed by emergency staff specialists (Health Education and Training Institute, 2020). The remainder, and thus the majority, were staffed by a combination of CMOs, SRMOs and Visiting Medical Officers (VMOs). Most states have ongoing professional development specifically for non-specialist doctors as they are otherwise overlooked. That is, they do not belong to or have formal professional training from a specialty College. CMOs are, however, required to maintain their own level of continuing professional development just like any specialist doctor. A hospital's decision to provide some professional development may be based on the employer's desire to improve clinical practice as means of retaining staff or for industrial reasons. Providing ongoing training, however, is not obligatory and is up to the individual hospital or state-based health care system. For example, in NSW, HETI provides a level of professional development to CMOs through the Hospital Non-Specialists Program (Health Education and Training Institute, 2020). A lack of an overarching organisation or body responsible for this group of doctors makes it difficult to monitor their skillset and performance, and subsequently, their mental health or wellbeing.

Being selected to a training program

Most doctors do, in fact, move on to a specialty or GP training pathway (Duckett & Willcox, 2015), and indeed, all of my informants expressed a desire to specialise or pursue general practice training. Statistics reported by the Medical Board of Australia reflect this trend amongst my informants. In the period from July to September 2021, 84,442 (64.7%) of the 130,476

registered medical practitioners across Australia were listed as specialists, of which 34,742 were GPs (26.6% of all registered practitioners and 41.1% of specialists) (Medical Board of Australia, 2021). That is, the majority of registered medical practitioners (which includes doctors in training as well as doctors who are registered but not practicing) are specialists, and a significant portion are general practitioners.

These specialty pathways differ dramatically depending on the field. Training pathways are structured programs supervised by specialty training colleges (such as the Royal Australasian College of Surgeons for surgical training). Training programs are between five and seven years; the time varies depending on individual circumstances. Medical specialty assessment usually consists of both written and clinical exams, as well as 'a range of clinical experiences in generalist or sub-specialty areas' (Duckett and Willcox 2015, p. 97). Some colleges require that trainees undertake periods of residence in different hospitals and locations; for example, the Australasian College for Emergency Medicine requires that trainees undertake a minimum of six months of full-time work in both a Tertiary Referral Hospital[10] and an urban referral or rural emergency department.

Some specialties are more accessible than others.[11] Going into this project, my mother, one of the first female orthopaedic surgeons in Australia, quickly corrected my assumption that she

[10] When a patient requires critical care that cannot be delivered by their local hospital, they are transferred to the Tertiary Referral Hospital within the network of hospitals. Critically ill patients in NSW are referred to one of ten Tertiary Referral Hospitals, for example (NSW Health, 2018).

[11] Whilst the Medical Board of Australia publish quarterly registration data that shows the numbers of qualified doctors registered across specialities and sub-specialities, data regarding the 'required' number of specialists needed for each speciality would be based on local recruitment requirements and thus is not compiled in a central location. Additionally, AHPRA does not place restrictions on how many people can be registered as specialists; rather, the Royal colleges have limits on entry into training programs and thus on how many doctors can become fellows of their individual institutions. This lack of centralised data gathering makes it difficult to know where there are actual shortages or surpluses of doctors in particular

had entered the training program she chose quickly. She explained that she had, in fact, worked as an SRMO, or unaccredited surgical registrar, for eight years before being accepted into surgical training with the Royal Australasian College of Surgeons (RACS). In this case, the time spent as an SRMO essentially waiting to be accepted to a program was longer than the training program itself. This extensive period of waiting causes uncertainty on several levels. Firstly, the junior doctor does not know whether they will be selected. Secondly, if they are, they cannot always be confident when they will finish. Being in this liminal state is particularly challenging for these individuals. They have neither outright failed at medicine (and thus been forced to reassess their situation), nor have they progressed to a program that provides them with greater certainty about their professional future. I discuss this predicament in Chapter Four.

After briefly mentioning medical school, her internship and residency, Mia elaborated about her aspiration to become a dermatologist. "I'm also always aware that I'm chasing something that I may not get. And all of this money and time that I'm spending is potentially all going to come to nothing, and it involves a lot of, like, pain and sacrifice." Mia, and her husband, Nathan, who wanted to be a surgeon, had already spent many thousands of dollars pursuing places on the training programs they hoped to enter. However, neither of them had yet sat the expensive entry exams or even applied to their respective colleges. They were both concerned that their CVs were not sufficiently strong to apply and that they were not yet well-prepared to sit the exam, considering its cost.

Each specialty or College has different entry requirements. Some demand that the applicant attains a minimum score on a specialised exam. These exams can cost upwards of several thousand dollars, depending on the College to which they apply. For example, the Royal

specialities. Bethell (n.d.) suggests, perhaps rightly so, that the issue is not a case of a shortage of doctors but in fact a maldistribution. Regardless, based on limits on entry into training, some specialities are significantly more competitive than others.

Australasian College of Surgeons requires applicants to sit the Generic Surgical Science Examination (GSSE), which, in 2021, costs $4,230 AUD but does not guarantee the candidate a place on the training program. Other colleges base entry on interviews and records of previous achievements, such as having a doctoral degree or a masters in a specific area as a qualification. To get on to the training program for Cardiothoracic Surgery, for example, a junior doctor needs to collect a total of 40 points across six domains to be eligible to apply. Primary medical qualifications do not count toward the applicant's points. Domains include qualifications, surgical and medical experiences, publications, presentations, skills courses, and awards. Each domain has a maximum number of points that can be claimed in that area. A Masters' degree for a surgical qualification is worth two points, whist a PhD in an area of medical expertise is worth three points.

Depending on the requirements, JMOs apply to colleges at different points in their educational careers. Most JMOs who wish to pursue general practice or physician's training, for example, apply during or immediately after their residency year because these programs are not considered overly competitive or difficult to enter. Others, like Mia and Nathan, work to establish their qualifications over an extended period after graduation to build a body of work that will best support their ambitions for more selective specialties like dermatology and surgery. Some specialties, like cardiothoracic surgery, give points for rotations undertaken in the field of cardiothoracics, so this often extends the time it takes for individuals to get on to training programs.

Miko, a junior doctor based in Sydney, made national headlines in early 2019 when she blogged about her experiences of bullying, harassment, and burnout as an unaccredited surgical registrar working more than three years in a particularly dysfunctional department (Kadota, 2019). Not long after its release, Miko wrote a follow-up post about the financial and emotional costs of surgical training. This blog post provided a concrete example of what a doctor who aspires to

become a surgeon may spend on top of university fees. She estimated that she had spent more than $30,000 even before being accepted on to a training program:

> For surgical training, here are the **compulsory** courses, examinations and application fees I have had to pay in order to progress:
>
> - Critical Literature Evaluation and Research (CLEAR).
> - Care of the Critically Ill Surgical Patient (CCrISP).
> - Australia & New Zealand Surgical Skills Education and Training (ASSET).
> - Emergency Management of Severe Trauma (EMST plus its refresher).
> - Annual "expression of interest" fee to the Royal Australasian College of Surgeons (RACS) to indicate my intention to apply for the training program.
> - The actual application fee to RACS.
> - The surgical sciences examination (which has become a pre-requisite to apply for the training program). (Kadota, 2019, para. 6)

Miko adds that further courses are highly recommended for different surgical specialities. She argues that they 'strengthen your CV and therefore make you a stronger candidate (that they may as well be compulsory)' (ibid., p. 7). These comments were virtually the same as those of my informants and support the experiences of junior doctors like Mia and Nathan.

Harry, for example, was another junior doctor who had initially hoped to pursue a career in surgery—in particular, eye surgery. He had spent a large part of his intern and residency years undertaking courses and research to bolster his CV to be ready to apply for surgical training. Perhaps unusually, aspects of surgery that had appealed to Harry included having a more balanced day-to-day lifestyle. As a fully trained fellow, he looked forward to days consulting patients in private practice and other days in theatre operating. However, when we met, he was "in a bit of a crisis", he explained, as he was unsure if he could meet the surgical requirements in

what he deemed to be a "reasonable" amount of time. He felt that it would take too many years to both get into a surgical program and then through this specialty training. He was thus trying to decide whether it would serve him better to pursue a different field of medicine that he might be able to complete in a shorter time—closer to the anticipated five or six years of training post-medical school.

When I caught up with Mia a year after our interview, she informed me that she had been accepted on to the training program not long after we first met. She was "still in shock" when we spoke; an element of self-doubt seemed to remain, despite her successful result. She had applied to the training program after spending only one year as an SRMO after her residency. In a text message to me not long after being accepted, she explained that she was "extremely nervous leading up to the interview." She had taken up regular yoga and employed both a clinical psychologist and an acting coach to help her prepare for the interview: "[Because] you keep thinking… fuck, thousands are applying… how could I possibly get this?"

The concern regarding getting on to a training program begins well before a junior applies to get on to the program. My informants shared a concern that, on graduating medical school, they would not be successful in applying to internships the following year. Notably, all the doctors I interviewed had made it to internship without any issues—I did not interview anyone who had found it difficult to get an internship or who had not found a placement. In NSW, at least, this demonstrates anecdotally that the system set up by HETI to ensure graduates are provided with internship opportunities meets the needs of the current number of JMOs.

Similarly, several informants explained how much doubt they had around getting on to a training program, only to later disclose that they had already been accepted. Seo Ah had recently successfully completed her fellowship exams when we met. She said she was "unfurling" from the stressful year-and-a-half of study and was looking forward to planning her wedding later that year. Seo Ah was initially doubtful that she would get on to her training program of choice,

oncology. "I remember thinking that it was such a long shot that I would get on to the program first year," she explained. So sure that her first application would not be successful, Seo Ah planned to take a short break from medicine: "I was saying, if I don't get on, I'll take a year off. But if I get on, I can't say no to the opportunity. Who gets on? And then I got it."

Arham was also concerned that he was not qualified enough to get on to the training program for surgery that he wanted to enter. Whilst Seo Ah got on to oncology immediately after her residency, Arham had not yet been accepted on to the Surgical Education and Training (SET) pathway with RACS. He had, however, passed the entry exam, was about to start a year as an unaccredited surgical trainee in a prestigious Melbourne hospital, and had gained entry on to a competitive pre-surgery program called the Pre-SET General Surgery Research Fellowship Program. These achievements all demonstrated that his skills were perhaps more advanced than he had led me to believe.

Whether or not the junior doctor gets on to a program comes secondary in my informants' descriptions of their training pathways. When interviewed, they described in detail how hard they worked to build up their CVs, network with more senior doctors, and study for exams. My informants explained the extreme amount of work involved in a way that undermined their own achievement. Instead of celebrating their success, they dwelled on the enormity of the process and on the preconceptions they had about how difficult it would be to get on to the program in the first place. Each one seemed to treat their experience of getting into the program of their choice as an exception; their anxiety suggested that they had been socialised to expect failure and delay.

Whilst the experience of getting on to a training program[12] in many cases suggests that meeting the requirements is achievable, the perception that it is out of reach seems to demoralise individuals. Not ignoring the fact that many junior doctors *do* struggle to get on to the specialty training pathway they prefer, they perceive it to be near-impossible and are so defeatist that, in the end, many change their plans before even trying. Harry's "crisis" of trying to decide between critical care training (such as emergency medicine or intensive care) and ophthalmology is an example of this predicament. Harry wanted to undertake ophthalmology training but worried that it would be too difficult to get on to the program and then complete the training, so he was deliberating other pathways that might be more feasible or that he may be able to complete sooner. His view was echoed by several informants who suggested they had compromised their original hopes of pursuing competitive specialities for a career in general practice. The perception that entry was so difficult meant that some specialities, like general practice, become the "back-up plan". These junior doctors did not necessarily experience rejection; they instead anticipated it and diverted to different options to avoid it. Individuals pursued these pathways in many cases, not driven by passion or enthusiasm for the discipline, but with a resignation that they have no other choice. This feeling of lacking choice and long periods of competition and uncertainty impact an individual's own level of job satisfaction in the long term and may influence the quality of patient care that they deliver. Junior doctors' vulnerability and anxiety often lead them to adjust their expectations to avoid facing failure. They increase their certainty in many respects by avoiding the riskier option. They opt for a more predictable path because the cost of the delayed, ambiguous outcome is too high.

[12] My informants overwhelmingly used the phrasing "getting on to a training program" rather than "into a training program" as one might expect. I have therefore adopted this phrasing throughout the thesis.

Conclusion

Junior doctors and trainees play a crucial but complicated role in the workforce of the Australian health care system. After university, these young doctors must spend at least one year as interns in an Australian public hospital before receiving full registration to practice as medical doctors. They then go on to complete a residency year which is made up of a variety of rotations through different medical specialties. Some JMOs apply for specialty-focussed residencies such as surgery, providing them with more focussed experience in a discipline of their interest. According to Duckett and Willcox (2015), most young doctors go on to apply for and complete a specialty training program (which includes GP training as it is considered a specialty in its own right). They continue to practice under the close supervision of their seniors throughout that time before moving into private practice or working as a consultant in a public or private hospital.

Some of my informants, such as Mia and her husband Nathan, Seo Ah, Harry, and Arham, worked particularly hard to build their CVs and application profiles, networking with more senior doctors and studying for exams as they expected getting on to their preferred training programs would be very difficult. These trainees are, in fact, motivated to work *more* because of their aspirations and sometimes to delay applying by the resistance they expect. Other informants went into general practice or physician's training straight after their residency year, choosing a "work-life balance" that these pathways allowed or, in some cases, as a backup plan to another pathway which they perceived to be beyond reach.[13] Training programs have differing entry requirements, some of which seemed unclear or simply out of reach to those I spoke with

[13] Physician's training in the Australian context refers to medical specialty training with The Royal Australasian College of Physician's. Physicians of differing specialities (such as respiratory, for example) work within the hospital environment. A general practitioner, on the other hand, provides patients with primary care as the first point of call and refers patients to specialists for more specific care needs. GP training in Australia is provided by the Royal Australian College of General Practitioners.

throughout the fieldwork component of this project. Senior clinicians and directors of training in hospitals can provide junior doctors with some guidance about what courses and research to undertake and in what time frame they should aim to have completed these in order to apply to their respective colleges. Medical colleges also provide a number of courses to prepare unaccredited registrars to enrol in their programs. These courses constitute a certain number of points in the application process. Regardless of the support available, the problem lies in the competitive nature of specialty training, which means that even those who meet these obligations may not be successful in getting on to their chosen program as only a certain number of positions are available to a large number of applicants.

The Australian health care system relies heavily on these individuals to maintain its workforce, despite these structures and supports for leading junior doctors through their training. Training doctors interviewed for this project reported often working overtime for which they were not always paid. As each health district has its own processes for managing workforce needs, in some cases, accessing overtime pay often became cumbersome and difficult for interns and residents new to a health district or hospital to negotiate. On the one hand, training doctors are essential workers within the Australian health care system. But on the other hand, they are quite precarious and often consider their status to be a transitory one, a step on the way to a more desirable speciality. JMOs do not always have a clearly defined role in hospitals; they may find it difficult and stressful to make decisions under pressure due to a lack of experience, and they are often subject to bullying. However, both accredited and unaccredited trainees are essential to the functioning of the Australian health care system, and their apprenticeship, in many ways, is as much about creating a class of subordinate workers as it is about training future doctors. Unaccredited trainees, more specifically, are in a holding pattern from their training so that they can be a worker in the meantime. This workforce or management strategy disguises itself as education, and often times, despite playing such a crucial role in the system, these junior doctors are treated with the least respect.

Chapter 2: "I'm just struggling to find my balance…"

"I did a talk on work-life balance," Anne laughed, "which is sort of amusing." Anne was a provisional trainee at an inner-city metropolitan hospital in Sydney when we met over a coffee on a windy morning in April 2018. As she stirred her steaming hot chocolate, she explained that she and some of her colleagues had organised a 'wellness' day for the new interns starting at their hospital. The day was organised with some assistance from their Director of Prevocational Education and Training (DPET) and incorporated presentations by individuals in their team on a range of wellness-related topics. These included, in addition to "work-life balance", bullying, assertiveness (or in Anne's words, "standing up for yourself"), mindfulness, and career pathways.

Anne went on to explain why she found the idea of work-life balance so amusing. "One of the things I sort of said to [the new interns]," she said, "is like it's not going to just happen. [Work-life balance] is not going to fall into your lap and work. You have to make it work." For Anne, this means being well-prepared before leaving for work with her gear for rock climbing packed in her bag. "Because I know if I go home, once I'm through the front door, I'm not leaving again. I'm just going to collapse on the couch and not move." It means making the effort to go to the gym after a day of studying—which I should add happens on Anne's days off rather than on days explicitly allocated for study. Creating a sense of work-life balance for Anne also means ordering pre-prepared meals as she neither enjoys nor has enough time to cook, and it means living close to work which both "frees up extra time for [her] to do the things [she] wants to do" and allows her to walk to and from work.

During exam periods when she is trying to develop her professional skills and move forward in her training, Anne finds it much harder to balance work obligations with other aspects of her life. "Like at the moment with exams, it's just been… certainly things [non-work activities] have gone by the wayside," she explained. "There's only so much extracurricular stuff I can fit in."

Anne suggests that work-life balance is indeed possible most of the time; yet, her description of establishing and maintaining this "balance" relies entirely on her motivation to do so, careful attention to planning, and a willingness to juggle a hectic schedule. She also defines life outside of work as 'extra-curricular activities' which seem just as exhausting as her work, rather than reinvigorating her. Anne must identify what works for her as an individual and continue to negotiate these differing aspects of her life around a demanding work and study schedule. Anne is handling her 'non-work' life in the same CV-focussed way she prepares to apply for specialty training. She is using the same management skills on herself that she has to use for her applications. And as she implies to the new interns, Anne is primarily, if not solely, responsible for managing these conflicting priorities. Being able to maintain a sense of balance promises positive personal and professional outcomes and is therefore desirable not just for the individual but also to the Australian health care system more broadly, but Anne's examples suggest that it is a high risk, management-intensive lifestyle requiring elaborate strategies to meet the many demands.

Neoliberalism is a system of political-economic dominance based on the assumption that the wellbeing of humans can be best achieved through the liberation of 'individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets and free trade' (Harvey, 2005, p. 2). The state is initially tasked with creating these institutions and ensuring their preservation whilst avoiding intervening where possible. Thus, in medical education, for example, doctors can achieve personal and professional fulfilment through the individual pursuit and development of skills, acting as entrepreneurs in all aspects of their lives.

Harvey suggests that neoliberalism has become 'incorporated into the common-sense way many of us interpret, live in, and understand the world' (2005, p. 3). This neoliberal hegemony has become so ingrained in the medical system that training doctors simply do not question that the

responsibility for their self-development and skill acquisition falls on themselves with little external support. They might resent or criticise the medical education system, but these individuals accept how the health system works whilst going to great lengths to get into their preferred specialty, despite the financial and personal costs. Like Anne, junior doctors even transfer these patterns to their lives outside of their medical education and training. The Australian health care system has always been particularly competitive because of the rewards it offers, and this competition precedes the domination of neoliberal economic configurations in the West. However, with increasing numbers of medical school graduates and limited speciality training opportunities, the competition has amplified, and the education system's neoliberal tendencies have a flow-on effect on the mental health and wellbeing of training doctors. Junior doctors and trainees seek to exercise a degree of agency within a system that, despite outwardly suggesting that they have freedom and choice, prevents junior doctors from asserting their preferences by making them feel insecure and precarious.

Additionally, these junior doctors, like Anne, for example, perpetuate the structures that oppress them. Just because these doctors are not poor does not mean that they are not struggling. This chapter contemplates the underlying neoliberal economic system structuring medical education. This economic organisation influences both the education system itself and the individuals who work within it. Practices, such as Western mindfulness, have been brought into the education system to assist doctors in coping with their demanding careers. Thus, the chapter takes into account both the recent literature around Western mindfulness and how this practice, or a particular version of it, have been implemented in the hospital environment in an attempt to help struggling doctors. Rather than assess the success of these initiatives, I analyse them as a paradoxical element of neoliberal developments and in the context of my informants' experiences to highlight the contradictory nature of these programs and the added pressure they place on the individual.

Section A: The Neoliberal Medical Education and Training System

The Effects of Neoliberalism on Medicine

Doctors in Australia have traditionally been guaranteed a secure job and income as well as a well-regarded position in society. This expectation has been fulfilled as long as the demand for medical care far outweighed the supply—that is, whilst there was a shortage of doctors. For the last two decades, however, the Australian government has been increasing the numbers of medical graduates in Australian universities, and as a consequence, Australia now produces more doctors per capita than almost any other country. Whilst this reaction has somewhat addressed the shortage as far as metropolitan areas are concerned, particularly for the more popular (and financially lucrative) specialities, we are now observing a significant increase in the competition among aspiring doctors. To some extent, this competition is offset by the ability of doctors and the medical-industrial complex to develop new treatments and to generate demand, in areas such as cosmetic surgery, for example (see McDougall, 2021), and the inherent growing need from an ageing population. Medical school graduates feel the ever-increasingly competition in a way that their predecessors did not.[14]

Many democracies all over the world have embraced neoliberalism since the mid-1970s. Neoliberalism suggests that 'individual freedom could be preserved only in a society that protected private property and had a competitive market as the foundation of economic activity' (Ganti, 2014, p. 92). 'Freedom of choice' refers predominantly to the domains of production and consumption and includes individuals having the right to 'plan their own lives' rather than having them dictated by a centralized governing authority. Alec Grant (2014, p. 1280) describes neoliberalism as 'new managerialism'. His work considers the impact of neoliberalism on the

[14] It is important to note that Australia continues to recruit overseas doctors to fill what are usually unaccredited positions in areas of workforce need; however, in some states, such as NSW, industrial relations-related policy prioritises Australian residents in the recruitment process.

university sector and higher education, in particular examining the training of nurses. My data from interviews with training doctors parallels Grant's argument that neoliberalism 'socialises academics to become more flexible and work harder in increasingly enterprising ways' (2014, p. 1280). Rolfe (2012) describes this shift as the 'knowledge business' wherein individuals are valued for how their knowledge can be bundled and traded. Training doctors similarly derive worth both from how much they know and from how hard they will work. Their value and chance to be selected to training programs result from the robustness of their curriculum vitae, for which they must take full, individual responsibility. My interviews show that when a junior doctor feels a degree of competition or lacks support from the institution in which they work, they tend to exert even more effort to prove their worth. They do not feel that an institution is responsible for their career progression or education. However, these institutions benefit significantly from junior doctors' increased knowledge and experience, which is produced out of a mixed bundle of motivations: feelings of obligation to the medical profession, anxiety about career expectations, ideals about how medicine can serve the community, and high expectations students have of themselves.

More and more anthropologists are concerned with the study of neoliberalism as changes in the political economy shape the lives of people everywhere (Ganti, 2014). Anthropologists have been 'well-positioned to document the varied effects of neoliberal policies and economic restructuring on people's lives and life-changes throughout the world' (ibid., p. 94). Indeed, in the context of this project, an anthropological lens has been helpful to observe the effect of this political and economic change on individuals within the Australian health care system. A body of ethnographic literature demonstrates how individuals 'engage with models of a neoliberal self' (Gershon, 2018, p. 173).[15] My research documents a shift toward neoliberal policies within the field of medicine in Australia and how it has affected training doctors and their wellbeing.

[15] See also Allan and McElhinny (2017) and Ganti (2014).

Neoliberal policy champions the individual and his or her freedom of choice to live his or her 'best life'. On the one hand, new educational structures empower and motivate individuals to make choices they may not have made otherwise. Individual development of skill and abilities can positively impact the position of that individual within society. Often, the individuals themselves benefit by having more skills which they can use to earn a higher income, obtain a different job, or fulfil a personal goal. The onus for self-development is on the individual. However, the neoliberal individual also strives for self-production to the benefit of the institution for which she or he works. The institution itself does little, if anything, to help develop the individual. The competitive structure of the system increases the stakes for individuals, requiring them to work harder, and as a result, extracts more from them as employees. We can see this neoliberal hegemony within the Australian health care system. Individuals are challenged and inspired to be excellent physicians. They work long hours and study for years on end to become doctors. Institutions (hospitals or the health department) then exploit the individual's skills as well as their aspirations and anxieties. Individuals feel they are serving themselves in becoming doctors—and they are—which is why they continue to push themselves to reach the ever-receding benchmarks. Yet, these individuals end up devoting themselves to a system that neglects to care for their wellbeing for the most part. The Australian health care system overwhelmingly benefits from developing an individual's sole medical identity, rather than the promotion of alternative identities that may provide a degree of resilience for the individuals themselves.

Neoliberalism also exacerbates job precarity, which keeps individuals aligned with an organisation out of fear of not finding work elsewhere. The promise of a 'flexible' career or workplace and a lifestyle that suits each person also places individuals in a difficult situation, forcing them to implement their own strategies to fulfil responsibilities both at work and in life outside of work.

Blurred Lines and the Embodiment of Doctoring

Training doctors are each a 'bundle of skills' or a commodity in the medical system. Urciuoli (2008, p. 215), in her analysis of the 'skills discourse', argues that neoliberalism entails 'a blurring of lines between self and work by making one rethink and transform one's self to best fit one's job', a trend which is 'highly valued in an economy increasingly oriented toward information and service'. This personal transformation is now highly valued in many industries.

Nick was a 26-year-old resident working at a smaller teaching hospital on the outskirts of Sydney. He hoped to pursue a career in psychiatry because he enjoyed what he described as the "social side of medicine—talking to patients, knowing where they come [from], some of the social and cultural things." Nick told me about his habit of taking his work home with him. "I go home wondering if I have missed anything. I should have done this, should have done that," he explained:

> You can remotely order things for patients [on your smart phone], and so like every Sunday night, I get out the patient list on my phone and start ordering bloods for them for Monday. I mean, it made my job easier on Monday, but that meant I was still up on my phone doing work.

My interviews, like that with Nick, demonstrate how junior doctors transform themselves to better match the requirements of their work. Informants talk about spending their "downtime" studying, attending teaching events, debriefing after shifts, or reviewing cases they have encountered at work to improve their diagnostic skills for the next time they might come across that same condition. Their friends and partners are predominantly, if not exclusively, in the medical profession, so they talk about work even in periods they describe as "time off". Several

participants described waking up during the night to call a colleague on the night shift to double-check they had written up a patient's chart correctly earlier that day.

These situations could be seen simply as evidence of dedication to their careers that extends beyond working hours. But these descriptions also demonstrate the *embodiment of doctoring*. That is, the lines between the self and medicine have blurred so much that the training doctors can no longer differentiate themselves from their role at work. These doctors have developed a pervasive medical identity. Thus, the trainees spend the time they describe as "downtime"—implying time during which they are out of action or unavailable—improving their skills or thinking and talking about their work. Instead of "downtime," they experience being "always on."

The training doctor takes on a responsibility not just for themselves and for their own career progression, but also a sense of responsibility for the patient's welfare and outcomes even when not technically at work. One of my informants, Arham, described this predicament:

> You know, in any job, if things aren't getting done, that's a problem. But in medicine, if things aren't getting done, that means patients aren't getting good care. They're spending longer time in hospital, more resources. It just has a wider domino kind of effect, and you feel responsible for that.

Junior doctors are more susceptible to feeling responsible as they are fresh to the system with little experience. My informants used the terms 'experience' and 'cynicism' interchangeably, suggesting that over time, a doctor becomes more proficient and, consequently, a better clinician, but with that know-how comes a distrust of the bureaucratised health service and decreased idealism about their profession. And so, whilst doctors are still junior, at the bottom of the hierarchy, they are exploited both in how much they work and the degree to which they care.

Arham defines good quality patient care as the patient spending less time in hospital, thus utilising fewer resources. He does not say, "if things aren't getting done," a patient will die. This definition demonstrates his internalisation of the managerial structures that discourage the use of too many resources. He sounds less like a junior doctor here and more like someone in charge of hospital management or finances. He has internalised not only a professional ethic but also a managerial ethos.

The situation that my informants are facing mirrors a quandary that Ilana Gershon (2017, p. xi) observed in graduates applying for jobs in corporate America:

> Instead of being a craftsperson, developing and honing a set of skills over time, you are expected to be more of a jack-of-all-trades, developing a range of skills that might be useful in an unknown and ever-changing marketplace. Instead of company loyalty, you are now expected to feel passion for your vocation and to be driven to prioritise work over all other obligations.

This passion and the prioritisation of work over other aspects of life is where the boundary between professional and personal life blurs. The individual's identity comes to be wrapped up in who they are within the workplace, rather than considering themselves holistically or reinforcing alternative identities outside of medicine. Doctors of previous generations also often had a dominant medical identity, but a subtle shift caused by the increasing impact of neoliberal management principles seems to have adapted this traditional commitment into a new obligation with problematic consequences. That is, the identity of being a doctor is now contingent not on community recognition of patients or running a private enterprise like one's own practice, but rather on increasingly bureaucratic and exploitative institutions in which many doctors feel they have less and less power or autonomy, especially whilst they are training.

This lack of boundaries has a significant impact on the individuals themselves. Whilst neoliberalism may well 'restore the power of the economic elites' (Harvey, 2005, p. 19), it leaves

behind the workers—in this case, the training doctors—who may not even be aware that their long shifts, expensive courses, and ongoing study are primarily benefitting the health system and their managers. Additionally, the hours they are expected to work—often more than the average 38-hour working week—does not allow time to fulfil the other requirements of their training or any type of 'personal life' outside of work. However, because these junior doctors are still 'training,' they make a kind of exemption from their normal expectations that work be only a particular portion of their lives.

Doctors of all levels across Australia are represented by the Australian Salaried Medical Officers Federation (ASMOF) in their respective state, which acts like a union. So, whilst a representative body exists for junior doctors, they also sit in an intermediate space between being a student associated with a university and being a fully qualified consultant. Some trainees belong to a training network that oversees their rotations and provides them with a point-of-contact throughout their training, but this set-up is usually dependant on which specialty program in which they are participating.

The 'JMO Tsunami'

Uncertainty haunts junior doctors during their medical training. Over the last few years, the threat of a 'Junior Medical Officer (JMO) Tsunami,' an unmanageably large influx of medical school graduates requiring intern and specialty training positions in the public health sector, has caused concern amongst junior doctors trying to get accepted on to training programs as well as medical graduates moving into internships. Irrespective of whether it is real or imagined, this threat forces medical graduates to wonder whether enough jobs will exist when they enter internship. Likewise, interns and residents are concerned that a surge in applicant numbers will make it even more difficult to get on to training programs for some specialties due to increased competition.

The ‘JMO Tsunami’ has not yet impacted internship positions for domestic Commonwealth Supported graduates. It may take several years for the ‘tsunami’ to hit this specific demographic group, if it does at all. Getting an internship position was seemingly achievable for all my informants, despite their worries. What training doctors really want, though, is a well-paid, secure, and fulfilling career, and it is at this future point that the anticipation of competition and worry about achieving their goals appears to them to be escalating. A report conducted for NSW Health by Dr Jo Burnand in 2014 suggested that an oversupply of candidates is, in fact, seeking positions in metropolitan areas. Burnand (2014) argued at the time that whilst 6,000 applicants are eligible for training doctor positions across NSW, only 3,600 positions will be offered. This oversupply of training doctors relative to available positions has not quite made it to regional and rural sites, which were still struggling to attract enough JMOs at the time of this research.

> Whilst increasing numbers [of applicants to training positions] do appear to be impacting on the recruitment to positions within metropolitan areas, this is not yet occurring within rural and regional areas. One rural doctor expressed it this way: “The tsunami hasn’t wet our feet yet.” (ibid., p. 32)

Burnand contends that the recruitment of junior doctors is becoming increasingly competitive with departments competing with one another for the training doctors they see as being the most ‘high calibre’ and that those who sit on selection panels are now required to make ‘high stakes decisions’ which have a significant impact on ‘both employment prospects and access to postgraduate training opportunities for individual doctors’ (2014, p. 32). Burnand’s conclusions validate the concerns expressed by my informants, apparently confirming their impression that they should work harder to remain competitive amongst their peers.

The threat of a ‘JMO tsunami’, however, acts as a disciplining device. This rhetoric tells junior doctors that they should be grateful to have a job as so many of their peers were not or will not

be quite so lucky. The image leads them to constantly question themselves and their ability to perform the job they have been trained to do. Arham articulated this underlying concern:

> I think everybody's worried that they will be seen as being inferior or incompetent, and that's why everybody needs to put up their guard. And not let it show that they may be flawed. Because every day for us is a job interview, if we don't perform in front of our bosses' eyes, if we make mistakes, I think we catastrophise it in our mind and say, "Oh crap. They're gonna think so badly of me. I'm not gonna get... I'm not gonna be asked to do this. I'm not gonna... get that promotion. I'm not gonna get on to the program. I'm not gonna get good references. I think that's kind of in the back of our minds when we think, "Oh, I don't want people to think that I'm dumb or incompetent."

This fear of unemployment and of not living up to the expectations of those around the junior doctor is fed by the competitive structure of the curriculum, as well as the spread of fears that they will be swept away in a demographic change. This fear reinforces broader neoliberal trends that extract more labour from the workforce. It also undermines collective action, pitting individuals against one another and ensuring that no one complains too loudly. All are encouraged to perceive their situation as precarious, potentially worsening severely in the future, and they must work especially hard to find the shelter of a training program or permanent position before that future arrives.

The Effect of Neoliberalism on People

This section presents three informants from this research to illustrate the impact of the neoliberal dilemma on those working within the Australian health care system. Mia's experience demonstrates the personal and financial lengths that an individual might go to in order to pursue their medical aspirations, whilst Jasmin provides an example of someone who performs a degree of 'emotional labour' to manage the stress they experience working within the medical

system. I also adopt Ilana Gershon's idea of the 'lived dilemma' (2018) in relation to Jasmin's case to demonstrate why junior doctors find themselves struggling to cope on a day-to-day basis. Finally, Jason's experience of working and training part-time provides an alternative approach to navigating the neoliberal hegemony to create a sense of work-life balance.

Anticipated Challenges

Junior doctors believe that they will inevitably face high levels of pressure and exhaustion during their internship years. John, for example, explained that the challenges he faced were largely ones that he had anticipated and accepted as part of the training process. He described his experience in our interview:

> I loved first year of internship for the most part. I mean, obviously, there are challenges. I'm sure you hear about them, but what I liked about it was the expectation that you have to be mature… There is an adjustment to full-time work, but I felt like I had something to prove to myself more than anyone else, and I liked that challenge.

The language that John uses alludes to an underlying assumption that being an intern is inherently difficult and that people are well-aware of this fact. "Obviously" and "I'm sure you hear about them" point to this assumption. John naturalises the hardship and stress that he faces. He then explains that although these challenges exist, he considers them worth overcoming for his own self-growth.

John also went on to say that finding a busy day hard is just an "easy excuse." This comment highlights two issues. Firstly, John demonstrates the sense of stoicism which seemed to be a trend across my informants' experiences and inherent to medicine—the notion that you cannot have a bad day or find a situation hard without it being shrugged off as an excuse—again, the responsibility of the individual is to learn to manage. Secondly, John has internalised the

systemic pattern of self-exploitation to improve oneself to the extent that he undertakes a degree of self-surveillance. He sees this as a way to improve himself for his *own* benefit, which may be true to an extent. Whilst he may believe that everyone will have busy days at work no matter what they do, John is also inculcated with assumptions about his worth and identity deriving from work and thus pursues an agenda of self-exploitation offered to him by the various organisations within the Australian medical system.

Mia: "I spent gazillions getting on."

Training doctors spend a significant amount of money on courses, exams, and tutoring each year, building up their CVs to get accepted into training colleges. Some are more competitive than others, even in specialities where a shortage of doctors is becoming a problem. These trainees receive no government financial support, and the colleges charge between $1500 and $4000 (AUD) to sit exams which come with no guarantee of a position on the program. Mia aspired to be a dermatologist—a College that is renowned for being difficult to enter. Mia was working both as a locum in regional New South Wales and on a research project at a tertiary hospital in Sydney. Mia estimated that she and her husband, Nathan, had spent upwards of $100,000 in the previous year alone on courses, exams, and what she described as "philanthropy", or a self-driven community-based fundraising project. She explained to me that this fundraising project had involved procuring iPads for children in underprivileged areas for educational purposes and was done specifically as a part of her attempt to get on to the training program. According to Mia, it seemed to have little relevance to medicine in much the same way that previously successful candidates for dermatology had participated in Olympic-level equestrian or human rights initiatives with the United Nations.

This young couple had spent money equivalent to a house deposit building their CVs to get on to the training programs they desired. This expense was in addition to the cost of their medical

degrees. Notably, at the time of my interview with Mia, neither she nor her partner had been accepted on to a training program yet. They were expecting to have several years of unaccredited training and development of their credentials ahead of them, which ultimately would cost significantly more money. That is, Mia had looked at the two trainees most recently accepted to the College and realised that she had to do something extraordinary to get in, such as undertaking a 'philanthropic' project, over and above the financial costs.

Mia, in fact, defied the perceived odds and got on to the training program for dermatology on her first attempt, and so she has the potential to earn a substantial salary and will get the personal satisfaction of having achieved her goal. She will now have to complete the program, a very stressful time in the life of a training doctor, all whilst trying to balance her work with life at home. I touched base with Mia through text message about a year after our interview, and she was working in a regional town north of Sydney as a dermatology registrar. "Loving it," she said, "worth the pain, although I have many more years ahead." I asked how she found the whole process in the end. "Stressful and expensive," Mia replied. "But I got on, so now I'm relieved and grateful."

Mia explained that she had been advised to see a coach before her College interview. In the end, she spent two to three months preparing with two coaches, both psychologists, who taught her "how to not crumble under the weight of this event", the interview. "The second coach pretty much focused on me like acting like I deserved the spot [because] we are so beaten down." This coach was originally a sports psychologist who had helped Olympians prepare for gold medal events—"like big shots with a lot riding on a single event." The other coach helped Mia to frame her answers to the interview questions according to the criteria set out by the College. She started a regular yoga routine and felt the coaching helped enormously.

"I was extremely nervous leading up to the interview," Mia said. Despite the financial and personal investments in her application to the College, Mia expressed surprise that she had been

accepted and given entry. “Still in shock a bit,” she said, laughing. “It’s the best!” Mia could not believe that she had been successful and attributed it to luck, even though she had obviously worked extremely hard, implementing a comprehensive strategy to be in the position in which she found herself.

Had she not been successful in 2019, Mia would have expected to work several jobs in a reasonably high-stress environment to fund the projects she felt were necessary to get accepted on to the program—a situation faced by many training doctors in Australia. This insecurity and the ambiguity about what sorts of credentials or accomplishments will materially aid them to gain entry, in many cases, causes junior doctors to go to extraordinary lengths, perhaps even overestimating what they need to do in order to be accepted on to a training program. These individuals end up self-exploiting not necessarily because they are finding it harder to get on to a program, but because they do not know precisely how hard it will be, nor which factors will be most important to selection committees, so they do as much as they can to improve their CVs just in case.

The health system will gain as much, if not more, for Mia’s efforts than she will as an individual. On top of this, Mia has willingly subjected herself to exploitation for this somewhat vague and insecure promise. This case suggests the financial savings alone of employing SRMOs or unaccredited registrars to meet workforce needs, not taking into account other benefits that the departments or local health districts would gain by employing training doctors who willingly work unpaid overtime and invest so much of themselves into their work in order to prove themselves to their seniors and gain entry to programs with opaque selection processes. The neoliberalisation of medicine in Australia means that a seemingly bright, friendly, and focused young doctor like Mia will spend most of her twenties and thirties working hard to the advantage of the system under the promise of reaping the benefits of her hard work later in life.

Jasmin: "You'd still be able to go home at the end of the day, right?"

Jasmin did not know what she wanted to do career-wise when she finished school. She had a background in molecular biology and genetics but explained, perhaps paradoxically, that she "didn't have the brains" or patience for research, so she pursued a career in medicine. Jasmin studied medicine as a graduate student, and after enjoying an Emergency term during her internship, she applied to the Australasian College for Emergency Medicine to complete her specialist training. When we met, Jasmin was an Advanced Trainee in Emergency Medicine at a tertiary referral hospital in Sydney. She was about to turn 31 years old and was fourteen weeks pregnant.

"I didn't think about the real-life implications of [a career in medicine]," she explained. "I think looking back, if I knew what I know now, I probably wouldn't've gone into medicine just because of the work-life balance, like hardly seeing my husband." Jasmin, like many informants, described "falling into" medicine rather than pursuing it with forethought and clear motivation. However, Jasmin also felt that she could not imagine doing anything else. This ambivalent relationship with medicine was common amongst my interviewees. Whilst Jasmin thought that medical school would be "difficult", she was under the impression that by the time she worked in the hospital system, the work itself would not be too all-consuming. Her experience has been much the opposite.

> Emergency Medicine isn't so bad because you do your rostered 40 hours a week, and then you get to go home and don't have to worry about [being] on call. But it is still so emotionally and physically draining that even on the day… that you are at home, you're still recovering from being at work.

Whilst Jasmin felt her workload was manageable as a senior registrar, she found that both the emotional and physical aspects of the work spilled over into what were supposed to be her days off. She felt that this affected her relationships, particularly with her husband and her family,

whom she saw rarely, and she was concerned about how she would manage her training and the exhaustion from work once she has a child.

Hochschild (1983) describes the regulation of feelings in social interaction as emotional labour, suggesting that it consists of two forms of emotional acting. The first is 'surface acting,' wherein an individual pretends to express emotion. The second form Hochschild refers to as 'deep acting,' which involves consciously changing one's thoughts or feelings to act positively toward someone else. Brotheridge and Lee (2003) argue that these forms of emotional regulation occur in order to meet expectations specific to employment. In 1983, Hochschild claimed that both forms of emotional acting caused a level of stress that had a detrimental effect on an individual's wellbeing. However, since then, a body of literature suggests that whilst surface acting produces emotional exhaustion, deep acting can have a more complicated impact on an individual(Bono & Vey, 2010; Grandey, 2003; Larson & Yao, 2005; Yagil, 2012). That is, 'deep acting involves displaying more authentic expressions, and has been found to be beneficial as it enhances communication skills that stimulate empathy toward others' (Rogers et al., 2014, p. 234). While evaluating the effect of surface and deep acting is not the goal here, considering doctors' experiences in terms of these forms of emotional labour can help us better understand the outcome of patient and peer interactions on the individual junior doctor.

Jasmin is performing a level of emotional labour whilst working under such pressure each day in a busy emergency department. Like many of her colleagues, she would be surface acting to try to appear level-headed and competent through a shift. According to several Emergency Medicine consultants I spoke with during the course of this research, a registrar working in a busy emergency department in Sydney, for example, is expected to see between six and fourteen patients during a 10-hour shift (depending on whether the patients are deemed acute or sub-acute). Engaging with that many individuals, particularly people suffering pain, could be

exhausting, and training doctors may therefore feel the need to emotionally distance themselves enough to cope.

Jasmin may feel that she has the capacity to make decisions related to how she engages with patients, how she organises her life around her work and family commitments, and how she goes about her own medical training. For example, Jasmin explained in her interview that even though she would have liked to have children earlier, the actual time point for when she fell pregnant was out of her control. "I put [getting pregnant] off because of the primary [exam]," she told me. "I kept thinking, I'll just get through the primaries, and I took ages on the primaries, and then it took ages for us to fall pregnant after we started trying, so it's a lot later than I would have liked." The health service in which she works actually undermines these decisions. Additionally, the emotional labour required to meet the requirements of her job left Jasmin so exhausted at the end of her work week that she questioned how she would live up to her own expectations of herself in her life outside of work. Had her work not been so all-consuming, leaving her so tired by the end of the week, perhaps she would have been able to get through her primary exams sooner. Jasmin struggled to fulfil expectations at both work and home. In her work on corporate hiring in the US, Gershon describes this as 'implementing the neoliberal model of self' (2018, p. 173). Gershon argues that job seekers, similarly to junior doctors, were told 'to represent themselves as a desirable employee' and often struggled to do so when this advice conflicted with other values (ibid., p.175). She uses the term 'lived dilemmas' to describe this struggle, and I adopt this term to describe the situation that Jasmin and other informants face as training doctors who struggle to balance an especially difficult training pathway with a desire to have a life outside of work—whether it be to get pregnant to start a family or to have the time to take up other interests. 'Lived dilemmas' describes the desire for a 'work-life balance,' expressed by my informants, which in many cases glosses over the specific detail of what this balance might entail for each person.

Contrary to Mia's experience in Dermatology, Jasmin divulged that she did not actually remember how she got on to the training program for Emergency Medicine. "All I remember is having to fill out a form and paying a fee, and I got on [the training program]… I am sure, I think, it was more complicated than that, but I don't remember." Getting on to the training program for Emergency Medicine was not as arduous as many other colleges because more training positions exist to meet an increased workforce need in emergency departments. Jasmin told me about one of her friends who had spent years trying to get on to the training program for Gynaecology and compared this to her own experience of getting on to the Emergency Medicine training program, which she struggled to even remember. Jasmin minimised her own efforts and abilities—a pattern I noticed amongst my informants who largely downplayed the work they had put in to achieve their goals.

Jasmin and Mia were both a similar age and at a similar point in their careers when we met. They both studied medicine at graduate level, were recently married, and worked in metropolitan Sydney. As they chose diverse specialist training pathways, they experienced the health system differently. I argue, however, that the influence of the neoliberalisation of medicine on each woman is similar. The requirement that they invest so much of themselves into medical training leaves them exhausted with little time or energy for other aspects of their lives. They find themselves predominantly developing their medical identity to the detriment of other possible avenues for self-realisation.

The total investment of oneself into a medical career significantly affects a training doctor's ability to participate in activities outside of those they categorise as "work". When asked to describe a typical day at work, Jasmin explained that the whole shift is "ridiculously busy". She said:

> So, like, a typical day at work, I won't stop to pee. I won't eat or drink. It has become a common occurrence now where I'll pop a piece of gum into my mouth, and I will still be chewing it at the end of the shift ten hours later.

Not eating for ten hours goes beyond an issue of work-life balance and moves further into the space of workplace health and safety. Jasmin described this habit as "terribly unhealthy", but this practice is also unsafe. She explained that she was making more of an effort to drink, eat, and go to the toilet now that she was pregnant. But Jasmin explained that when she was at work, "it is just too busy to actually properly eat". This situation highlights that maximum labour is extracted from the individual, leaving no time for their recovery. Neoliberal rhetoric insists that individuals have autonomy over themselves, when in fact, the timetabling and expectations to see a certain number of patients in a fixed time extracts so much labour from them at such a pace that they are left with no autonomy: they are managed to exhaustion, not by direct scrutiny or a supervisor's observation, but by unrealistic performance expectations. Jasmin must find time in her day to eat, drink water, and go to the toilet regardless of the pressure she faced as a senior training doctor within the department. Whilst Jasmin has a secure job and is on her desired training program, she still felt that she could not resist this pressure because of her precarious position and the broader job market; her continued high level of duress demonstrates that desire to win acceptance into a program is not the only reason for overwork. This feeling may be perceived or actual, but either way, it seems to profoundly affect Jasmin's experience in the medical workforce. Whilst junior doctors perceive that their work-life will improve once they get on to a training program, Jasmin's experience suggests that this outcome is not guaranteed. Here, we see multiple mechanisms for intensifying the work of training doctors, including not just holding out for the prize of admission on to the program but also using other management techniques.

Jason: "I've got the rest of my life to be a doctor."

Throughout the course of my fieldwork, I came across only one junior doctor who had done his internship part-time. Jason was 39 years old, the father of two young children, and partway through his residency when we met. Previously a commercial pilot, Jason decided to study medicine when health issues prevented him from flying. Jason was one of my older participants and had prioritised time with his young family and his children's needs over progressing more quickly through medical training. Based on Sydney's North Shore, Jason found getting through medical school with a young family trying.

Jason is an example of a junior doctor who has moved away from the usual confines or expectations of the medical training system and the examples of his peers by working part-time. He was pleased to do so; however, he felt that it made learning medicine more difficult:

> From a professional point of view, it's a bit of a challenge because, as a junior doctor, you're very much still learning. So, I don't get that repetition and reinforcement as much as my colleagues have. So, professionally, I don't feel like I'm progressing as well as I could be.

Jason alludes to a belief around how one might progress through his or her medical training. He feels that he is not meeting this expectation, albeit a non-specific or unspecified progression goal. Jason entered his internship alongside his colleague, Bonnie, who also wished to work part-time.

The government body which organises internships in NSW hospitals, the Health Education and Training Institute (HETI), requires that those wishing to work part-time submit a joint internship application with another person wanting to do the same. They are then treated as one individual throughout the recruitment process—a true 'job share' scenario. Jason and Bonnie submitted their internship applications together as a 'job-sharing team'. Jason told me that job sharing was uncommon, at least amongst his cohort. So far, his experience of job-sharing had

"worked really well from a home/life point of view". When Bonnie took maternity leave, Jason was allocated more roster-based rotations to avoid leaving medical departments understaffed during his 'week off'.

Jason's experience demonstrates that part-time work during training years can provide a way of prioritising home life alongside his professional career that many of my informants could not attain as full-time doctors. It may help prevent the severe exhaustion that people like Jasmin described. However, this balance can only be achieved when the actual term allocations of the training doctor are suitable for part-time or shared work. For example, before Bonnie's maternity leave, Jason found the part-time job share role difficult when it came to staying abreast of the caseload at work:

> It was fine on terms like the after-hours terms and the emergency department terms where there's no real patient handover.[16] You're just turning up, doing your job, and going home. But on the medical terms, where it really helps to have a good handle on your patients and what's going on with them because their average length of stay is a week or two, that was really difficult. Especially on the [weeks where I worked two days], I could spend a whole day just trying to catch up on what was going on with each of the patients. I had a day tidying up and preparing for the weekend. Never really got that solid handle on what's going on with the patients.

Jason alludes to three issues here. Medicine requires the perception of patterns and changes over time in order to treat a patient in a planned, proactive manner. If Jason was not at work for

[16] On a term like emergency medicine, a junior doctor would start her shift by attending to a new patient waiting in triage. She would not receive a formal handover about a patient who has been on the ward for several days, for example. On some occasions, a junior doctor would take over the care of a patient who was still being treated in a bed in the emergency department. Jason here suggests that part-time work is more suitable to rotations that do not involve a long, formal handover like they would on the ward. Shift work-type roles work better for doctors only working a couple of days per week.

half the week and then spent fifty percent of his work week familiarising himself with the current status of his patients, the limited time he had left was spent in a reactive state. That is, he was performing like a JMO on an after-hours or relief term. My informants overwhelmingly described the main priority of these terms as "keeping the patients alive overnight". So, the junior doctors who cover these terms are rostered on to *react* to the fluctuating conditions of patients on the various wards in the hospital. Continuity of care was not the focus for these roles. If, therefore, learning to be a doctor is partially learning to manage these types of patients, anticipate issues, and notice diagnostic clues that are only apparent when following a patient closely, then a junior doctor like Jason is not training for that type of medicine. Being part-time, in a sense, makes him a permanent relief doctor.

The second problem relates to the continuity of information which I describe as *interrupted information flow*. Reading patient notes keeps the doctor informed only to a certain extent. It does not compare to being on the ward day after day and watching the patient's condition change over time. Doctors in the wards are informed by the verbal interactions with staff and senior doctors, which provides information that is often not recorded in the notes and can approach them for clarification or to test ideas. The discontinuity of care from the attending doctor impacts upon its quality for the patient, but it also inhibits Jason's ability to learn what is required to be an excellent physician.

A lot can happen in a hospital overnight, let alone over several days. Many surgeons, for example, conduct hospital rounds over the weekend even when they are not on call, just to stay abreast of their patients' conditions.[17] So, whilst part-time work might be suitable on a rostered

[17] During a hospital 'round,' the doctor moves from patient to patient, reviewing their condition with the nurse currently on shift and making any necessary changes to their ongoing care.

term[18] like emergency medicine, full-time work is most beneficial for becoming a better doctor in specialities that do not work under a rostering management system, improving the continuity of patient care, and limiting interference in the flow of information.

Both Australians in a broader context and people in the medical profession more specifically often propose working part-time to women (particularly mothers) as a means of both having children and maintaining or further developing their careers. However, as Jason's case study demonstrates, part-time work makes learning medicine more difficult in the internship and residency years. Reduced knowledge during training due to interrupted information flow may have detrimental effects later when a JMO applies for training programs. Junior doctors who are perceived to be behind their peers in level of knowledge could find it more difficult to be accepted on to a program. In Jason's case, he wished to pursue general practice, one of the programs that my informants described as being 'easier to get on to' and often a 'back up plan'. Part-time work may not have such a significant impact on Jason's choice of career path. Yet, a junior doctor with hopes of becoming a surgeon, for example, might find it disadvantageous to work part-time, even if part-time work was the best solution to managing his or her mental health or balancing life at work with a young family.

[18] Some specialties roster clinicians on to specific shifts whilst others work set hours Monday to Friday. When interns and residents are doing a term in the emergency department, for example, they describe this as a 'rostered term' as they are rostered on to shifts. In contrast, a surgical or general medicine term would require working a variation of 8am to 5pm five days per week.

Section B: Collective and Individual Coping Strategies

The Implications of De-Accreditation

In response to allegations of bullying and harassment, several departments across New South Wales had their accreditation suspended from their respective training colleges in 2018. The ABC, the Australian national broadcaster, reported on November 1st, 2018, that the Royal Australasian College of Surgeons had taken accreditation away from the cardiothoracic department at the Royal Prince Alfred Hospital in Randwick, Sydney. Lily Mayers reported for ABC News that this decision came "after Westmead Hospital in Sydney's west was stripped of its intensive care unit training accreditation in September [2018]". The de-accreditation was an attempt to improve relationships between senior surgeons and trainees (Mayers, 2018), and both departments worked to improve the treatment of training doctors so that they could regain their accreditation to have trainees return for the 2020 clinical year. Removing accreditation from a department may be an effective method for bringing about a degree of cultural change.

The colleges play a complex role in the training of junior doctors. Firstly, they act as a sort of advocate for trainees in teaching hospitals. These organisations are not members of the public health system, but due to their authority as accreditors of training within hospitals, they play a significant role within the medical network and hold power over the hospital bureaucracies. Accreditation of a department means that the department can attract training doctors, as these doctors aspire to finish their training in a hospital with good standing in the medical community. The colleges re-accredit departments regularly (the length of accreditation approval differs between specialities) by having a panel assess the delivery of their training program. The panel assesses documentation submitted by the programs and visits the hospital to conduct a set of interviews with all the relevant stakeholders involved in delivering training. If a department fails to meet its standards, it risks losing its accreditation. De-accreditation of a department means that they can no longer employ doctors-in-training and support them through their

specialty program. This prohibition affects the level of specialty care that a department can provide its patients.

The de-accreditation of a department poses two challenges. It requires a top-down approach within the department to effect cultural change whilst also having challenging workforce implications. In most cases, a department is run by senior clinicians. Suppose they face losing the junior staff, who make their work life more manageable. In that case, they are inevitably forced to consider their behaviour and prove that they have made inter-departmental changes to the treatment of junior staff members.

However, taking accreditation away from a department requires leadership from the colleges, which depends upon a relationship between the colleges and the public health service or departments within hospitals. Many of the senior doctors I interviewed and have worked with over the years suggest that negotiating these relationships can be complicated and often cumbersome, as the colleges are independent organisations. The process of de-accreditation is slow. It is not a path anyone wants to pursue; yet, it is the only tool available to affect change and hold senior department leaders accountable. The colleges are stakeholders in the process of training junior doctors and staffing hospitals across the country, but they also have their own boards, CEOs, and councils that have the authority to make decisions independently of government bodies or Local Health Districts. The hospitals or departments are then required to implement these decisions or internal changes after de-accreditation for their training doctors regardless of whether it would make it difficult, or even impossible, to adequately staff the department.

Furthermore, when a hospital loses its accreditation, it loses its ability to employ accredited trainees, which leaves a significant gap in the workforce. A tertiary teaching hospital's emergency department, for example, would typically be staffed with fifteen fully qualified consultants and fifty training registrars (of differing levels). Without these registrars, who make

up the majority of the medical workforce, the department would be required to fill the staffing gap with unaccredited trainees or consultants. Unaccredited trainees can be hard to recruit as accredited training roles are generally better supported, and consultants are expensive, which would place even more strain on already tight budgets. Thus, the lack of accreditation can place pressure on the department both at an administrative and individual level—those left working in the de-accredited department are placed under more pressure.

The issue here is that de-accreditation, or its threat, is a very effective tool for forcing a change to the traditional functioning of the medical system, based on my interviews and discussions with colleagues. Junior doctors are at loggerheads with their seniors, who do not always feel a need for change in medical education. Some senior doctors believe that junior doctors should be put through the same arduous training practices they did during their own medical training. Annabel described a medical tradition of hierarchy and power dynamics in our interview. "I think a lot of the time in medicine," she explained, "you're supposed to just have blood, sweat, and tears to try and get there. And then you can be like bottom of the pile, treated like crap, but you better be grateful that you're there."

She went on to explain the practical implications of a College taking accreditation away from a department:

> There's been more than one time in the last two years or year and a half where they've [the College] threatened to lose accreditation for various faculty because the terms [rotations] just weren't up to standard. It's really comforting to know that you've got like a group of people that say, that's not on. This is the standard that [the Health Education and Training Institute in NSW] requires you to be at.[19] And this is where you're at. So,

[19] The Health Education and Training Institute (HETI) in New South Wales is a pillar of NSW Health which provides additional education and training to pre-vocational and vocational training doctors. They

> you need to fix something, or you won't get an intern or a resident. And that usually whips people into gear.

Without accreditation or if the standards set by organisations like HETI are not met, these departments would rely too heavily on the more senior staff, who cost more to employ, or on more junior staff who require additional supervision; the higher costs means the number of staff working in any one shift may have to be decreased, demanding more of the doctors who already feel pressed to meet the demand for their time. This scenario may also mean that fewer patients can be attended to, which flows on to the hospital or health services overall targets not being met. A College or governing body stepping in to advocate for the education of the junior doctors keeps the faculties or departments within the hospital accountable for the proper treatment of their staff members. This tactic is necessary when the alternative—that is, a bottom-up approach or one that comes from those experiencing the mistreatment—can be much less effective due to the ingrained power imbalance.

The Challenge to 'Change-Makers'

Thomas was a resident in a regional teaching hospital on the South Coast of New South Wales. He lived with his wife and daughter, who was only three weeks old when Thomas and I met for an interview during his paternity leave. Thomas studied medicine as a graduate student after his previous career as an engineer. He described becoming a general practitioner but struck me as having an easy-going, nonchalant approach to achieving his goals. "I should tell you that I only had a ten-year plan for medicine," he explained. "It's good to commit to it for that long to get the full spectrum of what it's like. But I could very easily walk away from it. And knowing that makes

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are not a College but are responsible for the allocation of internships across the state. HETI also are involved in the recruitment of physicians to the Basic Physician Training program, amongst others, and thus have a stake in medical education and training in NSW.

it a lot easier. This month's shit; it's not the rest of my life. It's just ten years." Thomas' attitude and his approach to medicine and life more broadly influenced his resilience during a troubling experience of burnout that he faced in his intern year.

Just the previous year, Thomas had found himself exhausted and on the verge of burnout. He explained to me that during a demanding term, he decided that he needed to take a day off for the sake of his mental health. Thomas took a sick day for mental health purposes and spent the day building a table—one of the many hobbies he enjoys when time permits. He then decided to write a post on Facebook about his 'therapeutic' personal day, which he described to me in our interview:

> I made a table on my day off. I was just like, ah, [and] took a photo of this sweet table. I said, 'I neglected 35 patients or whatever today because I didn't go to work because I just had to have a day off, and this was the best sort of therapy.' I was encouraging my colleagues to take a sick day if they were feeling exhausted because a lot of people weren't. I knew there were a lot of people [in my hospital] who weren't [taking a sick day] who really needed to.

Within hours, Thomas' Facebook post had amassed many views from the broader internet, going 'viral'. He received overwhelming support from friends and colleagues through comments on the Facebook post itself. Within a couple of days, he was contacted by Australian national radio station Triple J for a segment on their *Hack* news program. Thomas explained that even though he de-identified the hospital for which he worked during his Triple J interview, his supervisors found out about both the viral Facebook post and the radio segment. He described being called in to see the district director of medicine at 9am, immediately following a night shift. "[The district director of medicine] basically threatened me and said, 'Your reputation is everything. You're not going to get a job if we give you a black mark,' and all this sort of stuff. And I was like, 'Mate, all wrong. All wrong.'" Thomas decided that he would try to relocate to a

hospital on the North Coast to finish his training—a fair distance from his current workplace. But this move never happened, as his partner became pregnant soon after.

Although the expressions of support on Facebook from friends and colleagues might suggest that the potential for collective action exists, Thomas explained that actually enabling this support can be almost impossible for people who want to change medical education.

> But even when you are, like in emergency, for example, a couple of mates at the same time, you are ships passing in the night. Even if you're on the same shift, you're in different [areas]: you're in sub-acute and acute. So, you don't get that bonding time to actually pick up that they're struggling or not. And that's for people you know well. For people you don't know, it's impossible… So, in terms of talking about it, it's not that people don't want to talk. There's just not opportunities. And there's sort of a social thing that happens like end-of-term parties and the occasional other thing, but the same thing—it's difficult getting continuity of people.

Thomas explains how difficult it can be to support one another, suggesting that it would be complicated for this group of doctors to mobilise themselves to take action. That is, isolating work patterns exist: training doctors often work alone under time pressure with little opportunity to share time together outside of work in order to build the social relations necessary for coordinated action or solidarity. Whilst these junior doctors share the same conditions, they are isolated from one another to the point that it makes it hard for them to mobilise against the disempowering system within which they work.

Thomas' story demonstrates why solidarity does not arise organically and suggests the need for advocacy from an external organisation such as a College threatening de-accreditation and for more overt support from senior clinicians for juniors' wellbeing. The Australian Salaried Medical Officers' Federation (ASMOF) plays a role in this area of trainee advocacy and, in some cases, would be called upon by individuals or groups of training doctors to provide support or

negotiation on their behalf. Whether he meant to or not, Thomas' post drew national attention. He explained that he felt the post and the subsequent support he received from colleagues and friends were poorly received by his supervisors despite not aiming to criticise them personally. But this particular incident demonstrates a trend amongst my interviewees: a lack of workplace support when a junior doctor is struggling and needs it the most. In a sense, the very issue that these junior doctors need to advocate about—that is, being overworked—is also the tool that keeps them subjugated.

The Postgraduate Medical Council of Victoria's *Guide for Interns in Victoria* (PMCV, 2018)—a document written to assist junior doctors—suggests that the individual is obliged to 'not take criticism… too personally', placing emphasis on individual responsibility. Likewise, the changes made in recent years relating to safe working hours show that those with more authority in the field know that the issue of heavy workloads requires attention—particularly if an individual like Thomas feels so exhausted that he needs to use a day of sick leave to recuperate. Again, in marked contrast, the PMCV's advice exposes the hypocrisy of the situation, suggesting that time management techniques might help a junior doctor navigate this pressure, rather than acknowledging the structural violence of unreasonable hours and workload.

Governing bodies and in-hospital administration have focussed significantly on the matter of rostering over recent years in response to the media coverage of junior doctor mistreatment and suicides. Within specific departments, senior physicians or bosses (and perhaps indirectly the colleges) have demanding requirements to enter their programs and stay employed but continue to drive the processes leading to overwork and inappropriate hours.

Personal Management

"Do you feel like work significantly impacts on your ability to enjoy your life outside of work?" I asked Laura, a 29-year-old resident working on the central coast of New South Wales. "Sometimes, yes," she replied. "If you're on a bad term, absolutely! Because you're just anxious all the time." Laura had studied medicine as a postgraduate student after completing a Bachelor of Medical Sciences. She originally grew up in Sydney and returned there whenever she could to visit friends and family. Laura seemed to be highly passionate about medicine, describing her fascination with the human body. "I think this is one of the most amazing things ever," she said in awe.

I asked how she managed the anxiety which she had described, and she laughed. "Alcohol?" she said. "I think most of us have anxiety, anxious depression sort of tendencies," referring to her junior doctor colleagues, "but we don't really talk about it that much." Laura went on to explain that she takes St John's Wort when her anxiety "starts getting off the charts," and she had recently taken up mindfulness exercises, including implementing daily breathing techniques. "It's taken me ages to realise I actually need to do something about it," she shared, "because I don't want to live constantly feeling so stressed and chest tightness and feeling you can't breathe."

This type of Westernised mindfulness was mentioned by several informants and has become increasingly popular in medical education circles. Mindfulness courses or workshops are often scheduled on the program for teaching days in hospital departments, and training colleges promote 'wellbeing initiatives' such as having snacks available in the tearoom or the creation of videos about more senior staff's experiences during their careers. The Australasian College for Emergency Medicine (ACEM), for example, instituted its ACEM Wellbeing Award in 2018 to acknowledge the work of individuals and groups undertaking innovative projects in this space. ACEM's webpage describes the purpose of the award as 'to recognise those members and

trainees who are proactively putting in place a well-thought-through strategy to encourage and promote the physical and mental health of emergency department staff' (Australasian College for Emergency Medicine, 2020, l. 6).

Colleges, departments and in-hospital trainee support organisations encourage mindfulness practice and open discussion as a means of self-protection from the stress that doctors inevitably encounter throughout their working lives. Administrators and leaders within the system recognise the stress that training doctors experience and have tried to implement and develop strategies to help people cope. In doing so, however, they are not addressing the underlying structural issues that have led to the stress in the first place. Whilst it may be difficult for these leaders to individually tackle said structural issues, the problem may also lie in their recognition or identification of the underlying causes of the distress—some of which this project aims to uncover in order to inform future areas of policy development and research.

Mindfulness

The Royal Australasian College of Surgeons publishes a regularly-revised document known as the 'JDocs Framework' (2016). This document provides an outline for junior doctor training within the surgical field. The 'JDocs Framework' describes the junior doctor as an individual in charge of his or her own self-directed learning. The framework 'promotes flexible and self-directed learning' and 'provides guidance for the self-directed, motivated junior doctor considering applying to specialty training programs' (2016, p. 6). Whilst the framework was developed as a guide to junior doctors, within the medical system, these doctors are essentially considered individuals in charge of their own development. Training doctors are responsible for their career trajectories and must do—and often, pay—whatever is required to get on to the training program they choose.

The *Guide for Interns in Victoria* (2018), published by the Postgraduate Medical Council of Victoria, similarly advises young doctors entering their internship year early in the document:

> Many interns feel pressured by their workload. It can be helpful to sort out priorities, practise some basic stress and time management techniques, and talk to your supervisor and other team members about their expectations of you. Do not take criticism from your consultants or registrars too personally; learn from their advice.

This quote explains that the junior doctors themselves are responsible for managing the pressure of their workload. Of course, anyone in a job has a role and responsibility to manage their workload to some extent. However, the intern guide could instead highlight that management and those in charge of the workforce have the power to change this workload to reduce the significant pressure these junior doctors face. This quote is an example of placing the onus of dealing with the pressure of their workload on the individual facing this pressure, rather than the institutions and governing bodies responsible for making change.

The intern guide also advises junior doctors to have a trusted general practitioner they can call on when needed and to maintain good nutrition and have enough rest, exercise and curiosity in outside interests and relationships in order to 'help you retain insight and perspective into your situation' (2018, p. 4). These recommendations imply that the stress experienced by the junior doctor is only perceived stress rather than real stress. The guide suggests that, in a sense, stress can be reduced by changing how the JMO perceives their situation and casts the issue into therapeutic language or personal adjustment rather than helping the trainee to get their workload reduced or change their schedule. The assumption is that the stress these doctors experience is not actually liable for remediation, so any adaptation required must be made at the individual level.

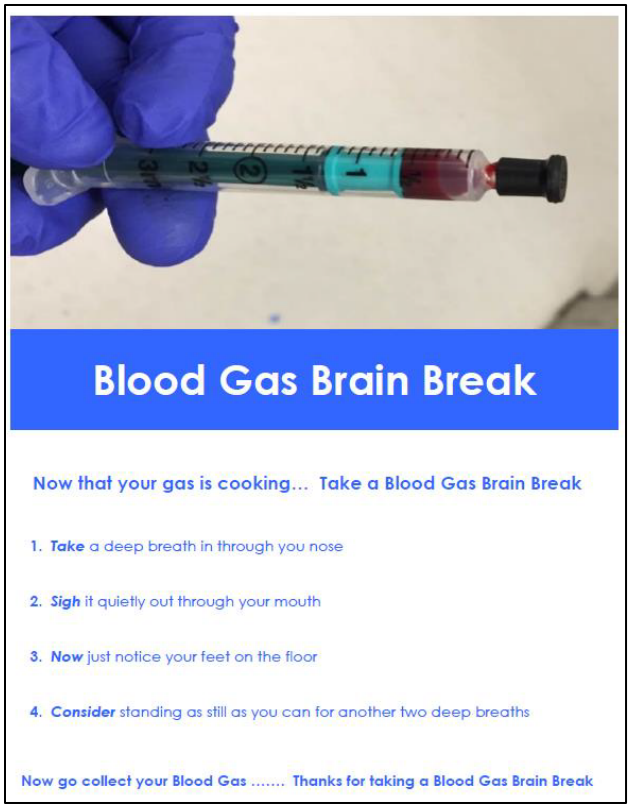
Many of the strategies in the intern guide are reasonable and practical given the circumstances faced by junior doctors in Australia and the conditions in which they find themselves working.

Moving into one's first job out of medical school may seem overwhelming. Practising mindfulness and learning how to effectively manage time are important life skills that my informants described as valuable in their day-to-day lives. The in-action research I conducted for this project included delivering a workshop entitled, 'Balance and Mindfulness in Medicine'. In this workshop, emergency medicine training doctors spent one hour brainstorming strategies around practising 'mindful medicine'—a concept which surgeon, Dr Ronald Epstein, wrote about in his 2017 book, *Attending*. My informants raised handwashing as a way of taking a moment during a hectic shift to focus and re-centre oneself. Handwashing is an essential part of safe medicine, and so, in the words of one workshop participant, "no one can tell you to stop washing your hands". It is a simple action, often done without attention, that can be transformed into a ritual that is particularly amenable to mindfulness. Washing his hands gives this training doctor a moment to himself, to feel the water on his skin and "be present", without a colleague hassling him to chase x-ray results or put a cannula in a patient. This exercise is less about practising mindful medicine and more a form of personal management to control one's actions in order to avoid them having a negative impact on their work. The trainees in these workshops described how taking these moments can help them avoid burnout. That is, they find that washing their hands gives them a moment to recalibrate on an otherwise busy shift, much like a bathroom break would provide space to regroup away from any distractions.

Mindful hand washing also acts as a social strategy or interactional tool to prevent other people from interrupting trainees to demand that they do something else. Hand washing, therefore, is important not just for its potential mindfulness-related effects but also for its social consequences. A practical activity—in this case, handwashing—has been turned into a wellness technique that intensifies the entire situation. Thus, the advice given by the Postgraduate Medical Council of Victoria is neither inaccurate nor unwarranted. It focuses, however, on the responsibility of the junior doctors themselves.

At a 2019 NSW symposium focussed on helping junior doctors to 'thrive' at work, one presenter outlined the strategy recently implemented in their hospital in Queensland. A poster had been hung above the blood gas machine encouraging trainees to take a 'Blood Gas Brain Break' (see Figure 1). That is, whilst the machine was processing the results of the test and the trainee waited for the result, the poster suggested that the doctor perform a short mindfulness meditation activity. Time was not allocated specifically for these seemingly important mindfulness activities, and an individual is also not allowed to take time out of their work to 'be mindful'. Instead, the poster encourages multitasking or overlapping self-care on an unavoidable delay in an otherwise very full day of work.

Mindful hand washing and the 'Blood Gas Brain Break' are examples of activities that hospitals encourage training doctors to do for the sake of 'mental clarity' without removing them from their work environment. The health sector maintains that the trainee is granted time to care for themselves and is given strategies for coping with the stress that they may experience at work, when in fact, these examples imply that the schedule has plenty of time already in it. This secular type of mindfulness has been referred to as 'McMindfulness', which Robert M. Rosenbaum and Barry Magid describe as a 'consumer-oriented, quick-fix approach to meditation' (2016, p. 4). In an article written for The Independent in February 2018, Peter Doran suggests that 'mindfulness is just Buddhism sold to you by neoliberals' (Doran, 2018). Furthermore, Slavoj Žižek contends that the '"Western Buddhist" meditative stance is arguably the most efficient way for us to fully participate in capitalist dynamics while retaining the appearance of mental sanity' (2001, p. 2). That is, mindfulness meditation acts as a commodity in two ways: the first is that it has become big business—a product that sells well to individuals and organisations who are struggling to find a solution to problems of overwork; and secondly, mindfulness is purported as a means of coming across as well enough to continue working and making an economic contribution.



Figures 1 & 2: Blood Gas Brain Break Poster (WRAPEM, 2018) *& Poster in Situ (ibid.)*

The traditionally Buddhist practice of mindfulness meditation has been secularised in the West and implemented strategically into workplaces in an effort to improve the wellbeing of employees (Cullen, 2011; Schmidt, 2016; Shapiro et al., 2012). Islam, Holm, and Karjalainen (2017, p. 2) describe this movement as a 'managerial phenomenon' because of the way it has been employed in business settings. The employment of mindfulness techniques has expanded within the health care community more specifically. Goodman and Schorling (2012), Irving and colleagues (2014), and Martin Asuero and colleagues (2014) researched the effectiveness of mindfulness-based programs for clinicians. Raab (2014) considers the relationship between mindfulness, self-compassion, and empathy to determine how these programs reduce stress among healthcare workers and thus improve patient care. She found that mindfulness initiatives and interventions for those working in the health care sector 'holds promise for reducing

perceived stress and increasing effectiveness of clinical care' (2014, p. 95) which suggests a benefit to both the individual clinician and their patients.

Whilst mindfulness exercises can be applied successfully to relieve individuals of distress, Bodhi (2011) cautions against a simplistic understanding of these practices—an issue that stems from the significant move away from its religious tradition. Mindfulness was introduced in 1979 as a therapeutic discipline when a program focusing on stress reduction was introduced at a medical centre in Massachusetts by John Kabat-Zinn. Since then, Kabat-Zinn has advised the UK government on the implementation of mindfulness into the National Health System (NHS) as it 'has unlimited applicability to almost every healthcare issue – and it's cheap' (Wright, 2013). Price and versatility have made mindfulness practices very attractive to a system feeling financial strain. However, as Wright justly highlights, we have seen a shift since its first introduction in 1979 toward mindfulness being synonymous with 'resilience,' with the following implications:

> This [the shift toward mindfulness being synonymous with resilience] buys into the idea that 'it is all down to you'. Whatever is wrong is the result of your own weaknesses, and with a bit of work you can put it right. So stressed nurses get asked: 'What is wrong with you?', not: 'What is wrong with the circumstances that have made you stressed?' (ibid., p. 27)

Junior doctors are placed in the same situation, again strongly encouraged to take responsibility for themselves without recognition of the role that the intensification of productivity demands and disappearance of many support structures play in this field and without hospitals taking partial responsibility for the distress that these employees face. Additionally, mindfulness is problematic because if it does not work, the claim could be made that the individual doing the mindfulness meditation is not doing it correctly. It is not like medication in the sense that if

taken as prescribed, any lack of therapeutic benefit is not the fault of the user but of the medication itself.

Wright (2013, p. 27) also points out that mindfulness tends to confuse 'non-attachment with detachment,' which resonates with Hochschild's (1983) theory of emotional labour. Wright suggests that 'non-attachment' 'helps [an individual] to be in the world' whilst acting with compassion and avoiding stress and burnout. In contrast, 'detachment' is a defence mechanism used to distance oneself. Non-attachment is a form of deep acting, and detachment a type of surface acting. Mindfulness can be a mechanism to engage more deeply with the world if used correctly, much in the same way that deep acting actually provides individuals with a sense of fulfilment. Yet, if divorced from its Buddhist origins and used as an avoidance tool, mindfulness becomes 'just another way of keeping people quiet instead of questioning and challenging' (Wright, 2013, p. 27).

The Debrief

The Postgraduate Medical Council of Victoria describes the internship year as 'an opportunity to learn in a relatively protected environment' (2018, p. 2), a curious description in that it suggests that the environment in which interns are learning is 'protected,' but not entirely so. All learning occurs at a point of incomplete 'protection' since the learner experiences or understands an idea or concept that they did not previously know before. In a sense, no learning is completely protected. Perhaps a better term here would be 'safe'—that is, the opportunity to learn should take place within a safe environment where the individual's education is not threatened by anything and can be fostered. In their *Guide for Interns in Victoria* (2018), they advise junior doctors embarking on their intern year, advice which many of my informants suggested they would have given their younger selves:

> Most interns find their year enjoyable and satisfying but it will also be intellectually, physically and emotionally challenging at times. It is important to remember you are not alone. There are others around you who have been or are going through similar experiences and it is often helpful to talk to someone you trust… (2018, p. 2)

Lillian, for example, described how she and her partner, another resident, "debriefed" together after their day at work. She said that she found this informal discussion helped her to "move on" at the end of the day. "Some of the stuff you see in hospitals is not that nice," she explained. "So [chatting to Noah] is kind of nice because you can really easily and quickly debrief about your day. And then you can just move on." Lillian was 24 years old when we met and a resident in a hospital on the Central Coast of NSW. She aspired to become a GP and work in a rural centre.

Lillian described a particularly distressing incident during her internship year when an oncology patient "bled out in front of [her]". By "bled out", Lillian means that the patient died due to excess blood loss.

> It happened at 9:30 on a Monday morning. It's a bit of a… It sounds very like a medical person thing to say, but it's an awkward time for a patient to die because 9:30 on a Monday morning, you have 1,000 patients to still see on your ward round. And you have a bunch of consults to make. No one else is stopping around you so you have no time to stop.

On this day, Lillian, two other interns, and a registrar were present when the patient died. The registrar told the three interns to leave and get on with their other jobs whilst she organised the paperwork. Everyone went back to their work, but at 3pm that afternoon, Lillian suggested they come together and discuss what had happened that morning. "Because this is abnormal," she explained. "This isn't something that we should just normalise and run away from." Later that day, Lillian sat down with her colleagues, and together they shared their emotional reactions and feelings about the distressing situation that had occurred that day.

Lillian described this as a "debrief." Yet, she also described several other markedly different scenarios as "debriefs," such as getting together with the other interns over a drink on a Friday evening to discuss their week. Based on my interviews, this "debrief" with other interns or residents seems to play a critical role in the wellbeing of junior doctors. And in addition, they define this sharing of stories as a 'debrief' rather than a normal conversation.

The idea that discussing one's emotions and reflecting in order to bear an upsetting experience, however, is a particularly Western concept, linked to the way that features of psychotherapy have entered broader popular culture through pop psychology. Researchers from Illinois State University, Jeffrey H. Kahn and Angela M. Garrison (2009, p. 573), argue that "individuals who talk about their unpleasant emotions with others enjoy greater wellbeing" than those who do not disclose how they feel. Their research was conducted amongst a group of 831 psychology students in Midwest America, with 85% of participants identifying themselves as "Caucasian" or European American. A significant body of literature on this topic comes out of the United States and Australia, suggesting that these ideas are, in fact, situated in a very recent, Western folk model of psychology.

Two theories are particularly relevant when considering the "debrief" with peers rather than with a senior clinician. The first is what Rimé (1995) outlines as the *theory of social sharing*. That is, individuals in some settings actively seek out other people with whom they can share their emotions after experiencing an upsetting event. The junior doctors I interviewed participate in the type of social sharing that Rimé describes when they meet with friends and "debrief" over drinks.

Perhaps more interestingly is the second theory posited by Stiles (1987). The *fever model of disclosure* likens bringing information to light to an illness in that, just like a temperature is 'both a sign of disease and a curative factor in recovering from disease', vulnerability or self-divulgence is both the display of distress and also a way of healing (Kahn and Garrison 2009, p.

574). Stiles, Shuster and Harrington (1992) demonstrate through their research that, in fact, individuals disclose more when discussing an upsetting event than a happy one. My informants described in-depth discussions about distressing situations they had found themselves in at work and rarely mentioned that they discussed the positive or fulfilling aspects of their work life over drinks on a Friday night. This pattern supports Stiles, Shuster and Harrington's argument. That is, in their catchups with peers, junior doctors spend a disproportionate amount of time "debriefing" or self-disclosing about stressful or upsetting situations they experienced at work. This sharing of tales of the trade also acts as a type of bonding.

Trust is an essential part of an effective debrief—an issue that the Postgraduate Medical Council of Victoria's document highlights. Lillian described how she felt meeting with her hospital's Director of Prevocational Education and Training (DPET) about another upsetting incident:

> I don't know how useful DPET meetings really are: a 15-minute conversation with a consultant you've never really met before. They're very friendly, but if I'm feeling so sad that the world is ending around me, I'm probably not gonna tell this random man that that's how I'm feeling. Especially if they work in the hospital I'm working in and have a bit of power 'cause then you don't want to be like, put on probation because I'm not feeling [great]…

Lillian appreciated the efforts of the DPET, but this particular person—someone in a position of authority with whom Lillian had little rapport—was not an ideal person with whom to share her emotions regarding a distressing incident at work because of their conflicting relationship: sympathetic peer but also potential evaluator. A "debrief" with her peers is a safer forum for self-disclosure, whilst self-concealment often occurs in the presence of a figure of authority (such as the DPET in Lillian's case). Larson, Chastain, and colleagues (2015) describe self-concealment as the active suppression of one's own negative personal information, which has detrimental health effects. Kahn and Hessling (2001, p. 42) suggest that self-disclosure, on the other hand,

has health benefits 'because of the reduction in psychological stress engendered by confronting a previously concealed stressor'. This assessment coincides with how my informants described their experiences of self-disclosure with their intern colleagues.

These authors also point out that considering self-concealment and disclosure as two opposite ends of a spectrum is overly simplified. Instead of seeing these as two opposed qualities, they are alternative facets of an individual, drawn upon in different situations strategically to provide the most benefits in the long term. When "debriefing over drinks on a Friday night", the situation is less about "getting it off [one's] chest" and more about providing a level of self-disclosure that shows the individual in a relatable light to those around them. Coming across as more relatable to one's peers has a positive effect in the workplace, as well as on the individual's career path, and builds camaraderie, solidarity, and interpersonal intimacy. Equally, in the case of self-concealment, junior doctors may find it beneficial for career progression to conceal negative information about themselves (such as emotional reactions to stressful work situations) from someone in a position of authority. Whilst the hierarchy within medicine would make junior doctors feel isolated, sharing their stories with their peers would be a way to bond and signal egalitarianism and solidarity.

Procedures that require junior doctors to share or debrief with an authority figure, or someone who could report their behaviour, seems to be common in Australian medicine. One of the issues here is that disclosing weakness with an individual who has the authority to report a junior doctor or not re-hire her when her contract expires mixes surveillance with pastoral care. Whilst authority figures, like directors of training, might care for their junior doctors, they also have the authority to discipline those individuals if anything came to light that seemed like it might have complicated consequences. This mixing of roles is not unique to medicine, of course; however, the design could be detrimental to training doctors who are struggling with personal issues that, although perceived to impact their practice, may not always do so.

In 2006, the Australian Medical Association (AMA) Council of Doctors in Training released a set of recommendations to junior doctors and the organisations that employ them. These included taking responsibility for one's own physical and psychological health, forming a good relationship with a general practitioner, incorporating strategies to maintain one's wellbeing into their lifestyle (such as exercise, adequate leave, and good relationships with friends and family), and understanding that ill-health may be to the detriment of others, particularly one's patients. Much of this advice is echoed by the Postgraduate Medical Council of Victoria.

On an extensive list of recommendations to organisations, the AMA Council of Doctors in Training endorsed a 'no-blame culture' in medicine so that junior doctors will feel comfortable asking for help without worrying about the impact on their careers. A widely discussed approach to address the high rate of bullying and harassment in the industry, a 'no-blame' approach nevertheless requires significant 'cultural change' across the medical profession and would need to address the hierarchy within medicine. Adopting 'no-blame' as a principle would require a top-down approach because 'blame' is administered by the institution. For a junior doctor to feel comfortable asking for help, she would first need to find her senior approachable and willing to teach. If her senior were to behave in a manner that suggested their disinterest in helping the junior doctor, or if the senior were to berate her for asking for help, the junior would likely feel uncomfortable. A disinterested or rejecting response would reduce the chance that this junior doctor would seek help for other issues in the future. Secondly, and perhaps more importantly, 'blame' in medicine is about seeing anything that goes wrong as potentially disqualifying. Within this Western education model, the higher the stakes, the more rigid and damaging evaluation becomes. Mechanisms are in place not to rehabilitate or help the physicians with issues, but instead, these procedures mean that if an individual admits to how they are feeling or to the problems that they are facing, their career could be impeded or derailed. In saying this, instead of simply being a one-on-one relational issue between a junior doctor and their senior, the key is

that institutionally significant actors who evaluate an individual's performance can be influenced if the individual tries to seek help and support.

In Lillian's situation, her Director of Prevocational Education and Training was very approachable, and Lillian did not describe him as having behaved inappropriately. Yet, she found it uncomfortable to discuss her emotional reactions to incidents at work. This example demonstrates that even in an open, approachable environment, junior doctors find the hierarchy challenging to navigate when it comes to opening up to and trusting in a senior. Even when individuals do their jobs well and are decent people, the structure itself means that Lillian cannot approach her DPET. She not only felt that he was a "random man" whom she had not previously met, but she also feared his authority and its potential implications. The problem here is that the junior doctor does not know how to navigate the medical hierarchy in a system geared to competition for her progression and is thus left unsure of how to talk to someone who will affect her future prospects.

The PMCV document goes on to say:

> Expect that you will have bad days, when you could have difficulty coping. You should expect things to happen that you will not be emotionally prepared for and you could also have days when you feel overwhelmed or irritable. Remember, this happens to everyone. Talk to your friends, family and peers about the good and sad experiences. This can be very therapeutic.

By including this section in the document, the Postgraduate Medical Council of Victoria attempts to normalise the emotional volatility of being a junior doctor and openly acknowledges issues of wellbeing among trainees. Normalising these experiences reduces the fear that these feelings might evoke, defining them as a typical or average scenario experienced by many. So, whilst an ordeal might be particularly unpleasant, junior doctors consider the experience itself okay because many other people encounter a similar situation. Likewise, the language the

authors chose endeavours to make readers feel as though they have been listened to by those with more authority to make a change. The language encourages a sense of camaraderie that junior doctors are not on their own, and someone is always around who has had a similar experience.

However, as is the case in many others in this field, the document encourages the junior doctors to transform their personal relations into support structures. It places the onus on the individual and offers no structural assistance. Yes, other people experience the same thing and talking to friends and family might offer some therapeutic value. But it is not a substitute for therapy, and it is up to the individual junior doctors themselves to reach out and find these people. In some ways, this document says, 'you do not need us to provide support because you should get other people to provide support'. It externalises it as much as it normalises it. Moreover, the document does not advocate action for change. Instead, it suggests that suffering stress and fatigue related to work is an natural component of the intern experience. The responsibility for relieving any stress or fatigue encountered is on the training doctors themselves. While it seeks to destigmatise feelings of anxiety and help junior doctor to seek support, the language also suggests that overwork, self-exploitation, and distress among workers in hospitals are not only ordinary but should be anticipated. In a sense, learning to cope with stress and the unexpected is also part of becoming a doctor.

Conclusion

My informants describe experiences that are consistent with pressures faced in a neoliberal system. Broader trends in education and employment produce a more productive workforce, encouraging people to better themselves, work harder, and contribute more to the workplace. However, this self-improvement agenda requires that training doctors working within the public health sector undergo a level of self-surveillance. They are concerned that they do not have

adequate knowledge to best perform their jobs and are anxious that they will thus be overlooked for an opportunity due to the competitive nature of the industry. This worry, in turn, means the doctors contribute even more at work, thus contributing to their own overwork and exploitation.

These patterns tend to help the Australian health care system, local health districts and hospitals, on the one hand. On the other hand, junior doctors spend years of their lives and thousands of dollars developing their CVs in the hope of being accepted on to a training program. These pressures are often rationalised as they may empower and motivate individuals to accomplish goals they may not have otherwise achieved. As Mia demonstrates, once accepted, they give themselves little credit for this achievement, putting their success down to luck or being in the right place at the right time. They blur the lines between work and life outside of work. They embody the responsibilities of the profession and of the health system, finding it hard challenging to separate their professional identity from any alternative identities developed outside of the medical world. This dilemma has a detrimental effect on their mental health and wellbeing.

Residents like Jason found that working part-time was the best way to balance his work and to spend time with his young family. However, in pursuing his training part-time, Jason felt that he decreased his quality of medical training. Part-time training causes an *interrupted information flow* that could have significant consequences for both the job satisfaction of these young doctors and the quality of patient care which the Australian health care system touts as being its primary goal. So whilst part-time training could be a solution to some of the wellness issues that junior doctors face, it has its own problems, which could have an even more significant flow-on effect on the hospital system.

Training doctors like my participant Jasmin struggle with the *emotional labour* of their work (Hochschild 1983), whilst the colleges and hospitals encourage them to manage this stress through mindfulness practice and debriefing with their colleagues. Adopting mindful activities

such as hand washing may be a practical tool that junior doctors can use to cope in the high-pressure environment in which they find themselves. These practices do little, however, to combat the underlying issues of the neoliberal dilemma. Encouraging practices like handwashing or the "Blood Gas Brain Break" during short periods when an individual is not occupied with another job intensifies labour demands in the workplace and suggests that the individual cannot have a break at all. That is, if the junior doctor is to find herself without a task to complete, she should busy herself with a mindfulness-related activity. She should not take a break, even when she finds herself with 'free time'. The junior doctor may then be left feeling frustrated with her employers' seemingly artificial or tokenistic attempt to encourage rest and mindfulness in the workplace. Micro meditations on the job cannot promote a true sense of rest and relaxation when it feels as though the junior doctor is being forced or simply having it added to an already crowded list of tasks that they are expected to complete.

Finally, Thomas provides an example of an individual who unsuccessfully tried to make change within this structure, which gives the impression that individuals have agency within it whilst undermining action. External organisations that significantly influence the health service—in this case, the colleges who, as well as being key training providers, could also be described as a pressure group—therefore, play an essential role in advocating for training doctors. In doing so, these organisations have the potential to fight for better conditions for training doctors working within the Australian health care system. Several colleges to date have attempted to advocate for their trainees by de-accrediting departments that have mistreated their registrars. Whilst this works in theory, we are yet to see whether the outcome of de-accreditation has any lasting effect.

Individuals, like Anne, are perpetuating their own exploitation. Trainees assist one another in personally dealing with the structures that make their lives difficult—in Anne's case, by organising the 'wellness' day. And in Jason's circumstance, by working part-time in order to cope with both work and life at home. But in doing so, these trainees deflect attention away from

the problems inherent within the structures themselves. Junior doctors thus are training one another and themselves into the idea that the problem and solution lie within the individual. Perhaps this outcome is one of the dangers of peer 'debriefing'. Whilst they might be giving one another feedback during these debrief sessions, it is hard to know whether the support they are giving is effective or accurate. Instead, they may be contributing to the problem by reinforcing some of the key assumptions that have led to these inherent 'cultural' issues. In some respects, mindfulness workshops and debriefing sessions function as hegemonic practices. That is, through ideology, these practices self-propagate so as to become the socio-cultural norm. Gramsci theorised this notion as 'cultural hegemony'—rather than forcing behaviours, cultural hegemony in fact maintains the status quo by way of consent of individuals within the particular institution or social group (Bates, 1975). Here, both the debrief and mindfulness workshops actually normalise stress, self-exploitation, and trauma., perhaps even blinding the rest of the community to what junior doctors are experiencing.

Part Two

Chapter 3: "I am not really an adult. Like, I'm just pretending."

Amy was 25 years old and undertaking a term in the emergency department in her residency year at a western Sydney hospital when we met. Having studied medicine as an undergraduate student with a prestigious university, Amy had spent the first half of her degree in Sydney and her final three years on placement on the north coast of New South Wales, not far from her hometown. Amy had already completed a wide range of rotations during her internship and residency years, including dermatology, neurosurgery, cardiology, and obstetrics and gynaecology. These experiences led Amy to a well-informed conclusion that she would pursue a career in general practice with a focus on sexual health on completion of her residency year. She hoped to one day move back to regional NSW but was planning to stay in Sydney for the immediate future as her partner was also studying medicine in Sydney, with hopes of becoming a urologist, so would need to stay in the city.

Toward the end of our interview, I asked Amy if she would describe herself as an adult. "I guess so?" she said tentatively. "Sometimes you just feel like you're pretending to do all that adult stuff, you know. I feel like I'm still between somehow." Amy shares this predicament with many of her training doctor colleagues. My participants overwhelmingly described themselves as moving through the uncertain period between adolescence and adulthood, having not *quite* reached the latter. Being responsible for their patients is one thing—in this instance, they are regarded as adults, albeit new and perhaps quite inexperienced ones. These young doctors may not feel that they hold enough knowledge to treat their patients; but for the most part, they are regarded by their peers, colleagues and seniors as being able to do so. On the other hand, the training doctors with whom I spoke, like Amy, described themselves as 'pretending' to be adults. They put on the guise of 'adult' whilst at work, in the presence of patients and colleagues. But at home, when they leave work, they feel they are not quite meeting the mark when it comes to what is expected of a 'true' adult. "I mean, I have to do all the adult things, like go to work, and

do your washing, and do your groceries, and that kind of stuff," Amy explained. "But I don't feel like I'm good at it."

So far, I have pointed to two significant issues: the first is that the neoliberalisation of the Australian health care system has had a significant effect on the mental health and wellbeing of junior doctors. That is, each individual doctor is responsible for his or her career progression and wellbeing, regardless of the fact that the individualist education system places significant pressure on these doctors. Even though research to date has tended to focus on what can be done in the workplace to improve the working conditions of junior doctors, few changes with actual flow-on consequences have been successful in relieving trainees of these stressors.

Second, these stressors cause great difficulties when it comes to balancing work with life at home. The conversation surrounding the issues that junior doctors face tends to understate (or, in some cases, ignore) the fact that these young doctors are not *just* doctors. They are also partners, sons, daughters, students, colleagues, friends, tenants, parents and homeowners. These young people, as was the case with generations before them, work in busy, stressful environments with enormous pressures placed on them on any given day. The discussion surrounding the mental health and wellbeing of young doctors tends to attribute their ill-health predominantly to workplace issues. Yet, before they have even arrived at work and again when they leave, these junior doctors and trainees live a life outside of hospitals. And in this life outside of work, these training doctors feel as though they are significantly lagging behind their peers when it comes to reaching adulthood.

This chapter considers the role of emerging adulthood, a developmental stage prior to adulthood that has become increasingly apparent in recent decades, in the lives of my informant training doctors. The chapter contemplates the importance of social interaction and support networks throughout this period and the influence that transitions through medical education have on an individual's progression toward adulthood. My informants raised these issues, amongst others,

when asked whether they would describe themselves as adults. These lived experiences, alongside the literature that both supports and critiques the notion of emerging adulthood, suggest that this demographic group of training doctors find themselves facing a particular host of difficulties such as not feeling financially secure enough to buy their own home or start a family with a long-term partner because of the unstable and precarious nature of this developmental stage.

Emerging Adulthood

Anthony was a 32-year-old resident at a tertiary hospital in metropolitan New South Wales when we met. He originally hailed from New Zealand and had spent some time living in London, England, but was now living close to the hospital with his partner. Anthony was in the middle of a paediatric term when we met, having completed his medical degree as a postgraduate student in Sydney. He enjoyed his work, finding particular satisfaction in "seeing a medical condition, recognising what it is and knowing how to treat it appropriately," but was not yet sure of which specialty he wanted to pursue. "So, at the moment, I'm kind of saying it's either adult medicine, children's medicine, anaesthetics, ICU, ob[stetric]s and gyn[aecology]," he explained, laughing. "I have a really long shortlist." A year as a senior resident, or SRMO, was "on the cards," he said.

Toward the end of the interview, I asked Anthony whether he would describe himself as an adult. "Umm, yes," he said, very hesitantly. "I suppose so." Anthony giggled as he reflected on what being an adult meant to him. "I guess, the opposite would be describing myself as a child, which I don't feel like I would still describe myself as a child." He went on to explain, however, that he found it difficult sometimes "feeling like I still want to adult a little bit more." Anthony wanted to buy a house but felt he could not afford it yet. His partner would like to get a cat, but because they were still renting houses and "being under the kind of, like you're at the mercy of your landlord," the couple could not get a cat. Despite feeling "reasonably adulty," Anthony told

me that he struggled knowing that if his landlords decided to sell the house he was renting, he had no choice but to move out. “I’m still at somebody else’s mercy when it comes to that,” he said. Anthony describes feeling a lack of control of his own life. This particular situation relates to a sense of disorder in life outside of work, placing him in a position of both uncertainty and liminality. This chapter considers these training doctors who find themselves in an in-between space: no longer a child, but not quite an adult.

To gain a better understanding of the lived experiences of training doctors in Australia like Anthony, we must consider the time between adolescence and adulthood. We have seen more broadly the advent of a new life stage in the last twenty years after individuals finish school and before they settle down to start a nuclear family, or rather, between social adolescence and adulthood. In fact, ‘young people are delaying marriage for longer than at any other time in history’ (Settersten & Ray, 2010, p. 77) due to factors like increased participation in higher education, higher debts, and instability in the workforce. Young people who are leaving adolescence behind and moving into the next phase of their lives are commonly referred to as ‘young adults’ or ‘post-adolescents’. Jeffrey Arnett (2000; 2015) coined the term ‘emerging adulthood’ to describe this life stage, which has become more common over the past two decades in a number of societies. Arnett’s (2000) work draws on previous theoretical research in the fields of development, psychology, and cultural studies by Erikson (1968), Levinson (1978), and Keniston (1971). ‘Emerging adulthood’ is culturally constructed, and Arnett suggests that it exists for the most part in the industrialised West where young people are allowed an extended period of independent self-exploration throughout the late-teens and twenties. However, a 2020 edited volume of works by Marcia C. Inhorn and Nancy J. Smith-Hefner cites the existence of ‘waithood’ in cultures globally including the Middle East, North Africa, Niger, Sierra Leone, Rwanda, Uganda and Guatemala (amongst others). The breadth of examples of ‘waithood’ demonstrates that this developmental period is not only a Western phenomenon but one that exists all over the world. It is a time for exploring ‘possible life directions in love, work, and

world-views' (Arnett, 2000, p. 469), and by the time one reaches their early thirties, one has likely 'made life choices that have enduring ramifications' (2000, p. 469).

Johanna Wyn (2004), an Australian researcher in the field, outlines other terms adopted to describe this exact situation. These include 'generation on hold' and 'arrested adulthood' used by Canadian author James Côté (2000), 'post-adolescence' in the United Kingdom, 'over-aged young adults' in the Netherlands, and 'extended transitions' in Canada and Australia (Dwyer & Wyn, 2001). More recently, the term 'waithood' has been more broadly adopted to describe this delay in marriage and child-rearing (Inhorn & Smith-Hefner, 2021). Wyn (2004) suggests that 'these descriptions have in common the assumption that something is amiss; that young people's transitions are faulty' (p. 6). She argues that the extension of adolescence is linked with the idea that these young people have failed to 'grow up in a timely manner'. Wyn and White (1997) maintain that these characteristics stem from an out-of-date perception that young people are unfinished, incomplete or under-cooked—and become complete, and thus cured, on reaching adulthood.

The phrases 'emerging adulthood' and 'extended transitions' are used interchangeably throughout this thesis. These terms imply that the life stage is a liminal period which concurs with the way my informants described their experiences. Developmental theorists including Sheehy (1976) and Keniston (1971) emphasized the in-between or 'liminal' nature of the young adult years. Notably, training doctors play two liminal roles: the first is in the workplace—they are doctors, but they are not *quite* doctors; and the second is the period to which both Sheehy and Keniston refer during emerging adulthood. The extending of transitions is not entirely negative for the individual nor society as a whole. Those who have transitioned through emerging adulthood more slowly may, in fact, arrive at adulthood more ready to overcome adversities they face, having built up greater skills and experience over a longer period.

The literature focuses on adulthood as the end goal of social and psychological maturation; this teleological understanding of development disregards some of the enjoyable and fulfilling aspects of emerging adulthood, such as not yet having responsibility for children and thus the time and capacity for self-exploration. This meaning also, to some extent, ignores later life stages such as retirement or grandparenthood, for example. This focus on the end goal may link with cultural notions of motivation and inspiration explored in Chapter Six and may be a consequence of a high-achieving personality type, which is prominent amongst those who pursue careers in medicine. Greater competition for jobs and a significantly less affordable housing market, amongst other traditional 'adult' goals, are not simply harder to reach but may not be achievable at all in many cases. The lack of certainty as to whether socially defined "adulthood" is attainable could demoralize individuals who might have otherwise appreciated time during which they could embark on a more personal period of self-growth and discovery.

In fact, as Côté (2000) suggests, 'adulthood as we now know it is a cultural artifact' and may be more an ideal than an actual end target (p. 13). Côté argues that most languages globally do not even have a word to express the concept, and the term 'adulthood' did not appear in the *Oxford English Dictionary* until the 1870s. Etymologically speaking, however, the term *adultus* is the past participle of the Latin *adolescere* which means 'to grow up, mature' (Côté 2000, p.13). Its meaning, 'grown', implies that an adult has indeed stopped maturing and thus is a finished product. But as Côté explains,

> the reality experienced by the average person has changed dramatically in the past few centuries because of massive social, economic, and technological transformations that altered the institutional structures of modern societies… people's lives became longer, healthier and less tied to offspring. These developments produced age groupings that grew internally homogenous and externally distinct from one another. (2000, p. 14)

Adulthood is thus perhaps a historic classification. And as Cheryl Merser suggests in her 1987 book, *"Grown Ups": A Generation in Search of Adulthood*, with such an outdated description of this life phase, how do we ourselves define such a period? 'If we can't use the benchmarks of another generation to guide us through the life cycle, what benchmarks will we use instead?' she asks (1987, p. 23). Arnett (2000, p. 496) argues that emerging adulthood results from a set of 'sweeping demographic shifts' including delayed marriage and parenthood to the mid- to late-twenties (or later) and increased participation in higher education. This shift began to occur during the 1980s when Merser herself struggled 'to understand why she and her friends did not feel like adults' (Côté 2000, p. 14). The transition to adulthood from adolescence is not brief, but rather 'a distinct period of the life course,' Arnett argues (2000, p. 469). He initially proposed 'emerging adulthood' as a new phase of development from age 18 through to age 25; however, Arnett (and others) have since extended the life stage through to age 29 as most 25-year-olds in the industrialised West have not moved through this period into the settled or established stage of life that is social 'adulthood'. Or, in Arnett's words: 'Nothing magical happens at age 25 to end [emerging adulthood]' (2015, p. 7). In fact, the end point of emerging adulthood is highly variable, depending on a variety of factors, including educational trajectories, the country of residence, and the group of individuals in question. Age of marriage and parenthood differ widely, and many people do not do one or either.

Training doctors in Australia—a group of highly educated individuals living in industrialised metropolitan or rural and regional areas–may not reach socially defined adulthood until well into their thirties. This demographic group rarely finishes university education until their late twenties and then takes on training positions in Australian hospitals for up to ten years post-graduation. Traditional roles associated with adulthood tend to occur once they are accepted on to a training program and are thus more settled into their careers. This trend means that junior doctors spend a longer time in this period of flux, making the traditional goal of adulthood seem less and less attainable over time.

Emerging Adulthood as a Developmental Stage

Some characteristics are distinctive to emerging adulthood: personality change, cognitive development, both an increased risk of psychopathology and, contradictorily, increased wellbeing, low rates of serious physical disorders, renegotiation of familial relationships, shifting friendships and romantic partnerships, and finally, the transition from school and study to work. All emerging adults do not exhibit all of these characteristics, of course; the very fact that people marry or start families later makes even the choice not to do one of these things provisional until later in life. When describing this developmental stage, I refer specifically to doctors who have both trained and worked in Australia. Junior doctors tend to experience a nonlinear transition from school and study to work. They begin working in Australian hospitals without fully completing their studies, which then continue alongside their in-hospital (or in the case of general practice, in-clinic) work.

Tanner and Arnett (2011) point out that although these characteristics exist predominantly, and perhaps most strikingly, during emerging adulthood, they often begin earlier than the period of emerging adulthood and then continue well into adulthood. This continuation into adulthood may explain why some of my informants described themselves as 'adults' tentatively or with hesitation.

Social Interaction and Support Networks

Hannah, a 25-year-old intern at a suburban hospital near Melbourne, liked the idea of catching up with her girlfriends over dinner on a day off but suggested it was logistically challenging. "Some of my friends live down this way," she said, "so we try and coordinate having dinner, but that's hard because [of] work." Similarly, Sydney-based resident, John, said that, although he tried to see his friends often, he found it difficult particularly since moving from Newcastle to Sydney after graduating from medical school. "I see my friends when I can," he said. "That is difficult, given a lot of my friends stayed around Newcastle… and you just have conflict in

schedules. No one is doing the same thing at the same time, so it is hard to align anything up." Bagwell and colleagues (2005) argue that friendships assist in the psychological adjustment and wellbeing of emerging adults. These relationships are often more important than those with family members. My informants explained that they often struggled to find the time to meet up with their friends due to shift work, which did not align with a traditional working week and the additional study they had to do on top of their shifts at hospitals. John explained that his friends who are not in medicine are usually at work when he has a day off, particularly during the week, as is often the case with shift work. "So, you kind of entertain yourself [instead]," he said. Here, John highlights the isolation that junior doctors and trainees often report facing during their training.

For this reason, the social interactions and support that training doctors receive from their colleagues and peers play an important role in the wellbeing of these emerging adults. Junior doctors without access to these social interactions suffer. In addition, relationships tend to be restricted to the medical world, which in turn socialises trainees and commits them to the competition and norms of the medical hierarchy. Emerging adulthood is also a time when individuals often enter into their first serious romantic relationships (Regan *et al.*, 2004). Until this time, individuals tend to rely on themselves for support and to deal with what several of my informants described as "life admin"—that is, all the jobs outside of work, such as paying bills and rent, cleaning, cooking, doing laundry, and purchasing groceries. These tasks can be shared with a partner or spouse, but when negotiating or moving in and out of romantic relationships, individuals are left to undertake these tasks on their own. This individual burden is thus taken on for longer, with the extension of the time between leaving their parents' homes and settling into a property they have purchased with a partner, an assumption expressed by most of my informants, increasing the doctor's sense of isolation and carrying responsibilities alone.

Marital status and quality, or rather, being in a happy marriage, have also been linked with a reduction in stress and depression and an increase in life satisfaction (Holt-Lunstad et al., 2008). In past generations, training doctors may have completed their training sooner, allowing them to marry or move in with a partner earlier. These doctors of previous generations may have ended up in relationships with a partner (often, the woman) who did not work and thus provided a level of support less common in contemporary social structures where a dual income is accepted as necessary to uphold middle-class financial commitments and lifestyle, particularly in metropolitan areas. Training doctors who delay relationships and marriage to prioritise their work and study are therefore at a disadvantage as they will not benefit from marriage or de-facto relationships as their predecessors may have.[20]

'Extended Transitions'

The school-to-work transition affects an individual's development throughout emerging adulthood. In the United States, for example, the rate of high school completion and graduation with bachelors, associate, and postgraduate degrees has increased significantly over the course of the last century (National Center for Education Statistics, 2010). Understandably, when it takes longer for individuals to enter a stable career, the length of their education begins to impact upon their ability to achieve financial independence. The subjects for this project are a highly educated group who have completed high school, undergraduate, and in many cases, postgraduate education. In many cases, these individuals have completed undergraduate (and doctorate) degrees in other fields before entering medicine. On graduation with their medical degrees, they enter a workforce, often with little previous work experience, despite being in their

[20] I recognise that some training doctors will not ever marry and do not have this as their goal. However, I have chosen to adopt this language as it is consistent with both how my informants described their own experiences and with the other literature around 'emerging adulthood' or 'waithood' (see Arnett, 2000; and Inhorn & Smith-Hefner, 2021).

late twenties or early thirties. Junior doctors are then forced to balance an increasingly stressful work-life with up to ten years of post-graduate study in their chosen specialty. Training doctors are in two liminal phases: the phase of transitioning from student to trainee and trainee to consultant while they move through emerging adulthood to adulthood.

The added challenge for training doctors, however, is that the changes that they experience do not take place in rigid sequence. They do not move from study or school to work in one single shift. Training doctors finish their university-based medical studies and begin working in a hospital as an intern and then resident. Two transitions take place here, both of a linear nature—that is, that one occurs after the other. The first is the shift from student to worker on graduation of medical school. In many cases, my informants suggested that they did not undertake any study during their intern year; rather, they gave themselves the year to focus on getting used to performing the work of clinical medicine. Others, though, finished medical school to begin internships but did not stop studying and thus did not complete a distinct study-to-work move. The second transition takes place between internship and residency. Even those who did not study throughout their intern year began some form of study to contribute to their CV as a resident. They also were required to adapt to the increased responsibility of residency. This transition requires an individual, if they have not already, to find a way of balancing the obligations of work with those of study—a balance that continues throughout the next transitional phase into general practice or specialty training.

Wyn (2004) warns that we must consider the context in which youth transitions occur to avoid misunderstanding these pathways. This approach is particularly important in considering the experience of junior doctors as they do not face rigidly sequential transitions. These shifts between professional roles do not occur one after the other but rather in a more staggered way. Whilst a training doctor is required to complete an exam or set of competencies before progressing to the next level in their career, which does imply a step-by-step path, they must

manage differing and often conflicting tasks and opportunities between these established milestones. Junior doctors, therefore, experience context-specific trajectories toward emerging adulthood, influenced in large part by the individualisation of medical education. Their individual career paths only make sense within the context of their own training routes.

Wyn suggests that individualisation profoundly influenced the developmental pathways of young people over the last thirty years, which is of particular consequence for training doctors. Individualisation, much like the neoliberal dilemma, 'places a person entirely responsible for their own success or failure' (Wyn, 2004, p. 7). Paramount to success, Wyn argues, is personal development—an issue that the training doctors were facing in both their professional and private lives. Personal development implies a process of a growing and changing nature and suggests that if an individual undergoes the required degree of personal development throughout emerging adulthood, he or she will be rewarded by feeling fulfilled with reaching adulthood. The problem here, though, is that 'adulthood' itself is going through a significant transition in the current global economic climate and is no longer an attainable goal for this demographic group. In fact, this transition began in the 1970s and 1980s, when 'a large proportion of Baby Boomers spent their twenties gaining higher education credentials or attempting to establish a career, or both' (Côté 2000, p.15). The concept of 'adulthood' that my informants describe thus echoes that experienced by generations in the first half of the twentieth century. A time when, as Côté suggests, 'the life course was more predictable: people tended to do things more in unison, both in the options they followed and in the timing of them. For example, they tended to marry in their twenties and raise several children in their thirties' (2000, p. 15). So, whilst a whole generation has since experienced a less predictable period of 'adulthood', my informants describe a yearning for simplicity and certainty in their future.

Would you describe yourself as an adult?

Based on their age, the majority of my participants are emerging adults. Understanding how they described themselves was an important analytical tool for this project as it opened up a whole new vocabulary surrounding the definition of both emerging adulthood and full adulthood, allowing for a discussion around the definitive tools for this life stage, over twenty years after the phrase was originally coined. The last question that I asked my participants in our interviews was 'would you describe yourself as an adult?'

"It's so funny," Annabel said, giggling. "I feel like, how old am I, 29? Like, 19 or 9-year-old me would be like, *such* an adult." She exaggerated this comment, emphasizing the word 'such'. "And then I look at myself, and I'm like such a mess. *Not an adult*." As she said this, Annabel tilted her head and looked at me straight in the eyes, giving me the impression that whilst giggling and joking around, she was also being serious. Annabel explained that although she "managed to buy a house and has an adult job," she definitely would not describe herself as an adult. She feels that if she were an "adult," she would have her life "together." In this context, the idea of having one's life "together" refers to attaining a degree of financial and personal (or domestic) order. This aspiration may also include professional goals. An individual who "has their life together", according to Annabel, would know when their bills were coming in, would have a financial plan of sorts, and would not get flustered by issues that arise. "I'm just much more, wait for those things to come to you, then deal with them," she said. "I find it so hard to see myself as an adult." Here, Annabel almost exclusively points to financial management issues being illustrative of 'adultness' and suggests that her perception of adulthood is a neat, chaos-free point that she will arrive at once her current state of "mess" is over.

Arham, a resident at an inner-city hospital in Melbourne, described himself as "feel[ing] more adult" this year than in years gone by. When I asked him, "Would you describe yourself as an adult?" he replied:

> Previously, if you had asked me that question about two years ago, or a year ago, I might have said, "ah, nah." [No.] But this year I've definitely grown up. I'm more independent with myself. I still am very childish, very cheeky… but I think that's part of my personality, and I think it's a part of my charm. And I'm not gonna let go of that, but I do feel more competent. I do feel more capable for looking after myself and looking after other people… feel more adult.

Arham here defines progression to adulthood as becoming more competent and more able to look after himself and those around him. He also discusses child-like psychological qualities with a sense of ambivalence as if he wants to be an adult and to seem capable and competent, but not in a way that means his boyish characteristics are lost.

However, much like Annabel, Arham suggests that based on financial goals not yet realised, he has a way to go before confidently defining himself as an adult:

> I still haven't done the other stuff, like own a house or have stocks or anything like that. Or a significant deposit for a house, or … What other things do adults do? I don't have … I'm not in a long-term relationship. I don't have any kids or anything like that. So, I guess I've still got those things to knock off before I'm 100% an adult.

These goals or barriers associated with successful initiation into adulthood have been described by Tanya Sharon (2016) as 'markers of adulthood,' or MOAs. Sharon argues that MOAs can determine or predict wellbeing in emerging adults. For example, the most important MOAs associated with wellbeing are 'those over which young adults have more control' such as 'relational maturity' (2016, p. 161). 'Relational maturity' in Sharon's work refers particularly to the establishment of equal relationships with one's parents. Arham's description of adulthood aligns closely to a pre-conceived or assumed social image of being a successful member of middle-class society, which highlights in a sense how Sharon's MOAs are actually symptoms of economic accomplishment rather than necessarily predictors of wellbeing.

Interestingly, Amy, the 25-year-old informant who was working as an emergency department resident when we met, compared herself specifically to her own parents when she considered the question of whether she had reached adulthood or not:

> …you think about what your parents did. I think about what my parents did for me, and they were older than me when I was growing up, but you just don't know how they did everything. Maybe they felt the same as this. They just seem to do everything so efficiently and not complain about things. I don't know. They seemed to do a really good job.

Amy measures how 'adult' she feels against what her parents achieved as adults. Here, Amy's MOA relates less to the establishment of an equal relationship with her parents and more to how she regards her parents. Parents act as a type of standard when considering whether an individual has reached the goal of adulthood. Amy is comparing how she feels about herself to her perception of her parents' achievements.

More commonly, during my interviews, participants evaluated their 'relational maturity' relative to their professional relationships. My informants described good relationships with their colleagues, particularly their more senior colleagues, as a marker of professional "adulthood" and often explained that they felt more like adults when at work than at home. This feeling of professional maturity coincided with being respected by their supervisors, which has implications for being socialised into the profession. This signals a level of emotional maturity that doctors develop perhaps prior to their peers in other professions due to the fact that they have witnessed death, dying, and suffering, and treated illness long before others their age, but it also signals again how invested their own identity can become in peer recognition. However, with the increasing age at graduation of medical school, many training doctors may have had these character-building experiences prior to beginning their practice of medicine. This demonstrates the complexity of adulthood, and indeed, of emerging adulthood, and shows that

medicine has, at times, contributed to an advancement in emotional maturity, but at other times, has delayed it.

Tania was 27 years old when we met. She was training to be a paediatrician but was on a period of leave. She described a change in being treated with respect after the birth of her first child; having children was a leading marker of adulthood amongst my informants:

> obviously, time is important for experience and knowledge and respect, like especially, a lot of people before I was pregnant with [my first child], like you could just get a vibe that they were kind of like, 'You don't have kids. You're young. Like, do you know what you're talking about?' So, it's like having a child now has built me more credibility…

The accomplishment of one marker of adulthood that Tania describes leads her to perceive an increase in respect from her colleagues, particularly those in more senior positions, which makes Tania felt more 'adult' in her workplace. In this case, she felt that achieving a level of social 'maturity'–parenthood–translated into professional recognition as more advanced or senior.

Having one's 'life together' implies that an individual has attained specific culturally defined markers of adulthood—a belief that my participants expressed. Both Anthony and Annabel suggest that being in control of one's housing and financial situations fulfils this sense of 'life togetherness,' and Annabel presents being able to manage her emotions as an important characteristic. These features of having one's 'life together' not only align with Sharon's (2016) markers of adulthood, but they also denote an individual being accepted by the broader community as an adult based on the ability to organise the various aspects of their life in a socially acceptable fashion.

Medicine as a second career, and its impact on identity development

Three outlying cases from my interview data demonstrate that going into medicine as a second career provides the junior doctor with an alternative identity that acts as a reservoir of 'resilience'. These individuals still found medical training stressful. They all had their stories of frustration, burnout, requiring mental health days, and an ongoing inability to balance what medicine required of them with other aspects of their lives. The striking difference between Bill, Jason, and Thomas, whose narratives I consider in this section, and their younger colleagues[21] taking on medicine as their first career out of school, however, was that these three people approached the challenges of their work and training with what appeared to be a sense of confidence. If they required assistance, they felt they could seek it unapologetically. If they needed to take a break from medicine, they did not hesitate to do so. And they felt assured in these decisions. Seeking help or making bold decisions did not seem to reflect on their individual identity, thus reducing the emotional fallout of any backlash they may have received.

When I met with these men, their narration of difficult experiences and their outlook toward the future appeared to be bolstered by a sense of calm. Medicine requires having a degree of maturity, and life experience can assist an individual to navigate the challenges and opportunities that arise throughout their medical career. These traits do not make it easier or less stressful, but the individual's prior development of an identity based not entirely on being a doctor, in turn, provides a sort of resiliency that might contribute to longevity in what can otherwise be a difficult career path to pursue. These three informants did not experience the convergence of professional and social indeterminacy, and because they were not also

[21] Age may have also played a role, particularly in Bill's case as he was in his 60s when we spoke; however, Jason and Thomas were not significantly older than my other informants.

confronting the issues of uncertainty around emerging adulthood like other junior doctors, they, in fact, saw the professional precarity as distinct from their identities.

On the surface, being resilient implies one's ability to stay strong and prevail despite any difficulties one might face. A broader psychological literature suggests that resiliency opposes vulnerability.[22] That is, an individual must mask their weaknesses in order to *appear* resilient. Showing up to work every day and doing what one can to deal with the difficulties of the medical system is one aspect of 'being resilient'. 'Being resilient' in this circumstance is more about a performance of resiliency. That is, a JMO must seem to be resilient, regardless of whether they actually are or not, in order to appear strong enough to be a doctor.

In the medical education sector, training doctors have been told to be resilient; in my own work with training doctors, I have been involved in wellbeing-related projects which focus on 'building resilience' in this group. These projects, however, disregard the importance of the role that an individual's own identity plays in motivation maintenance. When issues of resilience become a question of one's ability or integrity, or to imply that an individual must be struggling because she is not strong enough, challenges her whole identity. These three outlying cases demonstrate the importance of non-medical identities. Because they had alternative ambitions, these training doctors mitigate potential crises around ambition depletion, which in turn arms them with an empowering sense of flexibility and strength. Resilience, therefore, is not just a question of emotional toughness, although it is overwhelmingly defined in this manner or even about the appearance of being resilient.

Interestingly, all three of the residents I interviewed for this project doing medicine as their second career pursued general practice as their specialty. Perhaps these men felt calmer and more resilient as they had chosen the least competitive area of practice compared to specialty

[22] See Zolli and Healy, 2012; Brown, 2015; Duckworth, 2016; Sandberg and Grant, 2017.

medicine. Two of the three were working part-time (Bill and Jason), whilst the third was taking some unpaid paternity leave when we spoke (Thomas). They all explained that general practice would take them less time to complete, provide a more flexible lifestyle, and give them greater autonomy to structure their working life. Both Bill and Jason pursued an additional medical-related activity: in Jason's case, he was a trainee in the Australasian College of Aerospace Medicine, whilst Bill was joining the Army Reserves as a doctor (when I followed up with him a year after our interview, he had done so successfully). These pursuits, although still in the medical field, were tied to personal interests and contributed to the development of Jason and Bill's advantageous non-medical identities.

Jason: "[Studying medicine is] set up for a young man in his late 20s… it's not set up for families."

Jason came to study medicine in his mid-thirties after a career as a commercial pilot. Whilst eagerly taking on a new career, Jason continued to pursue his aviation interests and endeavoured to combine his two passions which both made up a significant part of his identity, along with being a husband and father to his two young children. He responded to my question about describing oneself as an adult with a very enthusiastic and resounding 'yes':

> I'm married. I have kids. I have a mortgage. Yeah. I have an accountant. I own a station wagon. I live in the suburbs. I have all the trappings of middle-aged life. I can't just get up and go and do something. My decisions impact multiple other people. I have responsibilities. I have people that I am responsible for.

Jason described himself as 'well and truly an adult'. He points to multiple markers of adulthood which were shared by my informants: marriage, children, owning a home or having a mortgage, and having significant social responsibilities. In the words of other informants, Jason had his life 'together.' The noteworthy difference in Jason's case was that he is still a relatively junior

training doctor for someone his age. At 39 years old, most training doctors are almost at the end of their formal years of medical education, if they have not already completed their training. Jason, however, was a resident when we spoke. He intended to pursue dual training in general practice and aerospace medicine, but as he was working and studying part-time, finishing these programs was still a while away.

During our interview, Jason pointed to friends and colleagues experiencing emerging adulthood whilst also completing their training:

> I look at my friends trying to get on surgical training programs, working unaccredited jobs, sitting their primaries, failing, working unaccredited jobs, sitting their primaries, dah dah dah dah dah, and that's to then get on the seven-year whatever training program where they're then going to get rotated all over.

Jason's language, vocabulary and grammar break down here, echoing the kind of disruption that his friends and colleagues are going through. He describes these friends as being "in that phase of life where [he] was when [he] was applying for medicine." They are relatively mobile with few responsibilities. "They're just chasing the job," he explained. However, he now finds that a significant portion of the registrars he works with are in the next phase of maturation—they are married and either have or are considering having children.[23] "They're in the middle of this training program, and they hate their work-life balance". Whilst Jason here describes individuals who perhaps are no longer emerging adults themselves, he highlights the issue that those studying medicine face: pursuing a career for which the training takes such an extended period does not fit in well with the lengthening of adolescence that is emerging adulthood. "The

[23] Whilst seemingly particularly heteronormative, getting married (or settling down with a partner) and having children were both used as definitive markers of adulthood by my informants regardless of their sexuality.

whole system [is] still set up for the way it was," Jason said, "which is the undergraduate degree, people pop out in their mid-twenties and go from there."

In fact, the Australian model of a generation ago of high school graduates studying undergraduate medicine in their late-teens and early-twenties is far more advantageous to those experiencing the extended transition of emerging adulthood. The requirements of medical training, such as moving between regional and metropolitan areas for rotations in various hospitals, for example, suit individuals with few responsibilities tying them to a specific geographical location. Taking several years to get on to a training program like surgery is not considered to be such a significant obstacle. Those who study undergraduate medicine today may fare better in this regard as they enter the workforce and the years of juggling work, study and life outside of work sooner than the majority of medical school graduates who have undertaken a postgraduate degree like Jason.

Jason compared his training in aviation to the study of medicine:

> There's a lot of similarities in a way, in that a commercial aviation career takes a lot of work to get into. It's a long slow road to get there. But then when you finally get there, life's pretty good.

He said that he would work twelve to fourteen hours a day as a junior pilot. He worked out in the bush for six days a week and earned a salary of only $25,000 a year. The difference Jason has found, however, is the timing of each stage of study. "This overlapped perfectly for the time of my life where I could do that," he explains of his early education in aviation. "Where I was young, single, totally mobile, so I could. Didn't matter that I just worked nonstop because I didn't have a life outside of work." He found that as he progressed in his career, the hours and remuneration improved much like they do in medicine. "I progressed through the industry, ended up flying for Qantas," Jason said. "Yeah, the job at Qantas, like I said, good balance between time at work and time off. It allowed me to do things in my spare time that I liked and

get set up in life." This progression coincided with Jason moving from emerging adulthood into adulthood, as would be the case for many training doctors who study undergraduate medicine. Instead, Jason has faced challenges in medicine, balancing the demands of a young family with those of his job—a balance he suggested is difficult to find unless you are working part-time.

Jason made it very clear in our interview that his previous life experience had put into perspective what he most values in life. This knowledge had led to the decision to work and train part-time whilst also pursuing other personal and professional interests in both aviation and through spending time with his young family. These different roles that Jason played in his life contributed to his varying identities. Whilst he enjoyed medicine and wanted to do well in his training, he also placed significant value on the other aspects that contributed to his identity and so invested in these areas as much as he did medicine. This character investment provided Jason with different identities to fall back on if his medical persona was harmed in any way. That is, if he had an unpleasant encounter with a senior colleague at work, the part of himself associated with work may be bruised, but the other identities in which he has invested will remain intact and can sustain him through this difficult scenario. A junior doctor who has not invested energy into the development of non-medical identities may find that the same negative interaction causes more damage to how they see themselves and their contribution to society. In this regard, having multiple ways of categorising or viewing oneself may act as a form of 'resilience' similar to that which wellbeing programs attempt to impart to training doctors.

Erikson's lifespan theory (1950) suggests that those aged 19 to 34, or thereabouts, are 'universally oriented to the resolution of self in relation to others (intimacy) and society (via work)' (Tanner & Arnett, 2011, p. 13). Young doctors tend to study medicine during the development of their individual identities. As medicine takes up such a significant portion of one's focus during this time, often leaving other interests aside, these individuals may find themselves developing a sense of self that is oriented predominantly toward the medical career

and community. That is, as Erikson argues, the self adapts relative to and heavily influenced by others, meaning that potential alternative identities which may otherwise provide a degree of strength are not always explored or developed.

Bill: "I can tell you that doing medicine at this stage of my life, I have a completely different attitude."

I interviewed Bill early in the fieldwork for this project. Bill was a recent medical school graduate in his early 60s, and thus, of interest when considering how life stages influence doctor training. He had pursued a career in medicine after being made redundant from his previous profession as an actuary during the Global Financial Crisis. Bill was well established as a social adult when he entered medical training but was moving through his own life transition post-redundancy. These experiences seemed to give him a different perspective:

> It's my life experience: The fact that it's a second career. The fact that I've had savings put away, and I don't have to worry about getting into the highest paying specialty or even a mid-paying specialty and that sort of stuff. So, in that sense, I'm completely atypical.

Bill suggests that he felt that having money to support him throughout his medical training alleviated the pressure of having to earn an income at all, let alone one that was more lucrative. In this, he identified finance-related problems for other students as one of the major issues that arose due to both the increased uptake of postgraduate medical degrees and emerging adulthood. An individual who completes an undergraduate degree and then continues into postgraduate medicine is more likely to be reaching their mid- to late-twenties by the time they complete their university studies and enter the medical workforce. They have had little opportunity to put away money as savings. Often, they enter the workforce when they hope to 'settle down' with a partner or to start a family but find themselves with limited savings to fund

these endeavours. This situation places added pressure on the individual either to enter their specialty sooner or to take on well-paid locum positions, which inevitably delay their admission to a training program.

"I can do stuff… without being worried I'm not getting paid for it," Bill explained. "But it also gives me this other perspective of the craziness." His life experience provided an alternative standpoint and placed him in a more established position both personally and financially to enter this demanding industry. "Yeah, it's a tough road being a JMO," he said. "For them, I think there's this pressure to do this other stuff[24] over and above their nine-to-five, which is not a nine-to-five job." Bill observes his younger colleagues struggling through the challenging medical pathway and empathised with them, but he told me that he did not actually feel this burden for several reasons: he is working part-time; medicine is his second career; and he does not feel the need to pursue what he described as a 'prestigious specialty' like orthopaedics. He, therefore, does not feel pressure to "do any research or turn up to extracurricular activities that [he does] not want to." His perspective highlights that, instead of the stress or demands coming solely from the job itself, junior doctors find that much of their excess stress comes from all the additional activities they feel they must pursue in order to remain competitive with their peers for admission into specialist programs.

Bill explicitly recognised that, for the other students, being within the developmental stage of emerging adulthood makes this period difficult to navigate without feeling immense pressure—particularly if it takes some time to get on to and then through one's specialty training. "Then, if you don't get on the program," Bill pondered, "how long are you going to hang in there?" When

[24] The "other stuff" to which Bill refers here may include extracurricular activities for CV development such as additional degrees, philanthropic work, and staying back at work after hours to attend an operating list. For example, to make oneself known amongst the surgical team or to those who are involved in recruiting future registrars.

Bill was a medical student, he met an orthopaedic registrar whom he admired. But it took this registrar seven years to get into orthopaedic training. “So, can you imagine, will I get in?” he explained. “You’re five years in. You’re still doing unaccredited jobs… and you’re applying every year, and you’re not getting on the program. And you’re thinking, you know, will I ever get in, and shall I pull the plug?” Bill raises a different stressor here: rather than just failing, the junior doctor must decide whether they will accept that failure as definitive or not.

Bill described this uncertainty and delay as “soul-destroying”. He indicates that the lengthy, uncertain process is what drove him to prefer general practice training. “This is the shortest training program, and it’s the easiest to get in because it’s the most number of training places,” Bill told me. He liked that general practice allows for part-time training—a more “relaxed” approach that suited his stage of life. He also liked that general practice allows an individual to fashion his or her work around their interests.

Thomas: “The more you can know in this world, the better, right?”

Thomas is the last of the three informants I interviewed who had studied medicine as a second career and is thus a curious case when considering how emerging adulthood and medicine overlap and intertwine. Thomas explained that he had moved into medicine from engineering as he “didn’t want to be sitting in front of a computer [his] whole life.” He had been inspired to pursue medicine whilst working in medical product design, where he was fortunate enough to see a surgical procedure. “[I] went in to see a surgery,” he described, “and it was just amazing!” After studying medicine as a post-graduate student, Thomas was thirty-three years old and in his residency year when we met. He described residency as “a lot better than internship”. He was also on paternity leave after the birth of his first child. Having a child helped him settle on his decision to pursue general practice, predominantly for the short length of the program and the flexibility a career in general practice would allow—similar to the shared by both Jason and

Bill. Thomas also explained that doing general practice training meant he would not need to relocate to complete terms and could "stay in the same house, practically the whole time."

Thomas pointed to two markers of adulthood that played a role in deciding which specialty to pursue. The first was having children, which my informants overwhelmingly identified as a milestone that makes an individual an 'adult'. The second was the desire for a steady home environment. As Thomas insisted, "not moving is really important, especially with a family." My informants often showed concern that many years working as an unaccredited registrar and lengthy specialist training programs made it difficult to find stable accommodation, whether that meant buying a home—another frequently noted marker of adulthood—or simply renting a home for an extended period without having to uproot and move for training terms or short-term contracts.

When I asked Thomas whether he would describe himself as an adult, he immediately responded by saying "yeah". He followed by clarifying that he felt like an adult because he paid his bills on time. I asked if he felt he was not an adult *until* he paid his bills on time, and he agreed but added that having a child also made him an adult. After another moment of thought, Thomas said that he did not feel anybody is ever really an adult.

> I think working is an unnatural state of existence. Maybe being an adult is where you lose your childhood liveliness and get constrained by financial and societal bonds into the mundanity of work. That's how I feel about it. So med school, doing it late was deferring that, but you know, there's always ways to defer it until you have to retire.

Later in the interview, Thomas re-considered his position on being an adult. He suggested that perhaps once he finished his general practice training and qualified, he would then "be a full adult, because then you actually have freedom and flexibility," Thomas explained. "Up until finishing your specialty, you don't have choices. [As an intern,] you're called a junior. It's like, 'screw that, I'm 33.' Some of the bosses are younger than you, certainly the registrars."

Thomas added that bullying in the emergency department he had worked in did not affect him as much as it may have his colleagues. “Being older,” he said, “it’s like, ‘no, that is not acceptable behaviour’ as a human to a human.” He said that he felt his age and life experience had taught him not to tolerate this behaviour. Thomas also clarified that he had set himself a ten-year plan for medicine. “I said I’d give it ten years and see what it’s like. It’s good to commit to it for that long to get the full spectrum of what it’s like. But I could very easily walk away from it.” Thomas believed that knowing he could leave made the challenges he faced at work as a junior doctor easier to manage. “This month’s shit. It’s not the rest of my life. It’s just ten years.”

Two aspects of Thomas’ perspective stand out here. The first is that his ten-year plan sets him and his young family up with a level of expectations of medicine that help him, and probably also his wife, to manage feelings toward his day-to-day life at work and aspects of his personal life. The second factor that seems to affect Thomas’ attitude is that, like both Bill and Jason, he came into medicine with previous experiences to draw on, particularly in more difficult situations. Thomas’ entire sense of self is not composed of his medical identity, which means that when he faces challenging encounters at work, he does not feel like his entire social person is at stake—just one facet of who he is. He can still go home to spend time with his wife and daughter. He can focus on his other interests, such as making a table to help him get through a period of burnout. Having multiple facets to his sense of self, multiple social identities endowed by various aspects of his life, provides Thomas with a greater sense of empowerment and, thus, resilience. One part of resilience, therefore, lies in the preservation of a meaningful social identity or multiple social roles.

Conclusion

Emerging adulthood occurs for those within the affluent middle class who benefits from the time period’s apparent luxuries—the familial or parental support both financially and

emotionally to take an extended period to study and to decide their career path. Individuals progressing through emerging adulthood, however, face difficulties themselves associated with the increased stress of financial and relationship instability. Additionally, we must acknowledge that each individual's experience will likely 'vary by cultural context, educational attainment, and social class' (Arnett et al., 2011), which is why Wyn's (2016) warning to consider the context of extended transitions is so important.

Kloep and Hendry (2011), amongst others, have argued that emerging adulthood is a period of self-exploration available only to middle-class groups who go to university and have the financial support of their parents, which allows them freedom throughout these years. Both Tanner and Arnett (2011) have argued that emerging adulthood includes individuals 'with a variety of educational levels, not just [university] students' and Inhorn and Smith-Hefner (2021) support this assertion, citing the existence of 'waithood' on a global scale. Certainly, emerging adulthood is relevant to training doctors who are well-educated, middle-class individuals living in the industrialised West. Goldscheider and Goldscheider (1999) argue that middle-class emerging adults live in a state of 'semiautonomy'. They have more autonomy than adolescents, but not as much as they will have once they reach adulthood. 'Their semiautonomy is emblematic of their in-between state as emerging adults on the way to adulthood but not there yet.'

In this sense, emerging adults often still live at home, and older individuals such as their parents take care of 'adult' things, such as preparing meals, paying utility bills, and cleaning the house. For the junior doctors I interviewed, some lived at home during their years of study at university with their parents contributing to some or all of these tasks; on moving into internship and residency, many became more independent, living alone or with flatmates and looking after themselves. Yet, their living arrangements alone did not determine their categorisation as

individuals experiencing this period of extended transition. And to describe these individuals in this way limits our understanding of their lived experiences.

Jason, Bill and Thomas provide examples of how undertaking medicine as a second profession may impact on their identity development and thus how they cope with the inevitable challenges of a medical career. Resilience arises in part from having a social role that is immune from whatever threat one is facing. If your social role as a doctor is threatened by failure or criticism, then one source of resilience is having another, not-at-risk and highly valued identity. For example, whilst an individual may be struggling to get on to a specialist training program, they are still a parent with loving children or a partner to someone who cares about them. They find fulfilment in various aspects of life, which provides a sense of strength.

These three cases also highlight the role that general practice may play in dealing with issues of junior doctor wellbeing. My informants overwhelmingly suggested that they went into medical school or internship with hopes of pursuing specialty training. Those who ended up pursuing general practice, in most cases, did so as their backup plan. This inclination may exist for a variety of reasons, but it would largely be due to the fact that specialists earn a higher income than generalists and are viewed as being of a higher social status. However, the reality is that more training places and jobs exist in general practice than in specialty training. And because specialty training is so competitive and coveted, it attracts a group of high-achieving junior doctors—which, in actuality, describes most individuals who pursue a career in medicine—so those who end up in general practice are often the lower-achieving individuals of the demographic.

Whilst Jason, Bill and Thomas emphasize some of the benefits from a lifestyle perspective that general practice may provide, the promise of a specific lifestyle may not be enough to encourage more junior doctors to find their passion in general medicine. The assurance of a better lifestyle, in turn, will not solve the problem of heightened competition in specialty training, which

inevitably extends training and leaves trainees in more precarious roles for longer. Additionally, as many of my informants demonstrate, general practice is often considered to be an option to fall back on if the plan to get into specialty training fails, which contributes to the way that training doctors and society as a whole view generalists.

Finally, my informants expressed a view that individuals their age who had not pursued a career in medicine were living a somewhat conventional 'adulthood' to which they therefore aspired. And the reality of whether their counterparts in other professions had made it to adulthood or not was less important than the fact that the perception made my informants feel inadequate. They felt a sense of pressure which stems from an image of what they think they should have by a certain age, and they described feeling held back from their imagined alternative. This social comparison causes stress in and of itself as these junior doctors juxtapose their position to vague impressions of what their other self might have been. In a sense, emerging adulthood or a delayed transition to a perceived adulthood creates an excuse for what my informants see as a messy or chaotic time in their lives. And it helps them to cope with the disappointment that their preconceived cultural image of an idealised adulthood might not actually exist.

Chapter 4: "I have to become comfortable with uncertainty."

At the time of our interview, Jenny was a 27-year-old resident-level doctor at a major metropolitan hospital in New South Wales. She undertook her medical studies as a postgraduate student after completing her undergraduate degree in science and psychology, followed by a master's degree in public health. Jenny was interested in pursuing a career in either surgery or radiology but had not yet decided. She was the president of her local Resident Medical Officer Association (RMOA), a role she enjoyed especially because of its social aspects.[25] When we met for her interview, Jenny was on a vascular surgery rotation. "It's a surgical term, a little bit radiology focused, which is a pretty good balance," she explained. "It's not particularly busy… you can leave most days on time if you want." Jenny mentioned several times throughout our interview that the specifics of her job were not particularly difficult. "There's few truly stressful medical situations because we're in such a big hospital," she said. "Someone more senior will come along in about 30 seconds, and regardless, you know what to do. We're well trained." Jenny suggested that the most stressful aspect of work was uncertainty around her career.

> The true hard part about being a junior doctor [is] the uncertainty, and the job uncertainty… the uncertainty of a career. I think it's more, it's really hard to work hard when you don't have any sort of certainty. And also, the whole system can be so nebulous, and yeah… It's just sort of a bit, it's all up in the air.

This chapter considers the role of uncertainty in the lives of junior doctors and how a lack of assurance intersects with emerging adulthood. Informants' expectations of medicine as a career are explored to inform a discussion around both if and how these expectations contribute to the

[25] RMOAs tend to organise events for interns and residents, with more senior doctors joining from time-to-time. They organise dinners, drinks, and sporting activities, and undertake advocacy work on behalf of junior doctors.

distress induced by feelings of uncertainty. Uncertainty does, in fact, contribute to an individual's capacity to persist with an already demanding career, I will argue.

A sense of uncertainty permeates global economic and political discourse. The Global Uncertainty Index[26], a measure of unpredictability in over 20 countries, reached a record high in December 2018, approximately one year into this project. The COVID-19 epidemic took hold during the writing of this chapter with significant impact on global uncertainty, and I note that this period of insecurity undoubtedly influenced the analysis of my informants' experiences.

Most of my interviewees expressed clear feelings of uncertainty about both their medical training and their personal lives. Junior doctors largely know what will be involved in pursuing their specialty, but along the way, they are faced with ambiguities that make it difficult to stay focused on the end result. Within the cohort of junior doctors interviewed in this study, uncertainty arose from four sources. The first area of concern was if and when they might gain entry into the training program that they preferred. This incapacity to plan especially affected those who pursue the most competitive programs, such as surgery and dermatology. The second anxiety that training doctors experienced was the specific requirements needed to get on to training programs. My informants listed a variety of courses, exams, extracurricular activities, and philanthropic pursuits, amongst other things, which they felt were needed to even qualify for such training programs. There seemed to be little consensus among them, however, about the precise requirements for each program; the standards or criteria for selection were not transparent. These junior doctors endeavoured to respond to a set of requirements, or in their words, "tick a set of boxes," not clearly defined. They engaged in as many activities as they could, hoping they would achieve sufficiently against an opaque standard without really knowing

[26] Economic policy researchers developed the Global Uncertainty Index in 2016 (Baker et al., 2016). This index is a measure of unpredictability in over 20 countries and is based on the number of times newspapers within these countries cite the terms *uncertain* and *uncertainty* regarding economic policy. This measurement shows how uncertain people feel toward particular significant political or economic events, such as 9/11 or the ousting of Australian prime minister Kevin Rudd by Julia Gillard.

exactly what they needed to do to gain admission. Third, my informants expressed a feeling of indeterminacy about how long their training would take to complete and whether they could pursue interests in their personal lives. The uncertainty here usually manifested as a fear of not being able to afford to buy a home or worry about whether they may be able to have a family and pursue a medical career at the same time. My informants explained that the geographical instability that comes with medical training contributes to their concern around the pursuit of other personal interests. Last, trainees described a type of nervousness when working night shifts. Several informants indicated that they felt the greatest stress leading up to night shifts, as senior support was not as consistent as during the day, and the case load was unpredictable. These junior doctors felt particularly unsure about how the shift would unfold and whether they would be able to perform as required. Hospital staff and services were often limited during after-hours shifts, which made treatment and diagnosis difficult. My informants described focusing on "keeping the patient alive" whilst on night shifts rather than actually performing procedures or doctoring as they would during the day when they had more support from their senior colleagues. In Jenny's view, the tenuous structural components within the hospital system exacerbated her feelings of uncertainty.

Finding Certainty in the Unknown

Arham described his anxiousness surrounding his desire to get on to surgical training and when this might occur. "That's what I'm really worried about," he said. "I can do all the right courses. I can do all the right rotations, but I still might not get in." Arham explained that he was on a pre-surgical training program, but this did not guarantee that he would get on to surgery. He also worried that even if he did get on to surgical training, he might have trouble completing the program. "My technical skills still need a lot of work. So that's what I'm worried about," he shared. "Like even if I do manage [to get in], what if I'm technically not that great?" Arham

highlights here the different layers of doubt vexing junior doctors.

Walking the tightrope

Annabel explained the steps involved in pursuing a career as a surgeon. “They want you to be a perfect human before they accept you” into the training program. “What do they want?” she mused. This language may suggest that whilst the College might aim to be a nurturing, educational institution, it perhaps inadvertently alienates those trying to join in an attempt to differentiate between those who have potential in the field and those who do not.

Annabel outlined that the surgical college seeks doctors still junior in their career but who have their sights firmly focused on their professional future. That is, the junior doctor needs to demonstrate a level of ambition and planning around how they might achieve the goal of becoming a surgeon. The College favour individuals who are technically excellent, but Annabel points out how difficult it can be to get this level of surgical skills training during internship and residency as the system demands that trainees in these positions work “effectively as a… clerk, because you’re doing most of the paperwork and the management of day-to-day things.” The College wants someone with intelligence, sound medical knowledge (“which makes sense,” Annabel admitted), and scholarly ambition. The individual is expected to have published research recently. Conference presentations and posters are important but should have been completed within the last five years. “So, forget it if you’ve done something before,” Annabel noted despairingly.

The applicant should also teach regularly, “so, not just to do a random tut[orial] here or there, but like x number of hours per year or per whatever.” On top of these extracurricular activities, Annabel explained that the College wants candidates to be sanguine and have achieved work-life balance. “Which is a myth,” she said, “but you have to pretend that’s what you’re really good at.” Medical schools and some training colleges have implemented personality testing in an attempt

to narrow down their searches to individuals most appropriate to a career in medicine and, more specifically, which medical specialty. How one might go about demonstrating an appreciation for work-life balance aside from outlining extra-curricular activities and hobbies is ambiguous and adds to the uncertainty. Presumably, and perhaps what is more of a concern, is that these tests could also be a tool for discrimination against people with mental health issues. The process is opaque and highly competitive in its nature, and so candidates do more and more to try to be successful in their chosen field. But, at the same time, the Colleges want individuals with a good 'work-life balance'; yet their own processes make this endeavour near-impossible. So, the doctors that the Colleges are actually looking for are those who do not show strain despite being put under significant pressure from the organisation itself.

Playing the game

Once applicants have demonstrated the desirable traits, they have to sit a general sciences exam which has a fee associated with it. In 2021, the General Surgical Sciences Exam (GSSE) run by the Royal Australasian College of Surgeons cost between $4,230 and $4,650 depending on whether the applicant has completed prevocational surgical training as a SET trainee. "A lot of people I know have done it more than once," Annabel confided. "You can't get a position as a [surgical] trainee with RACS [Royal Australasian College of Surgeons] until you've completed [the exam]. Like you're pretty lucky if you only have to pay for it once. I know people who have done it like three times." Annabel alluded to the significant cost of sitting, let alone re-sitting this entry exam multiple times, despite even a high score providing no guarantee that the individual will be admitted on to a training program. This cost and the uncertainty about the number of times one has to sit the exam are concerns that multiply when considering the marked ambiguity that persists around the attainment of an ideal curriculum vitae. Annabel said:

> My CV has a lot of courses, subjects, scholarships, things that I've been involved in. But none of that counts. None of that counts. Really. You have to have really specific things. So, I haven't done any research… my biggest weakness by far is that I have no research… experience.

Annabel expresses a strong sense of self-doubt here. The aspects of her CV that she says do not "count" more than likely *do* count. Instead, this language demonstrates that Annabel feels that nothing she has already done makes her feel confident in her application or abilities. She can only focus on what she perceives as weaknesses in her CV.

In contrast to her own experience, Annabel described a colleague with whom she had worked during a plastic surgery term at a metropolitan hospital in Sydney. This colleague was "PGY8"—"postgraduate year eight" —so he had been out of medical school for eight years. "His salary has reached its absolute cap," Annabel explained. "He's been working longer than a lot of the registrars have in other areas." Not taking into consideration any other reasons, despite these eight years of work and research, Annabel's colleague had still not gained admission on to the plastic surgery training program. So even though Annabel told me she felt that research was missing from her own CV, her colleague's experience suggests that this fact alone would not relieve Annabel's feelings of uncertainty about her entry on to the program. Here, Annabel refers to others' experiences to underline or highlight her own uncertainty around this process. It is not enough for her to talk only about herself—she must point out other examples. Whether these examples are true or not is less significant than the way that they reveal her anxiety. Annabel feels that she needs to draw on more examples because her own single experience is not sufficient to explain the extreme level of her fear.

"It's pretty intense," Annabel said. "You have to have your fingers in a lot of pies. I've never been good at playing the game. And it's a game." She suggests here that Annabel is indeed *in* the game. She feels that she needs to play the game, even though she may not be "good" at playing

it. “Playing a game” implies constructing strategic moves to progress through or that the admissions process is a distinctive activity, separate from doing well as a junior doctor, with its own rules and logic. And the game metaphor also suggests that not everyone will win in the end. Perhaps this metaphor explains why Annabel compared her own experience with that of her colleague. That is, the “game” threatens any faith or confidence that Annabel has in her own abilities. This comparison also deepens her own individual level of insecurity. The uncertainty in this sense feeds on itself. The process is opaque; yet in many ways, it pits each individual against the others, encouraging comparison and thus promoting the underlying sense of doubt in one’s abilities, undermining the confidence of the junior doctors.

These feelings of uncertainty persist well beyond medical training and acceptance on to a program; Annabel described the next stage, after a candidate’s CV meets the vague and unarticulated requirements. “So, you get offered an interview,” she explained. “And if you pass the interview, you're on the program. And then when you're on the program, it's like you've only just really got your foot in the door again. Because then you're a junior accredited registrar.”

Annabel indicated that a junior accredited registrar might remain at that level for up to six years before progressing into a senior registrar position. Based on her knowledge of the program and what she heard from colleagues, she felt that the insecurity might be reduced, despite the program taking a long time to complete: “I think once you're in, it's okay,” she explained. Annabel did not characterise this time as more relaxed, though, making a point of saying, “So it's a bit more, not chill, but… I don’t think it’s that easy to get kicked off.” The mention of being “kicked off” is similar to the concern Arham showed about whether he would be strong enough to finish surgical training. Even though Annabel expressed less concern about being on the program, she still alluded to an underlying worry that being on the program would not necessarily mean an end to the indefiniteness or finding a sense of job security.

Having acknowledged these concerns, Annabel went on to explain how strongly she feels that the focus should be on the process itself rather than getting to the end of training.

> It's almost like wanting to be a CEO of a company from the very beginning. You've got to work your way up to the top. And a lot of people see it as you haven't finished your goal. Mostly because the other training programs are much shorter, and you become a fellow much quicker. Which is okay because you haven't cut into somebody's thorax and have their heart in your hands, literally... It's not about finishing, it's about the journey to get there.

The perspective that time is required to develop the skills to be a good surgeon provides a kind of comfort by endowing the process itself with significance. In knowing you must complete a lengthy period of apprenticeship to develop the skills necessary to conduct high-risk procedures, the timeframe feels less pressured and more reasonable. This expenditure of time requirement actually produces many degrees or stages in confidence as one ascends in expertise and responsibility. The process means that admission on to a training program is not a single gateway but a staged initiation with demands to prove one’s increasing confidence and competence at each stage.

The goal is simultaneously immediate (that is, to get into a program) but also so remote that it is difficult to imagine arriving there. Annabel explained:

> The whole way through, you're already working in surgery. You're learning those skills; you're gaining those skills. And, in reality, you [the patient] don't really want a surgeon who's only worked for five or six years. You [the training doctor] don't know anything when you finish med school. Everything you learn practically is when you start your job. And you need that time to accrue just on experience, let alone knowledge. But seeing the different types of presentations, the way things go south, the way people can turn it

> around in theatre when the patient's compromised, you need time to do that. There's no rush. If you want to rush through and finish, that's dangerous.

Even toward the end of training, performance anxiety continued in the form of worry over successfully completing fellowship exams or requirements. Annabel explained that once aspiring surgeons, for example, have finished their training, they are then required to sit additional exit exams.

"When you finish [the exit exams], you become a fellow of the College," Annabel explained, "which is awesome. But it doesn't mean that you have a job as a surgeon."

> So, then you start again as a junior, and you're somebody who might be employed on a six-month contract for a hospital, working in a hospital. Maybe it gets extended to twelve months; then maybe it gets renewed every twelve months. But you don't have that kind of certainty that that's where you're going to work for a long time.

Annabel demonstrates the lengthiness of this process and the many hurdles encountered along the way. She also points to an ambiguity that exists across many specialties. The recently successful cohort of emergency medicine fellows with whom I work in a metropolitan hospital found it difficult to get staff specialist or consultant positions anywhere in Sydney. Many took on part-time permanent work—one or two shifts a week, for example, which was all that was on offer across metropolitan Sydney. The doctors anticipated filling their remaining time with Visiting Medical Officer (or VMO) shifts or other casual, short term employment. VMOs are not on permanent contracts; they are a consultant-level casual workforce and are thus not assured a fixed number of hours each week. Some emergency physicians take on VMO roles in several hospitals, hoping that this multiplication of work relations might increase their chances of receiving a full-time equivalent number of shifts. These new fellows' experiences align with Annabel's concerns about where or in which hospital one might work "for a long time." The work arrangements are fluid, so much so that the finally fully-qualified doctors do not even have

a guaranteed amount of work and might be more prone to accept unattractive shifts just to get enough hours to meet their expenses and gain more experience.

Similarly, with general practice training—which interviewees largely agreed was the least cumbersome specialty pathway—fear about gaining a place on the program still existed. Jason explained that whilst he had applied and been accepted on to the training program the previous year, he felt the process was a "fantastic exercise in uncertainty and anxiety provocation." He went on to say, sarcastically, "you couldn't, I mean, you would struggle to design a better system and have it marketed as a publicly acceptable way of getting on to a training program and not as an exercise in subtle psychological torture."

Jason said that when applying to general practice training, you would rank your preferences of every hospital network in the state. All of the applicants' rankings were entered into a computer program which, "however many months later, may or may not give you something that vaguely resembles what you're interested in." The result then affects where doctors will have to live and work and potential career options. Jason raised issues that had concerned him when applying to the program about the region in which he would be placed. "There's no way you can preference based on geography," he explained. "[So,] am I commuting? Do I have to drag the kids out of school? Does [my wife] have to change jobs?" An inability to plan too far in advance thus persists throughout the period that it takes for the overseeing college to provide Jason with an idea of where he may be posted. "It's two or three months where it's just, it's going to dictate all the choices you're going to make," he confided, "not only in your life but in the life of your kids and your wife." This unpredictability does not just affect Jason's life. It also makes him a less dependable father and partner, and it makes it harder for him to anticipate how his family will deal with other issues, such as the children's education or his partner's career.

At the time of our interview, Mia was preparing to apply to the Australasian College of Dermatologists, widely considered one of the most competitive specialty training programs in

Australia. Mia's husband, Nathan, was a Senior Resident Medical Officer (SRMO) at the time and was hoping to become a surgeon; surgical training is one of the other most prestigious and competitive programs. Mia described her relationship with her husband and the pressure that medical training had placed on it. She had spent a term the previous year essentially living on-site at the hospital to which she was rotating because of the long commute. She was studying for her master's degree and decided she did not have time to commute *and* study, even though commuting would have allowed her to see her husband. "So, I just didn't see him," she explained. "I had a lot of stuff to do, and I suppose you just accept those periods… but I do, like, get a bit worried." The worry is both a consequence of the unknown—not knowing whether the situation will improve with time, or in the worst-case scenario, decline—and concern about irreparable damage to their relationship.

The instability and uncertainty drive many individuals to work even harder, possibly because the only path they see to alleviating their concerns is greater achievement and more accomplishment. In Mia's case, she described her concern that Nathan, her husband, was moving to train at a regional site—that is, a hospital in a city or town outside the major metropolitan centres like Sydney and Melbourne—for a year: "That's going to be shit. But then I'm like, alright, I can't worry about that. I have to deal with that later." She explained further:

> Like it's not like, oh, I'm just going to work hard for six months, and then it'll be better. It's like, alright, probably the next ten years it's going to be crap. So, like you've got to adapt the way that you think and try and care less about some things. Because it's like a long-term gain.

Mia points here to the expectation that if she and Nathan make the sacrifices that are required now, the hard work that they have invested will pay off in due course. Mia knows what the next ten years will entail—hard work, disruptions to her life, periods of separations from her husband, changing living arrangements, and other sacrifices. Although the outcome of that hard

work is not certain, nor can she know the specific obstacles in advance, the pattern itself of unpredictability and short-term suffering for a long-term goal is. Certainty provides training doctors like Mia with comfort; yet this assurance does not come necessarily from knowing exactly what the next decade will entail, only that it will be difficult, and in time, they convince themselves that their dedication will be worth the effort.

Some of their uncertainty stems from a set of expectations formed by junior doctors well before they enter the medical profession. Having the intelligence and academic success to pursue a career in medicine and inspired in part by the wealth that they anticipate will come as a result of becoming doctors, medical professionals are in a position of apparent social prestige. The promise of this social status and eventual wealth motivates individuals to work harder as their career progresses. Their expectations provide a degree of certitude in an otherwise particularly precarious situation. The outcome they expect from the years of training with little immediate gain help these individuals to rationalise their decision to take up medicine and justify the costs-to-date, or sunk costs. Zeelenberg and van Dijk (1997, p. 677) define 'sunk costs' as the tendency for people 'to let their decisions be influenced by costs made at an earlier time in such a way that they are more risk-seeking than they would be had they not made these costs.' By the time junior doctors reach internship, residency, or provisional and advanced training, they have invested years of their lives studying medicine, hoping that it will eventually pay off both financially and in a form of professional accomplishment. They justify these struggles with the expectation of what medicine may provide in the future if they persist. And individuals may more easily forgive the system for placing them under significant pressure if they feel certain that, at some point in the future, regardless of how long it takes, their investment will pay dividends.

The issue here is that honouring or making decisions based on sunk costs is irrational. Prospect theory is used to describe decisions made under risk. Zeelenberg and van Dijk (1997) explain that the main feature of this theory is that choices are assessed based on a reference point rather

than relating to final assets gained (see figure 3). The reference point in figure 3 is *A*. An outcome is considered a gain when it rates, or falls, above the reference point and a loss when below. Individuals are more risk-averse with gains and more likely to seek risk in situations of loss. That is, the closer an individual perceives themselves to be toward achieving their desired outcome, or the longer someone has pursued their goal, the more likely they are to persist even if the end goal is still relatively out of reach. They use the effort they have already expended getting to their current stage to justify to themselves any future required work. For example, an individual who is only 2km into a 42km marathon will be more comfortable giving up than the person who has reached the 40km mark, even if running the additional 2km causes significant injury.

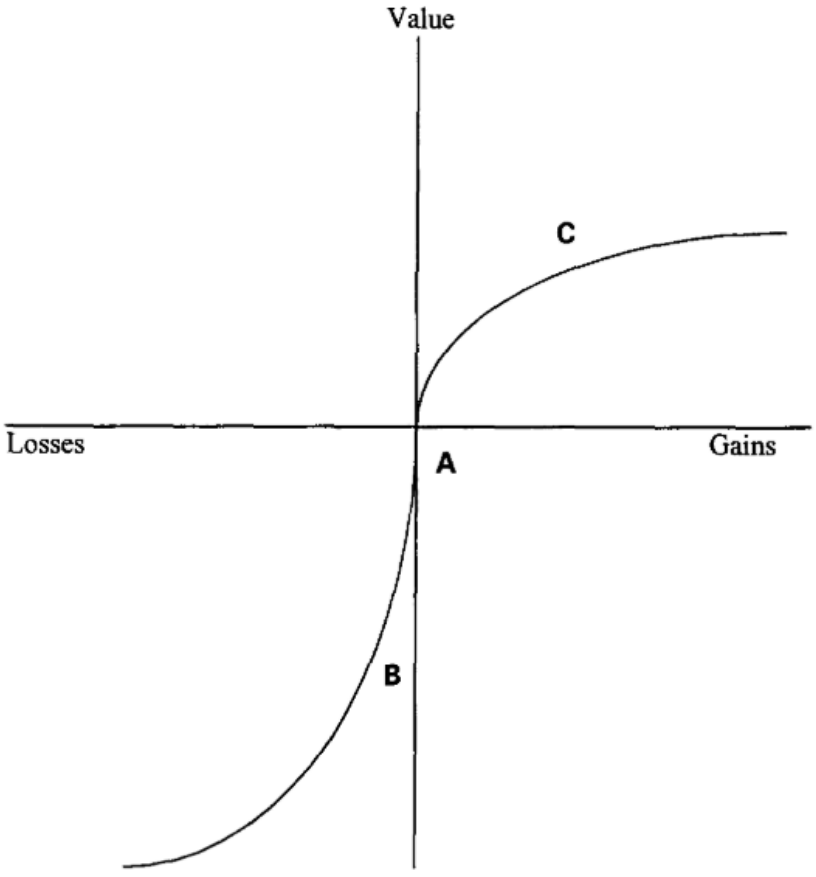


Figure 3: Prospect's Theory Value Function [as referenced by Zeelenberg and van Dijk (1997, p. 679)]

However, contrary to how individuals respond to the reference point, Kahneman and Tversky (1979, p. 286) suggest that 'there are situations in which gains and losses are coded relative to an expectation or aspiration level that differs from the status quo'. The junior doctors with whom I spoke demonstrate this shift away from the norm, toward decision-making based primarily on expectation or aspiration rather than a more typical loss and gain scenario.

Expectations of Medicine

Amy: "There's no way that medicine is the same as what you think it's going to be."

Amy hailed from a small town on the north coast of New South Wales. She particularly enjoyed the community aspects of medicine, getting to know her patients through seeing them regularly. She hoped to become a general practitioner with a sub-specialty in sexual health. Amy explained that she did not have any idea of what it would be like to be a doctor when she first enrolled in her medical degree. When I asked her had medicine been what she was expecting so far, she replied by explaining that no one in her family and no one she knows had done medicine or worked in the industry, so she had not been told by anyone what it would be like.

> I actually really didn't know what I was expecting at all. I went from high school to undergraduate medicine. So, I had no idea what it was, no idea what the job at the end would be like. I didn't know that there were different training programs. I didn't really know about anything beyond "I think I want to do that."

Even throughout her degree, Amy felt that she was not exposed to the "frustrating… bureaucracies" that she has had to deal with since graduating and so perhaps did not fully understand what medicine would entail until she began her internship in a larger, busier Sydney hospital.

> During my uni[versity education], most of my clinical university years were spent at Coffs Harbour, which [has] a very small hospital. People are very friendly. Doing things, like basic things, like making consults, is very easy. I think you don't face a lot of the politics and things like that in a small hospital. So, I had no idea.

Coffs Harbour is a small city on the east coast of Australia. Its hospital is a referral base hospital with 292 beds, which is small compared to a major metropolitan referral hospital such as Liverpool Hospital in Sydney's south west, which has 805 beds.

Amy suggested that doing general practice training would be a good alternative to working in the hospital system, which she described as "very clunky". "I just don't think [the bureaucracy is] useful for anyone," she told me. In general practice, "you don't have to go through all these systems as much on a day-to-day basis maybe." Amy explained that she hopes to one day move out of the city to work in a smaller community again.

Amy felt she made the right career decision though in choosing medicine. Despite the larger, busier hospitals being frustrating, working in them has also been a rewarding experience that she feels will benefit her later in her career:

> I decided to come to a big hospital in Sydney because I wanted to see a tertiary centre with all the different subspecialties and different interventions and complex patients… I find it sometimes frustrating being a student in Coffs [Harbour] that all these interesting patients with really interesting things or complex patients would get just flown out to somewhere else. So, I thought I want to go somewhere where they're flown to and see what happens… I think that's been a good perspective to get.

In Amy's case, despite having entered medical school with few expectations of what a career in medicine would entail, her clinical placements during medical school have shaped her feelings

toward the hospital system within which she works and have thus influenced her choice of specialty training moving into the future.

Lilian similarly described going into medicine without knowing what being a doctor might entail. “When I started, I didn't have a lot of expectation,” she explained: “Two of my cousins are now in medicine, but no one in my family was medical” when she started. Lilian described having some vague idea of what a GP did and feeling happy with the idea that becoming a GP would be satisfying. “I was kind of like, ‘well, even if I end up as a GP, I would be happy’.” She liked helping people and pursuing a science-related career without working in a laboratory. Even throughout her university degree, Lilian found it difficult to gauge what to expect from the career path upon which she had embarked. “Because you get so many placements in so many different hospitals, you kind of become confused,” she explained. “You don’t really know what to expect from your life” as a doctor. She described how she had wondered whether the lives of those around her progressed or unfolded a specific way because of an individual’s personality or because they were a doctor. This confusion and lack of insight into what to expect feeds into the ongoing sense of insecurity throughout one’s medical training.

Motivation throughout a medical career

Arham: “I want to help people”

Arham pursued a career in medicine for several reasons. “To be completely honest, it was kind of seeded into my mind from my Pakistani mother,” he explained. “I’m not going to deny that. But largely because of the ability to help people, the job security, and the status that it comes with.” These factors were touched on by many of my informants, predominantly the desire to “help people”. Arham clarified that whilst his mother’s influence had initially driven him to choose medicine—based on medicine being “a really respectable job”, that doctors “get more

high status in society" and that they "earn good money"—he found that he persisted with this path because he found it rewarding.

> I get a kick out of doing good for people. I love when I do get the time to actually sit down with a patient, listen to them, help them, give them good news, and they're grateful at the end of it.

Arham told me of a recent situation in which he cared for a woman whose husband was grateful for the help that Arham had given his wife. "I actually do feel I… did something well… It was helpful," he said. "Not just a paper pusher. And that felt really good. It felt really awesome that, you know, I actually did something for these people." Many informants described themselves throughout internship and residency as "paper pushers" or "glorified secretaries". These descriptions speak to two issues: the first is their subordinate position in their day-to-day job of a junior doctor in the medical hierarchy as well as the low status of those in administration in a clinical environment—a topic outside the scope of this project. The second is the importance of pursuing the work that they have been trained to do (that is, clinical work) to maintain job satisfaction and longevity throughout a lengthy training process.

Arham was not the only person I interviewed who focussed heavily on the desire to help patients. Based on both my work in the public health system and the fieldwork aspect of this research project, I believe that many individuals go into medicine specifically out of respect and concern for their patients. They want to "make a difference" and feel that by becoming a doctor, they can "help people" more than they could if they had pursued any other profession. Those junior doctors like Lilian interested in pursuing a science-related career felt that they would find clinical medicine more satisfying or rewarding than academic-focussed science. This attitude may reflect the specific personalities of those I interviewed who expressed this sentiment. Other informants told me that they liked conducting research, albeit through their clinical medical career rather than focussing on research alone.

If helping people was not the primary reason an individual gave me for entering medicine, it was typically the secondary reason. This trend suggests that the reward of the hard work put in to becoming a doctor is not always financial or status. Satisfaction stems from providing a service to patients, which improves their quality of life. Annabel posited that whilst she does find her work fulfilling, she feels that she actually *has* to find it satisfying, or at least find aspects of her work that provide her with a sense of pride. "Because otherwise," she explained, "you just go home exhausted, tired, bored, frustrated with the system and everything." Forcing herself to find meaning, reward, or satisfaction in her work helps to stave off the alternative scenario which is to become overwhelmed by the structures within which she operates.

Bishan was an unaccredited registrar in a regional centre in Victoria when we met. He had recently moved from the Melbourne metropolitan area and was trying to settle into his new work and home life. With a keen interest in surgery, Bishan was working on his CV, hoping to apply successfully to the Royal Australasian College of Surgeons the following year. I asked Bishan to tell me about the aspects of work that he found most satisfying. He explained that he comes from a "Judeo-Christian background" and that a lot of the philosophy and theology that he reads discusses bringing value to your community—a principle he strives to achieve both at work and outside it. "A lot of that for me is about people interaction," he said. "I think for me, really tangibly, is the fact that you can fix someone's problem and then send them on their way just ticks a lot of those boxes." Bishan also indicated that "good patient encounters" and discussing end-of-life decisions was rewarding. Bishan highlighted that challenging encounters with patients can affect the quality of the care he feels that he can provide to all of the individuals he is looking after. So that he does not find himself "falling in a heap at home," Bishan implements coping strategies in his life outside of work to try to avoid making mistakes in his work, which include playing sport, being involved in his church community, reading books, and listening to music. However, he had found it hard to get into any sort of "rhythm" with social activities such as church or sport due to the fact that over the previous four years,

Bishan had moved at least every six to eight months for work rotations. “That’s a little bit disruptive,” he explained. At the time of our interview, Bishan was not playing any sport as he was prioritising research that was a requirement of his application to surgical training.

Regardless of why an individual pursues a career in medicine, as the cases of Arham, Annabel, and Bishan demonstrate, reminding oneself of which aspects of medicine are most rewarding and which deliver high satisfaction provides ongoing motivation through the course of a long training trajectory. Bishan, for example, explained that he found great satisfaction in his work when he treated a patient, and they had a good outcome. “I think tangibly you feel like you contribute,” he said. “You see someone, you fix their problem, and send them home.” Likewise, the hope or ambition to achieve one’s goal—or rather, an aspiration—can help to keep momentum.

Alice Street (2016) suggests that a well-established expectation exists for professional caregivers to be driven by compassion for the vulnerable. Street’s own research considers healthcare workers in Papua New Guinea, where she worked as a medical anthropologist. She argues that: ‘we expect sentiments of care to flow spontaneously from Nightingale-pure souls and when other, emotionally sullied, motivations seem to be at play health workers are condemned for pursuing self-interest’ (2016, p. 333). This observation resonates with the reasons given by my informants for entering a career in medicine—for example, Arham’s original motivations included social status and wealth. Arham originally explained that his mother had planted the idea of medicine in his head because of the social status it would provide him and his potential financial earnings. During his explanation, he disclosed that these incentives still motivated him throughout his career, but he used phrases like “job security” instead. That is not to say that Arham was being dishonest when he described his motives for a career in medicine. Rather, similar motives are probably common amongst his peers but are perhaps disclosed less frequently due to the stigma to which Street refers. Street suggests that an opposition or friction

between self-interest and altruistic compassion places professional health-care workers in a difficult predicament, leaving them 'morally compromised' (2016, p. 333). Arham, for example, is reasonable to pursue medicine to have job security, particularly in the precarious, changing job market of the 21st century. However, his pursuit of job security does not contradict his desire to help his patients—or similarly, in Bishan's case, to contribute value to his community.

This type of motivational friction came under scrutiny during the junior doctor disputes of 2016 in the United Kingdom. Rachel Clarke (2017, p. xvi) notes that 'junior doctors are often described by politicians as the '"backbone of the NHS [National Health Service]," the workhorses whose slog… keeps the NHS alive.' However, strikes in 2016 occurred due to government enquiries around the terms and conditions of junior doctor contracts. The government sought to improve NHS services every day of the week—an election promise made by Prime Minister David Cameron to deliver a 'truly seven-day NHS'. The problem here was that the government did not plan to introduce new staff or funds to the system and thus had to cover this seven-day service upgrade with existing infrastructure and staff. Junior doctors were chosen to be the initial focus of the renegotiation, and soon rhetoric took hold that junior doctors themselves (not the government's own Treasury) were responsible for delivering this new service. Consequently, they were blamed for being a barrier to providing safe health facilities over the weekends when they resisted the change to their working conditions.

The moral dilemma in this situation resembles that of my informants when they expressed a desire to help people as the main reason for pursuing medical careers. Junior doctors in the UK no doubt cared deeply about good quality patient care. They felt that they could not provide this level of care under the proposed new conditions. But when placed in the spotlight, these junior doctors were criticised for being concerned over 'preserv[ing] our Saturday pay rates,' as Clarke puts it (2017, p. xx). The discursive emphasis on monetary reward obscured the more subtle issues at play which Clarke describes as 'concerns surrounding pay, patient safety, staffing levels

and morale', all of which were 'inextricably linked.' The public debate of the issue, in part due to conscious efforts of their adversaries, painted the junior doctors as inappropriately concerned about financial returns instead of being focused on patient care when, in fact, they were disproportionately responsible for providing that care.

Like the Australian health care system, the NHS is 'a supremely under-doctored health service. There is simply not the money to employ enough doctors' (Clarke, 2017, p. xx). This chronic understaffing leads to, Clarke suggests, 'at best exhausting' and 'at worst soul-destroying' working conditions, especially for junior doctors. Informants like Arham, Annabel, and Bishan, who find reward and job satisfaction in providing high-quality patient care and making positive contributions to patients' lives, cannot provide the care they want to give in an environment like the one Clarke describes. As a consequence, they are placed in a complicated moral predicament if they suggest that they hope to earn a good income or retain a level of job security from the career they have taken up. As Street (2016, p. 33) questions, 'do we always need to interpret care workers' pursuit of material recompense for their labour as an expression of self-interest?' The stigma around wanting to earn a wage proportionate to the efforts, years of training, and finances invested would explain why my informants shared this motivation less frequently or as a reason second to the more socially accepted altruistic motive of serving others. Even when Arham expressed his desire for job security, he did so in a manner that suggested he was embarrassed to admit that this was one of his goals.

Few informants suggested that they pursued a career in medicine due to pressure from their parents. My parents are both doctors, and I grew up in a community of children who shared similar experiences. Several of these individuals became doctors, but some studied medicine and either discontinued their studies part-way through or graduated and then did not pursue further medical training. This pattern could explain why those I interviewed did not mention parental pressure—their motivation, like Arham's, may have shifted throughout their internship and

residency years and was now focussed less on what others hoped they would achieve and more on what they themselves desired. The other explanation could be the increased uptake of postgraduate medical degrees. These require an individual to complete an undergraduate degree with good results, undertake an extensive interview process, and pass a reasonably challenging science knowledge exam for which an individual would have to dedicate study time. This process is lengthy, and one would need to be motivated by more internal drivers to sustain their effort in the long term.

Intergenerational Change – Emerging Adulthood or the New Normal?

Annabel: "I don't need to be grateful to be here. I worked hard."

After thinking a while about adulthood, Arham expressed some thoughts on whether adulthood itself is the coveted end goal that society depicts.

> If we're not adults now... then I kind of realize that in the same way that being a knowledgeable doctor, the longer you're in it, the more it just becomes obvious that nobody knows what they're doing. That's kind of like when you get into adulthood, and you're like, oh, so it's just been like a big joke the whole time. And no one, no one has their shit together. No one knows what they're doing all the time. And everyone's just kind of making it work.

Having considered the roles of uncertainty, expectations, and motivation in medical education and training, one question, in particular, remains: are these trends evidence of emerging adulthood as a new developmental stage or rather do they suggest that this way of working and living in the medical industry, but perhaps even more broadly, is the new norm for adulthood?

The friction between the stigma surrounding the pursuit of a comfortable financial position and job satisfaction is of particular interest, and an intergenerational shift of wealth has created a

quandary through which today's emerging adults must navigate. In the health care profession historically, hospitals treated fewer patients, and the medical knowledge required of doctors was not as dense or complex. Bill explained this difference when we were discussing the changes in medical education since my parents trained thirty years ago. "So, get a textbook from your father's era," Bill suggested. "*Davidson's Principles and Practice of Medicine*. See how thick it was. Okay… see how thick it is now. You'll find that it is much, much, much thicker." Here, Bill argues that "there's more medicine to know now." He also pointed out that a generation ago, undergraduate medicine was five or six years, whereas today, most medical degrees are postgraduate and four years in length. "The amount of knowledge," Bill says, however, "that's increased from here to here." He gestured with his hands to demonstrate the dramatic escalation in required medical knowledge.

> Can you explain to me how that works? It doesn't… I keep on telling people, this doesn't make sense. There's no satisfactory answer. The knowledge has increased. The amount of time to study it has decreased.

Bill explained that despite fewer doctors being employed in the previous generation, they were given more exposure to patients and so, during their university placements or shifts as an intern or resident, they had greater opportunities to practice skills and procedures. Bill said that whilst he was a medical student, he tried to gain experience to enhance his practical skills but found it difficult to do so. "When I was a med student, even though I tried to do it, but there's just not enough time. So, the anxiety level shoots right up." The Australian Medical Association (2019, p. 1) supports Bill's claim, suggesting that 'in many ways, the health and wellbeing of the Australian population is reflected in the demand shifts for public hospital services. The Australian population is getting larger, older, and as a result, in need of more care.' Statistics from the Australian Institute of Health and Welfare (2018) demonstrate the impact on the public health service of both an aging population and high rates of chronic conditions amongst

Australians. Around half of Australia's population suffers from a chronic condition—especially diabetes, obesity, or a chronic respiratory disease—making up 37 per cent of hospitalisations. Australians aged 65 years or more make up 39.2 per cent of public hospital admissions. Just as an example of the increasing demand that this places on the Australian health care system, between 2012 and 2017, the number of presentations to Australian emergency departments increased by an average of 2.6 per cent per year. The AMA (2019, p. 2) indicates that 'across all types of public hospital service, the rate of increased demand is outstripping the 1.6 per cent per annum rate of population growth…'

Anxiety increases when pressure builds and expectations cannot be met. But it also becomes a problem when the effort individuals put into their work has little, if any, reward. The previous generation encouraged hard work as much as is expected today. The difference, however, is that with diligence came a reasonable expectation of both financial and personal reward for one's contribution to society. Junior doctors today and the generation they represent are often described as "entitled," expecting significant gain for little effort. Emerging adulthood as a lengthening stage in doctors' lives is symptomatic of the fact that these social changes mean that what were previously reasonable expectations for hard work are no longer reachable in the same timeframe, if at all.

Additionally, the goals of 'adulthood' are based primarily on the living standards achieved by previous generations, especially the post-war generations who experienced a fairly rapid rise in social mobility throughout the second half of the 20th century. These goals include owning a home (and often, a house with a backyard suitable for raising a family, rather than an apartment), finding secure employment, meeting a long-term partner with whom you may potentially marry and, in many circumstances, have children. These goals, or markers of adulthood, depend predominantly on a stable economy, plentiful jobs available across industries, and an accessibly priced housing market—all of which are relatively precarious in the

current economic climate and particularly, in metropolitan centres where the majority of medical training takes place. Regional and rural communities may in fact provide better accessibility to reaching some of these 'goals of adulthood'.

Columnist for *The Washington Post*, Robert J. Samuelson, described these expectations in the US context in his 2018 article, "The Rise of Downward Mobility":

> It's an axiom among many Americans that each future generation will live better than its predecessor. New technologies, greater efficiencies and a can-do spirit will reward us with higher living standards. There might be periodic stumbles, but the long-term trajectory is up. And the people most guaranteed to enjoy this bountiful future are the children of today's upper-middle class. They have all the advantages: attentive parents, good schools, a College education and job-market connections.

These expectations stem from upward social mobility that resulted from modernised labour markets and improved access to higher education. Lex Thijssen and Maarten H. J. Wolbers (2016, p. 996) suggest that more opportunities became available to improve one's social class or status based on 'the increased enrolment in education, in combination with flourishing economies and a great(er) demand for high skilled labour.'

However, Samuelson argues that the 'real world isn't playing according to the script'; this expectation is not being met by many within the upper-middle class. These young people are not just failing to meet social expectations developed during the previous generations, but they are actually doing worse. Whilst ninety percent of children born in the United States in the 1940s eventually out-earned their parents, by the 1980s, only fifty percent earned more than the previous generation. And this trend continues, described by Thijssen and Wolbers (2016, p. 995) as 'downward social mobility.' Due to this shift, whilst institutions like hospitals try to reproduce themselves with new trainees, those individuals—and emerging adults—fall behind, failing to achieve the outcomes expected of them. This trend demonstrates that whilst emerging

adulthood appears to be a new developmental or demographic stage, it is also the outcome or a symptom of a generation fairing worse economically than their predecessors (Cribb, 2019). Emerging adulthood is a means to shift the social expectations of future generations, to get them to recalibrate to a set of more realistic and economically appropriate goals, but also to avoid recognising inter-generational economic decline. This generation is not described as poorer but as developmentally delayed because markers of adulthood are harder to acquire.

Conclusion

My informants' experiences demonstrate that when individuals struggle to meet socially prescribed objectives, they may also suffer mental health issues. Middle-class young people have been brought up by parents who instilled in them a sense of entitlement that governs how they interact with society more broadly. Jessi Streib (2018, p. 19) describes three beliefs embedded in this sense of entitlement:

> (1) that one's personal preferences are important and should be acted upon, (2) that one can and should customise their experience within institutions to ensure that their personal preferences are met, and (3) that institutional authority figures are fallible people who should be treated as equals—as people whose evaluations can be wrong and overridden.

The issue with these three beliefs is that they become a part of an individual's habitus and develop into a day-to-day tool or way of interacting with others across various aspects of life (Calarco. 2014; Streib, 2018; Lareau, 2018). Individuals trained with these expectations then find themselves being described by others (usually their senior colleagues and bosses) as expecting great reward for little effort. With junior doctors, they then must work harder to prove that they can and will commit as their predecessors did to prove their worth.

Anthony Giddens (1991, p. 39) argues that from infancy, 'habit and routine play a fundamental role in the forging of relations… and core connections are established between routine, the reproduction of coordinating conventions, and feelings of on tological security in the later activities of the individual.' This notion of ontological security refers to a sense of trust, order, and continuity in one's life experiences, which contributes to how an individual makes meaning of life and their place in it. 'All individuals,' Giddens contends, 'develop a framework of on tological security of some sort, based on routines of various forms. People handle dangers and the fears associated with them, in terms of the emotional and behavioural "formulae" which have come to be part of their everyday behaviour and thought' (ibid., p. 44). When chaos ensues, however, this on tological security is threatened, which significantly impacts on the individual's sense of self-identity. Giddens suggests that continuity in one's identity acts as a protective mechanism for the individual's integrity of the self as it is both 'fragile and robust.'

Fragile, because the biography the individual reflexively holds in mind is only one 'story' among many other potential stories that could be told about her development as a self; robust, because a sense of self-identity is often securely enough held to weather major tensions or transitions in the social environments within which the person moves. (ibid., p. 55)

My informants endeavoured throughout their careers, and indeed, in my interviews with them, to 'keep a particular narrative going' (ibid., p.54). This narrative is their identity as a doctor, and they believe it so much that it becomes their dominant, and in many cases, sole identity. This self-identity provides a degree of ontological security, but this security does not always protect the individual when uncertainty arises, especially against the very professional identity that provides security. The temporary status of training doctors and the promise of what is to come help to keep these doctors in their precarious position within the health care system. This temporality also assists junior doctors in managing their own stress and mental health issues. In a sense, they feel that their hard work will eventually pay off, but in the meantime, the reward

for excellence is just more work. And at some stage, these junior doctors fail to maintain the motivation they need to keep putting in the required effort. They begin to question the choices that they have made to this point which leads them to doubt the medical identity in which they have spent so much time and money investing.

Part Three

Chapter 5: "I didn't go into medical school to be a secretary!"

Vince was a resident in his late-20s when we met at a busy café on the south coast of New South Wales in June 2018. Medicine was Vince's second career, having been an engineer prior to his career change. I asked him how he had found internship and residency so far, to which he responded, "Uh, it's been good… yeah it varies between being quite boring and just you know being a secretary, just typing and scribing doing those jobs."

Vince found that he spent a large part of his internship and residency years feeling undervalued considering the years of training at university that he had so far undertaken. Many of my informants used terms like 'secretary' and 'paper pusher' to illustrate the contribution that they felt they made to the medical team during their first two years out of medical school. Interviewees described taking the notes on ward rounds whilst registrars and consultants discussed patient results and the next steps in treatment. Certain clinical rotations were worse than others, Vince pointed out. He found his anaesthetics term particularly engaging and hands-on, whilst a rotation in geriatrics "was a bit of death by paperwork," he said.

Informants expressed a sense of resentment toward playing the role of the scribe or note taker and felt it did not give them an opportunity to learn as much as they could if they were more involved in the practical or clinical aspects of medicine, such as the diagnosis and treatment of patients. Vince suggested that terms like emergency medicine gave more patient exposure to junior doctors. "[Emergency] was really good," he explained, "[be]cause you got to see the patients from the start and kind of work them up a bit. Do a bit of diagnosing yourself."

Vince indicated that on the wards, though, he did not get to perform this type of medicine and found it less satisfying. He also often felt out of his depth. "Then other moments where… you kind of feel like it's on you… all the nurses are like, 'what do we do doctor?'" Vince explained, "I'm like 'aw, shit! That's right. I'm the doctor.'" He felt as though he did not have the appropriate expertise to properly treat his patients, which presents a paradox of sorts. Despite

countless hours in medical school, developing the acumen of an experienced doctor takes time—particularly time spent working on the ground in a hospital. This experience establishes a hierarchy in medicine and thus places more senior doctors higher up the order. Vince also evidenced a lack of confidence more broadly shared by junior doctors in their own abilities, suggesting that they suffer from 'imposter syndrome.' That is, they feel that their skills are insufficient to fulfil the requirements of their role, even though the knowledge they possess is more than likely enough to meet their job's demands.

This section considers the impact of the historically structured medical hierarchy on the experience of individual junior doctors. I discuss the predicament of informants such as Vince, who are navigating the insecurities they have in their own abilities with the requirements of their work. At the same time, the junior doctor workforce is often treated as though they are not 'real' doctors but are instead secretarial or administrative staff with no clinical knowledge or competencies. This contradiction contributes to the phenomena of bullying and harassment, a significant issue in the field of medicine that is increasingly visible to the public. Both the medical hierarchy and bullying and harassment have a significant impact on the medical identities that these individuals develop from as early as medical school. When an individual's sense of self is tightly intertwined with her practice as a doctor, it can be difficult to separate the two when she is treated poorly by colleagues or in ways that suggest that she is not recognised as a legitimate doctor.

Even though many of my informants described feeling like secretarial staff, some also observed a flattening of the traditional medical hierarchy. That is, they felt that despite the continuing existence of a ladder-type structure within medicine, a shift in the way junior doctors were treated was starting to occur, and they were often being treated with greater respect for their experience or knowledge by those with more authority or seniority.

Hierarchy

I drove to the central coast of New South Wales on a cool morning in August 2018 to meet Caitlyn, a 26-year-old Intensive Care registrar, at her home. As she made us a cup of tea, Caitlyn told me that she was in her fourth year out of medical school, having studied medicine as an undergraduate student immediately following her high school graduation. “For a lot of people, it’s like, ‘Oh yeah, I really wanted to help people,’ but I just thought the subject matter [of medicine] was very cool and very interesting,” she explained. “And along the way, you do help people, but I still go into work every day [thinking] ‘this is really interesting.’” Although Caitlyn’s motives for entering medicine differed from many of my informants, her expectations of medicine were vague, like many of the others. “I don’t think I had any good understanding of what it would actually involve and how [many] sacrifices you would have to make,” she explained. “I kind of just thought it would be a job, like any other job.” Medicine is not like any other job though, Caitlyn said. “I mean, I’m glad I’m a doctor because I do enjoy the work most of the time. But I wish I knew about some of the things that… I’d have to sacrifice to do it.”

I asked Caitlyn about halfway through her interview whether she found work satisfying. She rationalised that whilst she found it satisfying most of the time, she had experienced moments throughout her career to date when she had felt “let down by the system.” In her intern year, Caitlyn faced a surgical term during which she felt neglected by her senior staff. “I think particularly in the surgical specialties that I did, you did feel very undervalued,” she explained.

> And I think also… particularly as a JMO [junior medical officer], like you spend all this time at medical school, learning all this medicine, learning all these facts and pathophysiology and physiology and pharmacology, and then you get to be an intern and you realize that for the first one or two years of your job, all you are is basically a paper bitch.

Caitlyn was not the only informant who described feeling like, as she put it, a 'paper bitch' during their internship and residency years. "You feel really cheated," she said. "I spent all this time at medical school doing this, and basically a secretary monkey could do this." This idea of being demeaned and disrespected by being required to do secretarial or notetaking tasks uncovers layers of hierarchy instilled in the medical industry (and the junior doctors' attitude toward administrative work). Ranks exist amongst doctors, nurses, and administrators, with secretaries considered at the very bottom of the hierarchical structure. As a consequence, they are often treated with little respect. Similarly, JMOs are subordinate in the hierarchy of doctors, with only medical students beneath them, so they too are treated as inferior workers and suffer the consequences, which often results in bullying and harassment.[27]

The other point to note here is the feeling junior doctors express of being treated beneath their level of expertise. Many of my informants, like Caitlyn, shared their disappointment after spending years studying and training only to do tasks that require very little, if any, medical expertise. Caitlyn, in fact, demonstrates that even as a junior doctor, she has already embodied the implicit hierarchy in the health care system. She exhibits frustration at her position within the hierarchy but also perpetuates it in her description of being the "secretary monkey". Whilst the tasks that Caitlyn refers to here may be tedious and unappealing to a new doctor who is keen to get into the "real medicine" aspect of the job, the acts of recording and taking notes on the work actually play an important role in medical training. And to separate these tasks from the role of the junior doctor to be delegated to a lower paid and less qualified staff member may cause additional problems in their training and professional development.

Interestingly, during the second wave of the COVID-19 pandemic, in 2021, NSW implemented an 'Assistant in Medicine' role available to fourth-year medical students in the public hospital

[27] Medical students are not employed and so do not tend to suffer the same exploitation as junior doctors. Perhaps also they are not yet knowledgeable or skilled enough to exploit.

system in response to a significant workforce need. It is too soon to evaluate the effects of implementing this strategy; however, this plan may provide a test of the benefits and challenges of such a role. And whether creating a new role in the care system contributes to the issues caused by the hierarchy, improves the situation for junior doctors, or just moves the stress they are experiencing further down the ladder to more junior trainees.

Caitlyn explained that she would have liked to have known about two particular aspects of medicine before deciding to pursue this career: a) the time involved in working and training, and b) the emotional toll— "compared to a lot of my peers," Caitlyn said, "I've had to grow up very quickly."

> You feel a significant burden on you to be an adult and be serious, and that carries over to your personal life, and you know… It becomes less and less as you get more experienced, but you still take things home. And you still spend a lot of time reflecting on what you do at work in your own personal time… It's not just a job. It's not just like you do your job, and then you switch off and go home.

Caitlyn highlights the fact that an individual who pursues a medical career path is not simply taking on a profession, but rather a lifestyle and indeed an identity that is caught up in the work that they do and the impact that they have on their patients. Whether they go into medicine hoping to help people or not, they inevitably take on what could be described as an altruistic role. Junior doctors find themselves struggling when they do not find satisfaction in their work or feel that their role is not important within the broader health care system. That is, they struggle when they do not feel valued by their seniors or colleagues or worry they are not making a worthwhile contribution.

Bishan and Annabel were intent on pursuing careers in surgery; when I interviewed these two young doctors, they were both working in regional hospitals—Bishan in Victoria and Annabel in New South Wales. Bishan talked about what he described as a "strict hierarchy of power" in

medicine and compared it to the Army. “It’s just so hierarchical,” he explained. “I think any time you have strict hierarchies of power, there’s space for abuse in that.” He went on to suggest that in surgery, he feels that “there is a distinct hierarchy in both knowledge and in your skill set” which may not be the case in other specialities such as physician training.

However, I observed a more implicit order throughout my fieldwork. Much like the metaphor of a ladder used in the corporate world, the structure of medical education and of the medical workforce imposes a chain of command from consultant or staff specialist at the top of the hierarchy down to the intern at the bottom. The intern, of course, has the least experience, but it seems that aside from continuing one’s education and training to progress, one must also know their position in the hierarchy: seniors treat junior doctors with less respect than would be considered professionally acceptable in other industries. In part, doctors are held in such high esteem by society more broadly for the risk and responsibility they take on in their work that they come to believe they are entitled to treat others badly. For a long time, bullying within medicine has not been addressed because it can actually be quite difficult to criticise these doctors who do take on a level of responsibility with which most people would not feel comfortable. And curiously, junior doctors play a role in perpetuating this pressure and behaviour as they feel it increases their clout amongst their peers. As Tara Kennedy and her colleagues suggest, “the pressure towards independence in clinical work originated in trainees’ desire to lay claim to the identity of a doctor (as a member of a group of autonomous high achievers)” as well as through the stress that comes with significant workloads and being constantly evaluated for one’s output (2009, p. 645).

My interviewees overwhelmingly described themselves as administrative or secretarial personnel. Throughout my fieldwork, I have observed senior doctors not only treating juniors in an unacceptable manner but also treating their secretarial staff poorly, perhaps because they consider them to be in a similar place on the medical hierarchy. In many instances, participants

explained that they expected this during their intern year, being "at the bottom of the food chain," but anticipated being treated more like a doctor and less as a secretary as they progressed to roles they thought would have more responsibility. Annabel explained that whilst doing this type of work is "a horrible job", it is "fine as an intern… great as an intern—if you're not too big for your boots." She implies that if a junior doctor knows her position within the hierarchy, she may find it easier to tolerate being treated as inferior and may learn from the experience. Having to continue doing this type of work later on in one's career was far less acceptable, in Annabel and other informants' opinions. "You don't need to be doing that three years down the track," she said. Annabel also pointed out that the senior doctors do not want their registrars to be doing the secretarial or 'scribe'-like tasks either as they require the junior staff for clinical work.

Annabel explained that, although being an intern can be really challenging, it can also be a very rewarding job and that you can learn a lot doing discharges and administrative work if you are open to the experience. That is not to say that secretarial staff do not play a crucial part in the medical industry; however, junior doctors feel cheated if they have spent many years studying to be clinicians, only to be held back from actually *doing* medicine for years after they have finished studying. It seems that both the amount and importance of record keeping is increasing and becoming a growing part of medical care. Junior doctors are largely responsible for this but feel that this work is not contributing to their education as clinicians, and like several of my informants suggested, they actually feel that the amount of clerical work they are required to undertake slows down patient care due to new technologies being implemented before they work efficiently enough. Perhaps the solution here is to employ 'medical scribes', or individuals who are trained in clinical notetaking, to ensure that this aspect of patient care is done properly and to allow JMOs to actually spend their time practicing the clinical aspect of medicine in which they have been trained.

Third parties, such as the colleges and the Resident Medical Officers Association (a hospital-based group that advocates for junior doctors), play an important role in advocating for JMOs who are spending too much time doing administrative tasks rather than learning the skills they need to progress through their career. Annabel explained the value of the Resident Medical Officer Association (RMOA) during our interview:

> Our RMOA does a really good job of keeping people together and doing some social stuff. But also making it pretty clear that, when things aren't working with your term or your rotation, they will speak up. And they will say, it's not okay to abuse the intern and make them do all of this stuff when they're supposed to be learning about whatever, psychology or surgery or whatever.

Those in senior positions hold more power in the medical hierarchy meaning that an organisation that can act on behalf of junior doctors in these circumstances is required. Annabel, however, here states that, in fact, too much clerical work borders on "abuse" of the intern. It seems that the senior doctor who delegates tasks and the intern themselves have very different understandings of what internship looks like and what tasks should be included in the position description of a junior doctor at the intern level. Annabel suggests that the priority of the intern should be their medical education and that secretarial or administrative tasks sit outside this scope. So whilst the RMOA plays an important role here, perhaps more importantly is setting expectations around what an intern will realistically do as a part of their job and what needs to be delegated to another person who is not learning to be a doctor, for example.

Beneficiaries of Hierarchical Progression

Both Bishan and Annabel described a flattening of the traditional medical hierarchy, albeit more likely the case in some specialities. They felt that the different levels of the hierarchy were working more closely together in a respectful manner and that the hierarchy was perhaps not as

rigid as it once was. However, whilst Bishan explained that he felt the approach his colleagues are taking is changing, the mere fact that he lists *seven* different levels within the hierarchy demonstrates that, if anything, the ladder is only expanding rather than flattening out.

> Even though [the hierarchy] still exists, and there's a consultant, and then there's a fellow, and then there's a senior reg[istrar], and maybe a junior reg[istrar], and then an unaccredited registrar, and then your residents and interns. I think all of that is being compressed so people perhaps don't feel the need to big note [28] or push the fact that they know more.

I asked if he felt that this shift meant that people were being treated with more respect. "There probably is more [respect]," he said. "I think it's partly cultural in probably the way we do education. The system is changing." When the JMOs I interviewed used the term "cultural", they referred to an ingrained, accepted way of behaving. Usually, the term was used to describe a trend in behaviours that were proving difficult to disrupt.

Even in the time since Bishan was a medical student, which was only a period of a couple of years, he believed a change in what was considered appropriate behaviour had taken place. "It was much more accepted that you could maybe be condescending down the phone," he shared. Since Bishan moved to Victoria, he had not experienced this type of behaviour. He felt people were less condescending and rude than in some previous interactions he had encountered. Yet, experiencing harassment through the telephone is still common—in fact, many of my informants described this same type of interaction, with some describing incidences of being shouted or sworn at over the phone.

[28] To "big note" oneself is an Australian colloquial expression which means to exaggerate one's importance or achievements.

Bishan explained that, as JMOs ascend the seniority hierarchy toward consultant level, they begin to benefit from other people—usually those in more junior roles—being obliged to do the more mundane tasks. “A lot of the paperwork or running around and chasing obs [observations] up,” Bishan said, “you can pass on to someone else.” Bishan describes a lack of autonomy or freedom to act. One privilege of the authority that senior clinicians have is their ability to make others do the parts of their job that they would prefer not to do. Whilst interns or residents can feel as though they are constantly being asked to perform “menial” tasks which are usually clerical in nature, this vulnerability decreases over time as they become more senior doctors. And if the individual works hard enough to move up in the hierarchy, they can then profit from those beneath them taking on the tasks that they would have previously been required to perform. These still-junior doctors start to become the *beneficiaries of hierarchical progression*. That is, they personally gain from those ranked lower on the medical ladder, but only after having served time in that role themselves. The hierarchy, therefore, perpetuates itself as it is in the best interest of those in positions of power for it to continue in its current state.

26-year-old Nick, who works as a resident on Sydney’s Northern Beaches, suggested that being subordinate in the hospital employment structure contributed to his burnout or profound exhaustion. Nick told me that whilst he realised that “you can’t do everything, or you just burn out”, he also felt that the workload would improve as he became more senior in the chain of command. Nick was nearing the end of a psychiatry term at a different hospital when he found he ‘burned out’ and had to take a break:

> There was just so much work, and the turnover was really high. And there was always just so much stuff to do. And then every now and then, there was the After Hours shift, which goes to 10pm. And every few weeks, I’d work a weekend from 8am to 10pm. And towards the end, it’s like, “Whoa, I am really tired.” … I don’t think I could have done that term forever… I do think [the workload] will get better, like as you get more senior,

> you're no longer the team bitch. I think it'll all get better, but I think it is still important to have some way of looking after yourself throughout the year.

Nick suggests that as a junior team member, he was largely exploited and taken advantage of with the promise that he will one day benefit from the hierarchy once he has ascended it. The promise of becoming a *beneficiary of hierarchical progression* motivated Nick to continue working hard despite the long, exhausting shift work and being the "team bitch"— the one responsible for all the tasks that no one else wanted to complete. Even the fact that Nick has adopted the aggressive and sexist terminology of being the "team bitch" to describe himself demonstrates a degree of self-degradation in his junior role. Whilst commonly used in Australian slang, this passing comment of Nick's really highlights how lowly or passive he sees himself within the team.

Similarly, Arham pointed out that his increasing seniority and skill set over time could be why he felt more recognised as his career progressed. "I was able to do more… and I was a little bit more helpful, and therefore that kind of changed people's interactions with me," he said. Here, Arham suggests that the demonstration of one's progression through the medical hierarchy commands a heightened respect from those in senior positions—another advantage of hierarchical progression.

The impact of the hierarchical progress may also explain why those lower on the ladder are more prone to experience higher levels of burnout and depression (Rogers et al., 2014). Hassan and colleagues (2009) suggest that potential career implications and professional integrity bring reluctance among their peers to seek support. And so the risk of *not* progressing or being prevented from advancing into seniority may be why junior doctors, at the same time, seem to be less likely to report mental health-related issues, based on my informants' own narratives.

Bullying and Harassment

Annabel described being "treated like crap" by senior doctors throughout her career up until our interview. "I think a lot of the time in medicine," she said, "you're supposed to just have blood, sweat, and tears to try and get there." She went on to explain that as an intern or resident, even as a registrar, you can be treated as though you are at the "bottom of the pile… but you better be grateful that you're there." Her account of a justification for the mistreatment of junior staff was not the only version I heard throughout the course of my fieldwork demonstrating that bullying and harassment associated directly with the medical hierarchy appears to still be commonplace.

Two of my participants from Melbourne described having worked in hospitals that had seen significant issues relating to bullying and harassment. These participants suggested that "major changes" had been implemented in these two surgical departments, which now made them great places to work, but did not go into detail around what these changes actually looked like aside from suggesting that perhaps some of the "problematic" team members had moved on to other hospitals. Bishan explained that "the last centre [he] worked at was kind of the epicentre of the whole bullying in surgery crisis." Once he arrived there, ironically, it was a particularly welcoming site at which to work. "I think they'd really taken [the widespread criticism and media coverage] on board, and it led to what was a very positive experience," Bishan said.

Arham described a similar experience, except that he had been a medical student in the hospital whilst the bullying took place. He explained that he hesitated to return there as an intern after his previous experience but found that the nature of the department and the behaviour of those working in it had significantly improved since his time there as a student. Arham felt that this might have been thanks to the introduction of a program whereby people can submit concerns regarding bullying or harassment that they have experienced anonymously to a central contact. Depending on the severity of the complaint, Arham explained, the perpetrator would be spoken to by someone their senior. "It starts off slow," he said, "where you start off with a coffee, then

you escalate it. Then you go further and further until something has to be done." Arham is referring to a first-line approach implemented by some organisations to deal with cases of poor behaviour. The idea behind the 'coffee conversation' is that perpetrators are pulled aside by a colleague in a non-confrontational manner to discuss their behaviour in the hope that it may cease before any further action needs to be taken.

The vagueness of Arham and Bishan's descriptions of bullying and harassment is a feature when discussing these types of problems. Arham was not sure whether a shift in the behaviour of the department to which he had returned was because of the introduction of this program or because some individuals had moved on. "I'm not sure if [the program] made a difference and made a change in the culture," Arham considered. "I think it's just, it's becoming more and more, medical professionals and health professionals are becoming more and more aware of the bullying and not accepting it anymore." Perhaps the reason awareness is so important and necessary in this space is because it is so vague, and that is actually part of the problem. Arham felt strongly that the publicity in the media around the issue and the fact that bullying and harassment in medicine were becoming more widely spoken about by the public had more to do with the "change in culture"—a euphemism that suggests that people were behaving in a more professional and nicer manner than they may have done previously. "There have been stories and articles where doctors have been harassed, and their career's been, they're black marked because of things," he said. "And so, because it's more widely spoken of, people are changing their behaviour, if that makes any sense?" Being "black marked" in medicine is not necessarily a formal strike against one's name but more a case of those within the medical community sharing negative experiences they have had with the particular individual, which leads to them not being rehired. If increased publicity of the problem actually leads to an improvement in the poor behaviour of senior doctors to their junior staff, then this would suggest that doctors are concerned about potentially losing the respect of the wider population. Doctors tend to be in high regard amongst the general public, and so shining a light on issues of bullying and

harassment may be key in reducing its prevalence. In large part, the very fact that the way my informants described bullying in such a vague and euphemistic manner may highlight why these bad behaviours have taken so long to come to light.

Surgery and the "Boys' Club"

Both Bishan's and Arham's experiences demonstrate a shift in social norms within medicine, but more specifically within the field of surgery. Surgery has a long-held reputation for being a cut-throat, harsh, and particularly sexist specialty, as many of my informants described. Some even gave these issues as reasons they had chosen not to pursue surgical training. Susan, a very senior surgeon who sits on the Council of the Royal Australasian College of Surgeons, described a recent run-in she had experienced with one of the surgeons with whom she had trained over twenty years ago. He made a gross assumption during a passing conversation that Susan, being a woman, must specialise in "the little things" such as hand or foot surgery. Susan quickly corrected her peer, explaining that, in fact, her practice encompasses not just hip and knee replacement surgery but also one of the most significant orthopaedic procedures, spinal fusion. Susan explained that her peer's assumption might have been common and perhaps even considered acceptable in the 1980s when they trained, but she was quite disturbed to have come across this behaviour nowadays.

Susan went on to explain that whilst women comprise more than half of all medical students Australia-wide, only 34% of specialists are women, and more specifically, women make up only 9.2% of surgeons, according to statistics from the Australian Medical Association (2020). Dr Danielle McMullen, quoted by the AMA of New South Wales, suggests that female medical students 'are avoiding specialities that are not perceived as welcoming to women due to a lack of female role models and their approach to parental leave or part-time training' (ibid., para. 10). Many of my informants used the term "boys' club" to describe the inherent masculine culture of

medicine, which includes sexist behaviour, exclusion of women in the field and denigration, which is particularly potent within the field of surgery. Gender discrimination and gender-related harassment, such as unwanted sexual attention and a lack of respect from colleagues or administrators, begin early in medical training, according to Rotenstein and Jena (2018). They suggest that male physicians 'continue to receive significantly greater compensation and recognition than female physicians' and cite issues such as women not being referred to as 'doctor' during patient rounds (with patients assuming that women are nurses or other allied health professionals). Women are also more likely to experience disrespect from both their colleagues and other nonphysician professions—both circumstances that my informants themselves had experienced themselves or witnessed throughout their careers.

Workplace Bullying and an Ethos of Individuality

Even within this "boys' club", however, each doctor is encouraged to act in his own best interest rather than in the interest of the group. I observed amongst my informants and during interviews that this ethos of individuality percolates from senior to training doctors even early on in their careers. The competitive nature of the industry and of specialty training encourages interpersonal competition, which contributes to bullying and harassment and patterns of disrespectful behaviour, such as swearing at and belittling junior colleagues and yelling at or humiliating other team members, including clerical and nursing staff.

Bullying and harassment in medicine have implications, not just for the individual doctors being bullied but also for patients and the Australian health care system more broadly. Bree explained that she had been on both the receiving end of harassment and a witness to this behaviour toward her colleagues. "To see the various ways that the bullying and the hierarchy… caused trouble," she said. "I saw other registrars and trainees who had started off so bright and sparkly and excited to be a doctor just become so jaded within a couple of years. That was really sad."

Losing enthused doctors to bullying and harassment is preventable and means that the system misses out on a group of doctors who may have otherwise contributed significantly to providing good quality care to their patients. “Some of [these doctors] were the best,” Bree gushed. “They were known to be the best doctors in their cohort, and they were just so… over it.” Saunders and colleagues (2007) draw on a body of literature by Price-Spratlen (1995), Vartia and Hytti (2002), and Einarsen and Raknes (2011) to suggest that workplace bullying has a harmful impact, not just on the employee who is the subject of the harassment, but also on the organisation itself, suggesting damaging implications of this trend for the Australian health care system.

Bullying is notoriously difficult to define, not because people cannot agree on a definition as such, but because there are a lot of different ways to bully, and some of them are intentionally ambiguous or difficult to condemn because it works well this way for the perpetrators who are often also those in a position of authority. Pinning down a clear definition or description of bullying is challenging as perpetrators tend to shift their tactics and use techniques that take advantage of the situation. However, Saunders and colleagues (2007, p. 341) argue that detailed definitions adopted by researchers in this field tend to include four criteria:

> (a) the negative effect of the behaviour on the target, (b) the frequency and (c) persistence of the behaviour, and (d) the power imbalance that a behaviour must create before the conduct is regarded as an example of bullying.

Whilst these criteria apply to workplace bullying that takes place within the medical industry, aspects such as frequency and persistence are less important to consider than the power imbalance that exists between the two parties involved in the interaction. That is not to say that these encounters are neither frequent nor persistent. Arham, for example, reported frequently calling to make a referral to a senior registrar over the phone and having it received with a “grumpy” tone which made Arham “feel small”. “There are times when [the senior registrar is] a

little unreasonable," he explained. The significant issue here is the power imbalance at play which leads Arham to take responsibility for the workplace bullying himself rather than the perpetrator who inflicted the harm. Arham himself is even diminishing the bullying putting it down to the perpetrator being "a little unreasonable" rather than behaving outright unprofessionally. "It's hard because… I've always said, 'Oh, it's my fault…' because, yeah, my referral wasn't that great. [That's] my reason why they were a bit shit—they were rude." Arham initially blamed his own history-taking skills and examination of the patient for the senior registrar's behaviour, rather than accusing the registrars themselves. Whilst he seemed to be emotionally affected by the registrar's "grumpy" demeanour, Arham has convinced himself that the benefit outweighed the cost. That is, Arham also attributes his improvement in his own abilities to this mistreatment. "It's made me a better doctor," Arham told me. "I mean, I know it was just being aware of the things that I need to be telling them and what they needed to know. And so, I've taken that on board, and my referrals have gotten better."[29] Whilst Arham might accept this behaviour whilst convincing himself that it is actually making him a better doctor, other junior doctors decide to leave medicine completely after facing similar experiences. And both the acceptance of inappropriate workplace behaviour as well as the victims taking responsibility for their own abuse mean that this behaviour continues to be perpetuated through the industry and is rarely sanctioned.

Gemma had a comparable experience to Arham with being "berated" by colleagues over the phone as an intern and resident. When we met, Gemma was a 35-year-old paediatric trainee at a tertiary hospital in New South Wales. She had originally studied medicine as a postgraduate student after completing an arts degree. Gemma was in her ninth year out of medical school and was married with two young children. She described trying to have both a family and train as a

[29] In this context, a referral is when a junior doctor phones a member of a different clinical team, usually someone in a more senior position, to organise a specialist consult for her patient.

doctor as “challenging”. Her employer had been extremely supportive since she started having children as they allowed her to work part-time, but she had found sitting her physician’s exams with a toddler particularly difficult—a “highlight”, she said ironically. However, during her internship and residency years, Gemma had experienced a far less supportive workplace. “Workplace bullying is a major issue in the hospital system,” Gemma explained. “I remember my third day as an intern working in Emergency, being berated over the phone and ridiculed by a gastroenterology fellow.” Gemma had worked professionally in other industries prior to her career in medicine. “I hadn’t been treated like that by any stranger ever,” she went on. “I had just not encountered that. The degree of rudeness that happens between medical practitioners, nurses and doctors is staggering occasionally.” Gemma found that this behaviour was far less common when she moved into paediatrics at children’s hospitals. “Because those types of personalities don’t do well in paediatric hospitals. That doesn’t fly. [And] people who want to work with children don’t tend to be like that,” she explained. However, Gemma has since done some locum work in hospitals for adults, and she is still “kind of shocked” by the way that senior specialists speak to the registrars for no particular reason. Swearing appears to be common language based on my informants’ descriptions as well as being told by more senior doctors that the junior is wasting their time. “They’ve just gotten into the habit of being a bully to the junior doctors.” This “habit” of bad behaviour is linked directly to the medical hierarchy. That is, as a doctor progresses up the ladder in seniority, they learn from those who came before them that bullying those in more junior positions is acceptable, and thus they should reproduce this behaviour in order to impress upon the JMO a sense of their own authority.

I asked Gemma if she felt that this behaviour was dependent on the level of experience of the junior doctor. She explained, much like Arham suggested, that a less experienced doctor may ask a question that the senior doctor would assume they should already know the answer to. The problem, however, comes in the attitude of the senior doctor when responding to the JMO. “The kind of response you get is ‘do you know that in my entire medical practice I have never, ever

been asked that question by a junior doctor before, so I don't really understand why you're asking me that question,'" Gemma explained. This tone is of a belittling nature, and whilst the junior doctor may have indeed asked a question that they should know the answer to, the response they receive from their senior is neither pleasant nor encouraging. The junior doctor is supposed to be doing her role as a part of her education in medicine, but her seniors act as though she does not have anything to learn. Instead of motivating the JMO to be a step ahead, Gemma feels that this behaviour perpetuates itself through the generations of doctors. "I think there are people who model themselves on their superiors, and they see their superiors getting away with it," she said. "I think it's perpetuating."

> When I reflect on when I was an intern and being ridiculed by that gastroenterology fellow, and I actually burst into tears and was sent home from that shift. But… if someone abuses you over the phone, I think he actually called me an idiot—he was… abusing me and shouting at me, you know—they should be formally disciplined. I think until there is a formal disciplinary process for bullying with a low threshold for intervening, rather than just saying, 'everyone knows he's difficult. Don't worry about it. It's him not you.' I don't believe there will be a change.

Gemma suggests that she feels as though a "broader cultural change"—or the elimination of harassment-type conduct—is unlikely to occur until those who bully their colleagues are disciplined. The problem lies in the fact that two roles that are expected of the senior clinician are clashing here. The senior doctor is expected to be both a teacher and supervisor. And in some cases, also to provide a degree of pastoral care. On top of this, the student is also in the role of 'less experienced subordinate'. Gemma highlights two sets of expectations or approaches for dealing with the problem: one approach suggests that the bad behaviour must stop, and the other advises that the behaviour should be ignored. But these frameworks are heavily conflicted, and herein lies the main challenge for attempting to make any type of organisational change.

Investing, or Not, in the Individual

Gemma told me about her sister, who is a lawyer and was shocked to hear of the kinds of behaviours that Gemma had come across in her time in medicine. She described one particular encounter with a senior colleague who had yelled at her over the phone, calling her an "idiot". "He was actually abusing me and shouting at me," Gemma explained. "[My sister] said this just does not happen in her field. People don't speak to each other like that." Interestingly, Bill made a comparison between the health system and his previous experience working as an actuary for a big banking corporation. "So, I've worked in banks before," Bill said, very seriously. "You wouldn't put banks as the epitome of HR excellence, would you? No. [The health service in my state] makes banks look great." I expected Bill to laugh. But he went on to explain why exactly he felt this way.

> Just an example, every 10 weeks you go for a new rotation. Okay, so you do paed[iatric]s, ED [emergency], obs and gynae [obstetrics and gynaecology], surgery, geriatrics. So, you're with a new team all the time. Nobody is invested in your success… Nobody's invested in me, because it's… random allocation… So, nobody's invested in anybody else.

Bill explained that whilst some specific senior doctors are indeed interested in teaching their junior trainees, they do not feel that they gain anything personally from contributing to that individual becoming "a good doctor". This may also explain why senior doctors are not motivated to change their behaviour or to restrain each other from behaving badly. "I mean, I try to help you become a good doctor, but I'm not invested in you…" Bill said. Comparatively, at the banking corporation, Bill described being in a "sort of managerial position" with employees who reported to him. "So, you've got the interview. You select one out of five [candidates]," he explained, "and I'm invested in him, because if he doesn't work out, I have to fire him, which is pretty traumatic for everybody." The threat of having to repeatedly hire and sack individuals from his team and thus having others question his abilities as a manager made Bill keenly

interested in seeing his staff succeed. “So, I’m going to do everything to make sure that he succeeds when he comes into the job,” Bill told me. “I talk to him. ‘How are you going? Are you settling in okay? Do you know how to get things done? Have you got enough tools?’” He explained that he would manage his staff by checking in on their wellbeing and making sure they knew what they needed to be achieving each day. Bill feels a sense of commitment to his team member for both the sake of the team and for his own reputation as a manager of subordinates.

However, Bill noted that junior doctors training in hospitals do not feel that any one individual within their workplace considers them a valuable enough resource to which they might devote greater attention or guidance.

> On the wards, everybody can give you a job—the nurses can give you a job. Pathology can give you a job. Radiology can give you a job. Your team can give you a job. You do a consult, they give you a job, and you've got these jobs that everybody just gives you without any consideration to all the other jobs on your list, and their job is the most important.

Bill here describes that the lack of one main report or line of authority makes it difficult for the JMO. Whilst officially, they report to a consultant or director of training who runs that particular rotation, they are actually logistically accountable to anyone who needs their assistance. This ranges from medical colleagues to nursing staff, radiologists, pathologists, and their own team within the department they work. Bill argued that the way that this setup functions is “completely flawed” and “doesn’t make sense” primarily because no one is invested in the success of that individual doctor. Anyone can “use” the junior doctor whilst they are employed in that role, but no one benefits in the long term as the JMO is on a temporary contract or rotation. This short-term motivation to exploit overcomes any long-term return from training the junior to be a permanent part of the team. They are not likely to devote the required time or energy to the junior doctor because they themselves are unlikely to benefit from that

resource in the future. The cost and benefits of contributing to the educational development of interns and residents are not accruing necessarily to the same individual or even to a particular department or hospital, which makes it harder to motivate these seniors to put in the effort or restrain themselves or each other from abusing the junior doctor. The collaborative and itinerant nature of medical training militates against any individual restraining from mistreating their junior colleagues.

This scenario changes, of course, as a doctor moves through their training. Once on a training program, the success of the junior doctor is very much of interest to a department director as it impacts the flow of patients through a department and on individual patient outcomes: the junior doctor who is now in a more fixed position provides a consistent resource which also encourages greater protection. However, for interns and residents undertaking ten-week rotations, as Bill suggests, "If I do a half good, half bad job, they're not going to get worried… if I don't completely stuff up, but it's not the best job in the world, it's okay. If I don't develop my skills too much, it's also okay because I'm going to be moving on anyway." Whilst the model appears to be educational, the actual structure is of a junior worker who has fewer qualifications. The key here is that the 'rotation' structure itself means that the people providing the education have little incentive to do it well.

Likewise, if an intern or resident is treated poorly by a more senior staff member, they are less likely to report the behaviour if they know they are going to rotate to a different term in ten weeks or less. My informants often said that they tolerated being spoken to in an unprofessional manner because they knew that their rotation was almost over and that they would not need to work with that particular person anymore. Senior staff members may also be less motivated to treat junior staff well if it does not reflect poorly on their department and if the individual junior doctor's resilience and wellbeing is not going to impact heavily on the department in the long term.

The issue that we are seeing exhibited here is an example of when an economic logic colonises a social phenomenon. The junior doctor has been taught to see themselves as a commodity or resource. But to be a valuable resource, senior doctors need to spend time and effort educating the junior staff so that they can eventually make a more senior contribution to patient care. However, the problem lies in the fact that the seniors are being asked to bear an individual cost for the creation of a common good, which is actually in opposition to the individualised incentives at play. The delayed benefit is good for the Australian health care system itself but will not make daily life easier for the senior staff member who is in charge of training the junior doctor. It may not even contribute directly to that specific hospital. The benefit of training is either generalised to the whole industry or is for the individual junior doctor herself. The teacher or the teacher's corporate group, in this case, the hospital, does not profit. The key is in finding what motivates the seniors to feel that the junior doctor is worth their energy.

A 'Deep-Rooted Cultural Problem'

In a 2018 opinion piece written for *The Guardian*, Australian oncologist, Dr Ranjana Srivastava, wrote that 'when doctors are bullied, all of society is harmed.'

> The healthcare system's time-honoured response to bullying is to ignore the bullied and cover for the perpetrator… There is still a propensity to treat bullying of doctors as some kind of aberration rather than what it really is, a deep-rooted cultural problem.

This 'deep-rooted cultural problem' was brought into the spotlight when the College of Intensive Care Medicine of Australia and New Zealand (CICM) stripped the Intensive Care Unit at Westmead Hospital in Sydney's West of its accreditation in 2018. During this ordeal, however, as Srivastava points out, news coverage suggested that Westmead's ICU was still safe. That is, despite doctors being bullied with seemingly the only way to protect trainees being to remove them from the department altogether, 'it's not like anyone was turning the ventilators off'—

patients would still be treated (Srivastava, 2018). Reassuring the public that the quality of care at Westmead was not affected by its de-accreditation completely undermined the fundamental issue of bullying itself and ignored the fact that mistreatment of training doctors does have a significant impact on the care that these doctors can provide to their patients. Srivastava argued that 'in one fell swoop, this [news coverage] succeeded in diminishing the serious issue of bullying and harassment and make it out as a problem of individual doctors rather than a rotten system.'

Yet, the individual experiences of bullying and harassment of my informants, their colleagues who they observe on a daily basis being illtreated, and Srivastava herself demonstrate that bullying and harassment in the medical sector is still widespread and does have implications for patient care. Srivastava was yelled at, told she was 'a disappointment to medicine', and had opportunities taken away from her. 'The bile used to rise in my mouth as I neared work and my most constant companion became fear. What would I be blamed for today?' she writes. Despite not making any major errors in her practice during this period of her training, Srivastava felt that her clinical acumen was not good enough. 'I was emotionally depleted,' she explains in her article. 'I treated the disease but not the person. I prescribed drugs but couldn't find compassion. I knew that medicine should mean more but I had nothing to give. In those circumstances, making a grievous error was only a matter of time.'

Srivastava suggests that an impact on the quality of patient care because of bullying and harassment was inevitable and 'only a matter of time'. This comes as a result of seeing the problem as an 'aberration' rather than what Srivastava describes as a 'deep-rooted cultural problem perpetuated by those who should know better but get away with behaving badly because they have power and influence.' Her experience also demonstrates how bullying and harassment can contribute to burnout amongst junior doctors.

'Teaching by Humiliation'

Kerry O'Brien and Quentin McDermott presented a *Four Corners* investigation on the Australian Broadcasting Corporation (ABC)'s network in 2015, entitled *At Their Mercy*, which told of bullying and harassment of junior doctors in Australian hospitals. O'Brien and McDermott argued that 'a toxic culture of belittling, bullying and bastardisation is poisoning the lives of young trainee doctors in some of our major teaching hospitals' and quoted their own informants' experiences who outlined 'an entrenched cycle of abuse where teaching by humiliation is routine.' This idea of 'teaching by humiliation' aptly describes Arham's earlier description of how he got better at making referrals because he was treated disrespectfully when he made a less-than-perfect phone referral to a senior specialist.

In contrast, during our interview, Matt explained that the tension that comes from senior doctors over the phone inhibits his ability to learn and improve his clinical practice. A 26-year-old intern based at a metropolitan hospital in New South Wales, Matt had completed an undergraduate medical degree in Sydney and regional NSW. He described internship as "a fun job" but had not yet decided which specialty he wanted to pursue. "I'm not too sure what I'm interested in," he said, "either physicians' [training] or critical care." One aspect of work he did show a keen interest in was being able to improve his clinical expertise to become a better doctor. He found this difficult though, when he discovered that more senior doctors were not so concerned with teaching him. Matt described a phone call he had recently made to a surgical SRMO—bear in mind that an SRMO is a senior resident, usually working in an unaccredited role whilst trying to get on to their preferred specialty training program. Matt had called the SRMO to ask about some medications that a patient had been prescribed. "I was like, 'Oh, I think these analgesics aren't working. I think this [other] analgesic could be a good one to try.' And [the SRMO] was like, 'Have you ever used that one before?'"

Matt told the SRMO that he had not used this particular analgesic before as it was his second day as an intern. The SRMO replied, "Okay, then don't use it." Matt felt discouraged by this response.

> I was just like, how am I ever going to learn if I don't use what I think will work? I'm asking you for confirmation that it's safe kind of thing, and do you think it's appropriate? And that I could learn from this patient. He kind of just shut me down, and it was probably because he was busy…

Matt understood why the SRMO may not have been enthusiastic about explaining to him why he should or should not prescribe the new analgesic. But he was frustrated by the experience and found it "annoying." Matt's dual roles put him in a position where he could not learn. He is both a junior staff member with little experience and a doctor in training. These two roles clash in that the way someone speaks to a less competent subordinate may be incompatible with helping that person learn and improve their skills. Even though Matt was not necessarily humiliated by the more senior doctor on the other end of the phone, he felt let down by the interaction, which demonstrates the impact that this type of friction can have on the training of junior doctors who could otherwise learn a lot from interactions of this nature.

Making Telephone Referrals

Making referrals was one aspect of their workday, which my informants described as especially anxiety-inducing. 23-year-old Kavya worked at a teaching hospital on the outskirts of Melbourne. She grew up in regional Victoria and had studied medicine as an undergraduate student straight from school. When we met in October 2018, Kavya was nearing the end of her intern year. She was working on an emergency department rotation and described a recent confrontation with her boss. "It had been an awful night," she explained. "The whole hospital

was like bed blocked,[30] and a lot of people that probably shouldn't go in to the short stay unit [a part of the emergency department]… got put in there because there was nowhere else for them to go." Kavya was the in-charge intern overnight, and by the time her boss arrived in the morning, she felt that she had "survived the night." However, her boss was "so grumpy when she came in," and Kavya was berated for her handling of the department. "She was so grumpy and asking me really specific questions. There were so many patients and that same feeling of incompetence. I thought 'oh, I've survived the night,' and then I was like, 'oh no, I haven't. I've done really badly.'

This experience and hearing from her colleagues who had also faced similar situations made Kavya feel particularly anxious every time she was required to make a referral to another area of the hospital. This anxiety seems to stem from the self-doubt, which was exacerbated by the consultant after Kavya felt she had managed to successfully get through a really difficult shift without any senior support. I asked Kavya what sort of circumstances during her internship made her feel anxious. She explained that making referrals was especially challenging. Not necessarily because she had come up against any nasty specialists over the phone yet, but because "there's so much hype around [making referrals] and so many bad stories… you're always just waiting for someone to be furious," she explained. This story illustrates how, even though *every* junior doctor is not bullied whilst making a phone referral, they go to work each day afraid that they will be treated in this way. The stories of distressing phone referrals are shared amongst fellow junior doctors in both solidarity with those who get bullied and fear. And this fear leads to heightened levels of anxiety. Bullying also has structural effects that are not

[30] Hospitals often reach capacity. In this circumstance, doctors and administrative staff refer to the hospital becoming 'bed blocked'. That is, new patients cannot be admitted as those currently occupying the beds are not in a position to yet be discharged.

purely individual. The stories spread throughout a cohort, and an entire class of vulnerable worker is terrorised.

Conclusion

One young doctor referenced by O'Brien and McDermott echoed Gemma's description of poor behaviour when they said, 'in one moment, I could just see how this all happens. Someone bullied him, he bullied someone else, and now it's my turn.' O'Brien describes bullying and harassment of junior doctors as 'an endemic and widespread problem.' The *Four Corners* investigation concurs with Srivastava in that it concludes that this problem does not just put junior doctors in harm's way but also risks the quality of patient care. The risk to patient care comes from the inability of junior doctors to practice at their best due to emotional and confidence barriers. Matt also points to the issue that a level of friction between senior and junior medical staff impacts upon the junior doctor's capacity to learn and increase their level of medical competence.

The medical system of authority gives those in superior positions significant power and influence. The fact that those who progress through the junior years of their training then become beneficiaries of this elaborate system of ranks means that this hierarchy perpetuates itself from generation to generation. And in turn, as Arham and Gemma suggest, those in junior positions feel that they—the junior doctors—are individually responsible for the harassment inflicted upon them.

Medical professionals take on a level of responsibility and risk that the broader population cannot even imagine. And in a sense, these high stakes give doctors increased moral capital. A pattern of behaviour that might seem justified in lifesaving situations becomes habit in less stressful, day-to-day type settings. This capital makes it impossible to criticise doctors and, in

many respects, actually excuses their bad behaviour. They get permission from the public, and their peers, to ignore normal social behaviour, inappropriate or not, because of the social value placed on those who pursue a medical career. So much so that senior doctors are not often held accountable for their actions. And as the hierarchical ladder becomes more elongated, and as more and more roles are created within it, those who have managed to climb the ladder to the more senior positions feel more justified in their unprofessional actions because of the steps they have had to overcome to reach their position of authority.

My informants suggested that they found themselves reflecting on their abilities after unpleasant interactions with senior colleagues, and some felt that these encounters improved their clinical knowledge and practice. However, these interactions also eroded their self-confidence, motivation, and capacity to make necessary decisions relating to patient care and treatment. That is not to say that junior doctors' clinical practice should not be properly supervised and critiqued to ensure they are practising within their scope. Instead, interactions with senior doctors could empower JMOs, improving not only their clinical knowledge and practice but giving them the courage to speak up and ask for assistance rather than shy away when they are unsure.

With their identity so entangled in doctoring and practising medicine, negative interactions with those who inspire them and act as role models do not just cause a short term, superficial discomfort to training doctors. These harsh and belittling encounters permeate deeply to the core of how they identify themselves in society, which can contribute to more significant issues such as leaving the field, burnout, mental health issues, and, in some cases, even self-harm or suicide.

Chapter 6: "I just became cynical and burnt out."

Harry had just finished a particularly taxing semester when we met. At 28 years old, Harry had recently moved in with his girlfriend into an apartment about a 45-minute drive from the main hospital in which he worked. He had studied medicine as a postgraduate after completing a Bachelor of Oral Health and was in his second year out of medical school, working as a resident. He had recently taken on a master's degree to help to improve his CV for specialty program applications:

> I'm actually really enjoying [the master's degree]… It's really been helpful in terms of learning about everything that we were supposed to know in med school, about how to understand journal articles that [I] probably never had the time, and we were just never really taught it that well… It's been good!

However, the most recent semester Harry completed was challenging after he took on six units,[31] which he felt would be manageable based on the distribution of credits for each subject. "That ended up being just absolute hell," he explained. "So, I felt completely burnt out after that." This burnout and the lack of spare time–Harry found himself unable to spend time with his girlfriend who had lived half an hour away and who also worked full-time and studied–inspired the two to move in together.

Harry described "burnout" as an overwhelming feeling of being "completely unmotivated to do the work." He felt as though he was "done with everything." "I don't want to go to work. I don't want to do anything," Harry explained. "I just want to go home. I just want to do nothing for like a week, two weeks, three weeks. I don't know how long it will take to get back to things."

[31] In the Australian context of tertiary education, a 'unit' is a course of study.

“It was weird,” Harry told me because he had never had a similar experience. “I’m more like the turtle in the race and just press myself through a little bit every now and then.” But during this semester, Harry felt the experience of burnout was largely due to the difficulty he had balancing full-time work with all the assignments he had to complete simultaneously. “I just wasn’t coping with the amount that was there. So, I just needed a break.”

‘Burnout’ is frequently discussed in medical education and training, and the term arose throughout the course of my fieldwork as a conversation topic with informants. On the surface, ‘burnout’ seems to be a simple metaphor for describing a feeling of emotional exhaustion. Yet, informants used this term frequently and in very specific ways, which suggests that burnout is not just a case of individual failure or condition, but in fact, a recurring pattern produced by this educational system.

My informants tended to describe themselves as having burnout retrospectively; that is, they described situations in the past where they had become burnt out over time, but which they had not realised until after recovering. Additionally, some of the training doctors disclosed that they only became aware of their “burned out” condition once it was noticed by someone else—a colleague, close friend, or family member. “Burnout” also provided informants with a legitimate category in which to class an experience that is neither mental illness nor physical ailment. The concept provided training doctors with a diagnostic tool to explain their experience of severe emotional exhaustion to their peers, colleagues, and seniors, and in some respects, excuse past periods of reduced productivity without implying either a medical or psychiatric condition. The concept also helps these individuals to navigate and make sense of their own experiences.

For this reason, the chapter first explores the history of ‘burnout’ as a cultural category and legitimate complaint. The term is more of a moral or ethical judgment about being overworked than just a simple descriptor of the sufferer’s condition. This broader history provides a context for the analysis of interview data in which informants describe their experiences of burnout and

helps us to understand why the term has been so widely adopted in medical education.

A Brief History of Burnout

American clinical psychologist, Herbert Freudenberger, first used the term 'burnout' with its current meaning in 1974 to describe a particular type of emotional exhaustion, or as Emily Nagoski and Amelia Nagoski (2019, p. 2) define, 'the fatigue that comes from caring too much, for too long.' This exhaustion leads to a collapse of empathy and compassion and results in 'an unconquerable sense of futility'; individuals no longer feel that their efforts are having any impact (ibid., p. 3). Cynicism and a lack of a feeling of purpose in their work characteristically come with the physical and emotional exhaustion of burnout, which leads to reduced productivity, or with many of my informants, a substantial time out of the workforce and away from progress on their career trajectories. Burnout is thus of great concern amongst young, training doctors.

Freudenberger originally borrowed the term from the illicit drug scene, where it was used in a more informal sense. In that context, 'burnout' described the alarming consequence of chronic drug abuse. Freudenberger first observed this 'gradual emotional depletion, loss of motivation, and reduced commitment' among those volunteering at a free clinic in New York and sought to research the trend after experiencing it in his own work (Schaufeli, 2017, p. 107). Freudenberger (1986, p. 247) argues that burnout 'is the result of a person's sense of dedication and commitment to a task or job, coupled with a need to prove oneself' which may explain its increasing use amongst the group of high-achieving, career-focussed junior doctors.

Arlene Vetere and Helga Hanks (2016), however, suggest that the analogy originated in the world of engineering, where 'burnout' referred to rockets not properly watched and managed and thus burned out. Vetere and Hanks draw similarities between the burnout of a rocket and the human experience of burnout. 'In people,' they argue, 'a similar process can occur when

[individuals] work so hard that they become physically and emotionally exhausted and are quite unable to continue (run out of strength and energy)' (2016, p. 75). The parallel between humans and rocket engines suggests in some respect that humans, or in this case, junior doctors, are expected to operate like robots or machines. When they reach the point of burnout, a mechanical fault has occurred, which can sometimes be fixed given the appropriate resources, and other times is discarded.

Whilst Freudenberger's work was predominantly autobiographical, Christina Maslach (1976) considered the plight of human service workers such as nurses, for example, where she noticed that emotional exhaustion was followed by developing an overwhelming sense of negativity about their patients and workplaces. These workers used the term 'burnout' to describe this feeling of defeat. From this local experience, Maslach developed what is now the most commonly used questionnaire for assessing burnout, known as the Maslach Burnout Inventory. Burnout is common in the 'helping' or 'caring' professions, particularly medicine and allied health services as well as in teaching (Heinemann & Heinemann, 2017); until the mid-1990s, Maslach's questionnaire was worded specifically for those fields. Burnout is experienced more broadly, or at least the term applied more widely, across different professions and industries today, and the Maslach questionnaire has been updated, just as the term has circulated much more widely outside of psychology. Versions of the survey now exist to focus on professions such as teaching, administration, manufacturing, customer service, and management, amongst others (Maslach, 2010). Questions differ depending on which survey is being used. For example, the survey designed specifically for those in human services uses statements such as, 'I don't really care what happens to my patients,' which are then rated on a scale by respondents, whilst the survey for those in other occupational groups uses the prompt, 'I doubt the significance of my work'. The 'burned out' condition also implies the merit or virtue of the sufferer because it points back to the initial idealistic or highly motivated state that has been damaged, in a sense implying that the situation is produced, in part, by the sufferer's own high level of commitment.

What is damaged or lost is not merely the current state but the starting motivation when a person becomes 'burned out'; something valuable that helped to drive them is damaged, perhaps irreparably.

Commercialisation and neoliberalisation in the medical sector have placed growing demands on those working within it to deliver better, more personalised service to patients and clients while still operating with efficiency and increased demands to document care. Wilmar Schaufeli (2017) suggests that the emergence of burnout during the 1970s correlated with the rapid professionalization and bureaucratisation of the human services industry, issues facing those working within the Australian healthcare system today. An increase in '[patient's] demands for care, service, empathy, and compassion intensified' after the Cultural Revolution of the 1960s when professional authority within human services weakened (2017, p. 109). Health professionals are at greater risk of burnout when they are not rewarded or recognised for their increasing efforts, especially by those in the broader population. Medical professionals were once revered within their community, but that is not always the case anymore, with their authority often questioned by patients.

Social fragmentation—or the absence of ties between people and their communities—and an increase in individualism have also contributed to a rise in the frequency of burnout. Schaufeli (2017) suggests that a shift in the significance of traditional neighbourhoods, social groups, and networks has left individuals feeling isolated. Where a church or neighbourhood may have once provided a junior doctor working away from their hometown with a sense of belonging, a trainee living in similar circumstances today may feel lonely and lack the deep connection required for the prevention of burnout. Richard Sennett (1998) proposes this seclusion results from 'flexible capitalism', which has replaced predictable social traditions with institutions that are constantly changing and upon which an individual cannot rely.

Many of my informants described periods of burnout throughout their medical careers. Notably, medical education pits individual against individual, undermining connection and collective support, and contributes to the increase in burnout amongst junior doctors and trainees.

Burnout or Compassion Fatigue?

Vicky was a visiting medical officer in respiratory medicine at a tertiary hospital in Sydney when we met in 2018. During her interview, she mentioned that she had experienced a period of burnout during her medical training, which she had only recently completed at the same time she was having three children. I asked her to describe her burnout experience, and she replied, describing it as though it was happening to someone else ('you'):

> You're just a bit uninterested, you know? Everything pisses you off. The fact that nursing staff page you for stuff which they need to page you about annoys you. And the inefficiencies. They could just write it all down on a bit of paper, and you could come and do it in one hit, but they don't. They just keep paging you.

Vicky felt herself getting "angry about everything". She considered leaving medicine but stayed after an elective term in Zimbabwe. She ended up doing a Master's in Public Health, had children, and found that she enjoyed medicine a lot more when she finally went back to practising. Having some time away from medicine may have helped Vicky to re-find her motivation for pursuing a career in medicine, but something about her elective term overseas may have also contributed to her becoming enthusiastic again about her work. Reconnecting with her intention outside of the day-to-day banality of the hospital environment may have assisted in coping with her burnout.

The disinterest and feeling angry toward everything and everyone around them were characteristics of burnout. But the anger and disinterest are also a result of compassion fatigue.

Compassion is an essential attribute for doctors who spend their days treating and caring for sick patients. However, being compassionate day in and day out, particularly in the relatively thankless roles in which many very junior medical staff find themselves, can be challenging and often results in a specific type of fatigue. Osseiran-Moisson and colleagues (2015) consider the plight of nurses in emergency departments or acute-care hospital environments in Australia, suggesting that burnout is actually an element of compassion fatigue. They also argue though that compassion satisfaction can, in fact, protect an individual from burnout. Arohaina Nimmo and Peter Huggard (2013, p. 37), on the other hand, suggest that compassion fatigue along with 'vicarious trauma' and 'secondary traumatic stress', are terms 'used to describe the potential emotional impact on health professionals of working with traumatized patients and clients'. More specifically, they describe compassion fatigue as 'the diminished capacity of a health professional when experiencing the distress at knowing about or witnessing the suffering of their patients and clients', whilst vicarious trauma describes 'the undesirable outcomes of working directly with traumatized populations' (2013, p. 38). These responses seem to cause the health professional to feel empathy toward the patient or client with whom they are engaging.

Clinicians who experience compassion fatigue, vicarious trauma, and secondary traumatic stress report similar consequences or outcomes as those who report burnout, such as increased rates of absenteeism, reduced work quality and efficiency, and in the end, leaving the workforce or moving into a different industry (Darr & Johns, 2008; Gorman & Brooks, 2009). Figley (2002), however, suggests that if compassion fatigue can be recognised early, burnout may be preventable. Compassion fatigue and burnout are thus intertwined and overlap in many respects, but each lends itself to different ways of imagining the problem and potential solutions.

The Individualised Nature of Burnout

The nature of burnout is different from simply being irritated with work or negatively affected by a challenging encounter with a colleague. When an individual says that they are 'fed up', some, if not all, of the blame is directed at the situation with which they are frustrated. Experiencing burnout, however, is more individualised. Reaching a point of burnout does not depend entirely on the situation itself. That is, whilst being 'fed up' is of a situational or interactional nature, the context that the junior doctor finds themself in when experiencing burnout is not always relevant. Burnout individualises the condition rather than recognising it as a social tangle of overwhelming responsibility. As Vetere and Hanks (2016, p. 75) put it, much like in rocket science, burnout implies 'a malfunction within the individual.'

With these implications of limited resources and malfunction comes an overwhelming sense of shame and self-blame. Vetere and Hanks use the example of abused children who often take responsibility for the abuse done to them. These children often say, for example, "If only I was nicer, if only I had not said [that], if only I had told someone of the abuse…" (2016, p.75). When describing their burnout, my informants often used similar phrasings to those of the children in Vetere and Hanks' account. Maggie, a 35-year-old training doctor, for example, said she felt as though she "shouldn't have ever become a doctor". Other trainees suggested they wished they had known more of what to expect before pursuing medicine, or they felt that they should have approached their director of training for support to avoid periods of burnout. This language suggests a degree of self-blame amongst my informants, much like the children described by Vetere and Hanks.

Hyun-ae was a recently graduated Oncology fellow in her early 30s when we met in May 2018. She describes having "fallen into medicine" straight out of high school but continued pursuing this path when she realised that it was a career that she could mould to suit her interests. Once she had decided to go into Oncology, Hyun-ae applied to the training program on the proviso

that if she did not gain immediate entry, she would take a year off: “I remember thinking because of all of this burnout stuff, a friend of mine and I were really considering taking a year off.” She explained that a few of her colleagues had made the decision to take a year away during training to avoid suffering from burnout. Whilst Hyun-ae had not yet experienced a period of burnout during her time in medicine, she was prepared to make the decision to take a year away from work and training altogether if it meant reducing the risk. This decision would delay her training and mean that she would be placed a year behind where she might otherwise be in relation to her earning capacity. Many of the training doctors who I interviewed expressed similar worries, having altered their working habits or behaviours at some point throughout their medical career either to reduce the severity of the burnout or prevent it from happening altogether.

Although junior doctors were aware of the tough work conditions they faced, they also demonstrated agency in mitigating the consequences. A doctor working long hours at low pay with little administrative support faces an increased risk of developing signs of burnout, which include but are not limited to physical illness, emotional problems (or mental health issues), absenteeism, negative attitudes, and reduced quality of patient care. Sochos, Bowers and Kinman (2012, p. 62) define ‘burnout’ as the consequence of ‘prolonged work-related stress,’ whilst Guthrie and colleagues (1999) found that particular aspects of being a training doctor—ward rounds, being on call, and academic study, for example—cause significant stress. Markwell and Wainer (2009) identify longer work hours without breaks or recovery periods and unpredictable schedules as two of the factors contributing to burnout, and subsequently, mental health issues.

Yet, burnout appears to be a more complicated equation than mere exhaustion related to a lack of breaks on a shift or erratic schedules. Hyun-ae said that she only wanted to take a year off if she did not yet onto her chosen training program. Her experience demonstrates that burnout

seems especially likely when training doctors are stuck in the 'holding pattern' of labour relations during which time they are 'training' doctors in the sense that they have a lower status in the workplace and less autonomy, but they are not yet on a training program and so are not getting closer to their specialty qualification.

Markwell and Wainer (2009, p. 441) suggest that junior doctors struggle to gain control over their work-life balance and are perhaps 'less willing to accept the personal costs traditionally associated with a career in medicine.' Work-life balance in this context does not only refer to a lifestyle trend. Instead, finding a level of balance between the time spent at work or doing work-related activities and life outside of work (which might include but is not limited to family time, hobbies, and exercise) might assist in the prevention of burnout. In contrast, the majority of junior doctors I interviewed were very familiar with the personal costs associated with the careers they had chosen and were almost always willing to accept these costs. My informants also demonstrated self-awareness concerning their own limits and, in many cases, took leave before or when they felt they needed to recuperate. Having this self-awareness is both a protective mechanism for training doctors and perhaps a way of prolonging their ability to cope throughout an inevitably challenging career. However, this solution also demonstrates the highly individualised nature of this coping strategy. The individual themselves must know when to take leave to avoid threatening the culturally constructed notion of 'work-life balance.'

Georgina: "There's always time for coffee…"

Georgina was a 32-year-old resident at a regional hospital on the central coast of New South Wales when we met. She had just finished a shift on a psychiatry rotation which she was enjoying primarily because of how "abnormal" she had found the interactions with her senior consultants. "I think they're trailblazers," she gushed, "in looking after us [junior doctors] as a person rather than just a clinician." Georgina told me that her consultant had phoned her at

4:30pm each day to check that she was finishing up her work to leave on time. "[He] offered to see if there was anything he could do to help me be able to leave on time," she explained. "And I missed coffee one day—we usually go for coffee after our morning meeting—and I got told that there's always time for coffee and never to miss coffee again." Her consultant had told Georgina that she was "always to have [her] breaks." This level of support and a recognition that people have a life outside of medicine was, according to Georgina, a "different" approach. Georgina explained that she had not come across this support on other rotations and had found that it made a significant difference to her experience "because… I feel like I would move heaven and high water" for the department she was working in. Feeling well-supported meant that Georgina felt loyal to her team and was prepared to work harder as a consequence. It could be argued, however, that whilst well-intentioned, this support also extracted greater loyalty and commitment out of Georgina.

Georgina's account was an outlier amongst the narratives presented by my participants. Her experience demonstrates the importance of providing support to junior doctors. The health service would clearly benefit as a result of having a well-supported, happy staff member, the risk of burnout would be reduced due to the more balanced pace of the workplace, and the doctors also then feel that they have support should they need to take some time off. Georgina explained that in a "normal" situation—that is, compared with a rotation outside of psychiatry—, she would feel that seeking help from her seniors would be a risk to her career. "I'd have to be feeling pretty bad to risk [talking to someone]," she expressed. I asked what it was exactly that she felt she was risking, and she explained that she believed that an individual would be risking their confidentiality. The world of medicine is small, and in Georgina's experience, word makes its way around the industry quickly. Information about junior doctors circulates in the same way that junior doctors themselves move around the system. This circulation of information might be important as the stakes for a department are so high if a JMO is unable to cope. Or it may be that having an underperforming or unwell junior doctor makes life more difficult for the senior

staff members. Either way, Georgina felt that the medical establishment was not "that progressive in their views on mental health," so even the concept of "being tired, it's… still considered, I think, a bit of a weakness."

Taking sick leave was a point of contention that Georgina had noticed in her few years working as a junior doctor. "Even when people call in sick, there's usually some remark from one of the seniors that maybe they're a bit soft," she admitted defeatedly. "Even if they've been coughing for weeks or looking like shit, like they haven't slept for weeks. There's still a bit of that culture where you, yeah, you keep going, and you're tough…" The ability to take leave requires a socially sanctioned rationale. The COVID-19 pandemic in early 2020 demonstrated that doctors across Australia were not even using their sick leave when they needed to do so to prevent the spread of an infectious disease. As I observed, infected doctors continued to treat patients in Intensive Care Units and Emergency Departments. Whilst an extreme example, the case of COVID-infected doctors refusing to take time away from clinical work proves the necessity for a socially sanctioned rationale for taking leave—in this case, a new type of leave was created called "COVID Leave" in the NSW public health sector for doctors who were awaiting test results after coming in close contact with an infected patient. The new category of leave seemed to diminish some of the stigma associated with taking leave or the doctors' reluctance to report being ill (or at risk of being ill).

"Burnout" seems to play a similar, important role in a non-pandemic situation. The condition, ill-defined as it is, provides an alternative rationale to take leave that might not otherwise be considered acceptable. Burnout as a condition or category can be used instead of saying 'I'm exhausted', 'I cannot do this anymore', 'it is too hard for me', or 'medicine is not the right career choice for me'. Burnout does not reflect on a junior doctor's own sense of identity, capability or level of competency. And it does not require the individual to question their decision to pursue a medical career. That is, the doctor themselves is not a failure. Burnout instead steps in and

expresses the individual's experience of being temporarily defeated by the demands of the job. A junior doctor may not get the same result from telling her colleagues that she is suffering from compassion fatigue. Burnout implicitly references having too much work in the preceding timeframe. And it validates the junior doctor's behaviour by blaming either the structures she works within or her work ethic rather than attributing it to the individual's mental health.

Perceived Shame & Identifying Burnout Retrospectively

Despite the perception that burnout plays an 'in-between' role that blames neither the individual nor the educational system explicitly (although it may blame the system implicitly to some degree), informants still resoundingly suggested that shame is a consequence of claiming to have been burnt out. Shame refers to feelings of humiliation related to one's perceptions of personal shortcomings or disreputable behaviour, particularly associated with not living up to expectations of being a successful physician. The internalised shame related to being perceived as a broken individual or having reached the limit of one's abilities could explain why many of my informants only identified their periods of burnout retrospectively. They did not know that they were 'burnt out' until they had recovered. In some cases, they identified it with the help of colleagues, family, or friends, and in others, the junior doctors identified burnout themselves.

As a medical registrar in her fourth year out of medical school, Jiang was on the Basic Physician's Training program when we met in June 2018. She was based in regional Victoria and hoped that through medicine, she would be able to "give back to the community." In Jiang's case, during our interview, she reflected on feeling as though she had avoided reaching the point of burnout because she had taken six months off the previous year. "I think maybe if I didn't have that [time off last year], I'd be at a much higher risk of burning out," she explained. "That wasn't because I thought I was burning out or anything. I just planned it. More as a prevention sort of thing." Jiang highlights two issues here: the first is a suggestion that in order to prevent

burnout, the individuals themselves should be responsible for managing how they respond to being overworked to the point of complete emotional and physical exhaustion; and secondly, the sheer pace of work and study, and the intensity of the demands she is required to meet, mean that Jiang feels that interrupting the flow of her medical education and career progression for a period of time is wiser than risking burnout. This concern of Jiang's may be in part due to the increasing discussions amongst junior doctors and their managers regarding burnout avoidance. It may also be that Jiang and her JMO colleagues are actually hyper-aware of the potential to burnout *because* of its increasing focus when, without this focus, the issue may not be quite so familiar. Jiang is pre-empting a period of burnout regardless of whether she is actually at risk herself.

Jiang described the situation of overwork that can lead to burnout. "When you're on call, and it gets really busy, that can be challenging," she explained, "especially when you've got back-to-back days of on-call. That can be really exhausting." She went on to detail how, when a training doctor does call, they do not have time to exercise or sleep well. They lose sleep and miss exercise often when they are called overnight for advice by more junior doctors on the night shift, and in many cases, they go into the hospital to review a patient or provide assistance. Consultant doctors also experience these issues when on-call, and in many instances, it would contribute to burnout amongst the broader medical community.

Jiang noted that she has watched colleagues burn out over the course of a year but feels that it does not always become obvious until after the fact.

> You see them at the start of a year, and they're going okay. And then you see them a few months later, and you can see that they're starting to get more and more tired and stressed. And yeah, by the end of the year, they're just cranky and depressed and, yeah, just not coping with it very well.

Jiang describes the cumulative effect of burnout on the individual. A junior doctor may, therefore, not realise that she has become burnt out until she is well-and-truly affected.

Thomas, who described to me the consequences of taking a day off to build a table, suggested that he had reached a point of burnout when he decided to take the day off, so I asked him to describe the lead-up to this experience. He started by highlighting how much he enjoyed the work:

> I was loving it actually. Just loving going in and being in this intense ward round and the pager, this one day… I had like 62 pages[32] or something which is a big day. 30-50 patients a day and then just bouncing around in the ward and time flying.

Thomas indicates here that he was enjoying the busyness of the rotation for the most part, and to some degree, the pace of the work was keeping him moving, which distracted him from the sheer amount of work that he was expected to do. However, when issues arose around pay and rostering and the pile of discharge letters that Thomas was required to write up started to spiral out of control, Thomas began feeling stressed. "[The discharge pile is] always hanging over your head," he said, and the documentation that Thomas was expected to write felt overwhelming. "You've got to write this fricking epic it feels like, and there's no guidance on what should be in it." He found himself spending several hours a day writing discharge summaries on top of his lengthy ward rounds. "The days are really full," he explained. "My [senior] reg[istrar] was doing her exams at the same time, so she was disappearing. Another one had kids in daycare, so she was in and out. Really patchy cover." And perhaps the final straw was having a boss who would turn up at random times requiring Thomas' assistance which made it difficult for him to get the other tasks done efficiently, if at all.

[32] Thomas is here referring to being paged 62 times throughout his shift.

Thomas found himself persisting despite feeling overworked and exhausted. Earlier in his career, he had felt excited about the work that he was doing. He did not identify himself as being on the verge of burning out until he woke up one morning and decided that he would take a day off. Even then, rather than describing the experience as burnout, his reaction was more defiant. "I'm not bending my back for you guys," he said, referring to his department and the hospital more broadly. "I'm just going to not go to work. See then how much you value me." In the moment, Thomas felt that he did not have the energy to "crawl into [his] clothes" and go to work again. He described this experience as burnout with hindsight after thinking retrospectively about it. Thomas' first defiant interpretation of this situation was one that claimed agency in his decisions when faced with the impression that agency had been taken from him. He is not just trying to avoid burnout here but also demands acknowledgement for his efforts and feels socially invisible. Burnout usually expresses a failing amid a lack of control, whereas Thomas' approach demonstrates a retaking of control from the people who he recognised had been exploiting him.

Thomas was not alone in his retrospective identification of burnout. During Bill's third year of medical school, his wife fell ill. "[It] was pretty serious", he explained, "so I had a bit of time off while she had surgery and such." Bill found this year particularly difficult to manage. He told me that on top of studying, third year also involved five days a week of clinical practice in the hospital. Students are then required to sit their third-year exam which takes place toward the end of the year and covers "half of medicine". "You're expected to study on your own time", Bill said, "over and above turning up five days a week to the hospital." When Bill's wife became seriously ill, and it required him to take some time off, he felt defeated. He described a conversation during this year of medical school with one of the heads of the clinical school:

> I turned up, and I said to [the co-head of the clinical school], I said, "Look, I don't know what more I can do, okay? I will do everything for this, but I'm not going to give up my marriage, and I'm not going to give up my health." So, we had a talk.

Bill explained that whilst he found this conversation useful, he did not quite understand the gravity of the situation until several years later. This same co-head of the clinical school came to him when he had finished medical school to express how concerned she was for him at this time.

> She said, "I was really worried about you. I thought you'd burn out at that stage. You know, you were really on the edge at that time." I didn't think I was, but apparently her assessment of me was that I was.

Bill's wife also brought up his behaviour with him around the same time, which he described as "'This-is-the-worst-our-marriage-has-ever-been' talks, from her to me."

> I said, "I'll get better… I'll behave better. I'll do all this sort of stuff." It sort of got better, and then the same talk again… This is not good. So, I actually went to a psychologist about that, about med school, about marriage, that sort of stuff. So, we're good now.

Bill's experience of having burnout highlighted to him by another person was not unique amongst my informants. Like Thomas and Jiang, Bill only recognised the burnout retroactively. "In retrospect" Bill realised that the situation was "pretty dire". He thought he was okay until his wife told him otherwise. And even then, he struggled to recognise the gravity of the situation. An individual in this situation would struggle to perceive his or her own level of motivation as the experience is so exhausting and demanding that only immediate concerns prevail. If a person's motivation is slipping and they are just getting by, perhaps they cannot perceive it in themselves as it is not immediate. Rather, the consequences are long-term. Bill's experience suggests that only a third party, someone close to the person experiencing the burnout, can really identify the problem, which may explain why informants often identified their own burnout experiences retrospectively. That is, because the situation was so demanding whilst they were in the thick of

it, these junior doctors could label this pattern or period of their lives after the fact in order to make sense of what they were doing. A person in the midst of burning out may be going through the motions, not demonstrating typical behaviour in other aspects of their life, having lost the ability to see these changes as they occur.

Through their collective retrospective recognition of burnout, Jiang, Thomas, and Bill all highlight a sense of shame associated with the experience. They described themselves as struggling 'in the moment' despite recounting it retrospectively and explained that they lacked the motivation to competently deal with both work and personal issues. They also find it difficult to recognise that the underlying cause of these issues is that they have run out of the emotional resource that would normally maintain them in the face of their challenging lives. The shame response exists in part because burnout is an experience that is highly individualised: junior doctors feel personally at fault for their inability to remain resilient. But shame also derives from the inherent misunderstanding of burnout within its cultural context. Shame may also prevent my informants from recognising that they are burning out whilst it is happening and could explain why they tend to become aware of the experience in retrospect. Burnout as a social category provides informants with a way of describing and making sense of their shifting behaviour and experience.

Understanding the Experience of Burnout through Metaphor

One particular junior doctor made national news in Australia in early 2019 when her blog post, entitled "The Ugly Side of Becoming a Surgeon", went viral. Miko, a junior doctor who resigned from her position as an unaccredited surgical trainee after experiencing bullying and harassment in a Sydney hospital, unpacked her own experience of burnout which ultimately led her to quit medicine. Miko starts the post by writing:

> I never thought I would say this, but I broke. I give up. I am done. I surrender. I am handing back my dream of becoming a surgeon. I have nothing left to give. I don't want it anymore. I've lost my ambition. I've lost my spark.

As Miko articulates, when an individual 'burns out', they inevitably 'lose' their 'spark'. The spark lights the fire in the first place and then keeps the fire alive. In contrast, 'burnout' provokes images of a fire at the end of its life, a fire that flared too quickly or burned too intensely and used up its fuel. This depiction of burnout offers a way to envision and thus explain the physical and emotional aspects of the cultural understanding of this human experience.

George Lakoff and Mark Johnson (1983, p. 3) argue that 'metaphor is pervasive in everyday life, not just in language but in thought and action.' That is, the way we think, act, behave and contextualise the world around us is defined by implicit metaphors. Metaphorical concepts 'structure what we perceive, how we get around in the world, and how we relate to other people,' so it makes sense that the way junior doctors describe their circumstances influences their experiences and those of the individuals with whom they interact each day, particularly their peers.

The pervasiveness of metaphor, however, is not obvious, and we are typically unaware of its effects. Studying metaphorical language allows us to consider the behaviour or actions of junior doctors and build a greater understanding of what it is they are doing. Metaphors also provide insight into the society within which they are used, as they are inherently tied to our culture. Lakoff and Johnson (1983) use metaphorical concepts related to time—*time is money, time is a limited resource,* and *time is a valuable commodity*—to demonstrate the way that metaphors reflect their cultural context. They influence how Westerners conceptualise time, but other societies do not necessarily conceptualise time in this way. These metaphors 'structure our basic everyday activities in a very profound way' (1983, p. 8). Because Westerners act as though time is a precious commodity, they also '*conceive of* time that way… Thus we understand and

experience time as the kind of thing that can be spent, wasted, budgeted, invested wisely or poorly, saved, or squandered' (1983, p. 8). For example, English speakers use phrases such as, *'I've invested a lot of time in her,'* or *'you're running out of time'*. This language suggests that time is finite and should be used carefully. The metaphor influences how the user behaves, how they manage or negotiate their time, and therefore how they comprehend time.

In much the same way, my informants do not just use the term 'burnout' to describe their experience; the metaphor influences how they understand their experience and hence how "burnout" is actually felt by that individual. Burnout, like time, is a metaphor used specifically in the modern industrialised West—it is tied to a particular culture and would not be understood in the same way elsewhere. *Time is money*, like burnout, may not hold the same meaning in different societies or cultures. 'The meaning is not right there in the sentence', argue Lakoff and Johnson (1983, p. 12), 'it matters a lot who is saying or listening to the sentence and what his social and political attitudes are.' To those building rockets, 'burnout' has a very different meaning to the junior doctors that I interviewed. The burnout metaphor provides junior doctors with a way of empathising with and understanding one another's experiences of being overworked and reaching a point of severe exhaustion.

Miko uses the 'spark' metaphor to describe her inspiration and motivation. She suggests that the spark she had within her—her ambition—, which may also be metaphorically described as a 'fire within', is what allowed her to continue in the face of adversity. The spark that fuels her motivation and inspiration is all-consuming—but contained within this image of inspiration as a spark is an implicit danger of the spark being extinguished or of it igniting a destructive fire. The passion she originally held for surgery had been overwhelmed by the extreme exhaustion, bullying, harassment, and loss of control of her situation.

Miko repetitively uses first-person narration. She does not name an institution here and only talks of herself being broken rather than the problem lying inherently with the educational

system. This erasure makes it impossible for those reading her post and for herself to blame anyone or anything other than Miko. The anonymity of the blog post as the forum she chose to describe her experience exacerbates the decontextualization of her account of burnout. She states that she is 'handing back [her] dream of becoming a surgeon.' Whilst the dream is one with which she identifies personally, Miko implies here that she never owned this dream, and her choice of language suggests that if she does not follow through on her dream, she must return it. The 'dream of being a surgeon' or doctor is not an individually contrived or driven aspiration—it is instead a product of the person's social context, in this case, the Western aspiration of pursuing a financially rewarding and professionally fulfilling career in medicine. Becoming a surgeon or doctor is a pathway or vocation upon which one feels called to embark. With this vocation comes a level of responsibility to fulfil the expectations of the community or greater society more broadly.

Miko goes on to express that she has 'nothing left to give' suggesting that she feels she is finite and cannot put any more of her personal energy or identity into her training regardless of whether or not it is for the greater good. Having nothing left to give implies that her resources or capacity have been all but exhausted. Miko then calls the dream 'it' ('I don't want *it* anymore'). The dream becomes de-personalised or de-individualised. We see a clear lack of identification with what her dream once was as a professional and an increase of distance to the job (once also her dream). Turning the dream back in separates her individual identity from what was once a vocational calling.

The imagery of 'burning out' differs from that of being physically or spiritually 'broken'. 'Burnout' suggests a fire burning so quickly that it puts itself out. The passion or ambition for a career in surgery extinguishes in a similar way. 'Burnout' is an experience that happens *to* an individual rather than an outcome that the individual themselves has some control over.

Burnout provides training doctors with a diagnosis of sorts of their diminished enthusiasm and lack of energy.

Burnout as a Culture-Bound Syndrome

The diagnosis of 'burnout' is not enough to warrant paid sick leave because the cultural category does not sit neatly into a biomedical model. The World Health Organisation includes 'burnout' in its 11th Revision of the International Classification of Diseases and describes it as an 'occupational phenomenon' rather than a medical condition (2019). That is, 'burnout refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life' (WHO, 2019, para. 5). The World Health Organisation defines burnout as:

> …a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions:
>
> - feelings of energy depletion or exhaustion;
> - increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and
> - reduced professional efficacy (WHO, 2019, para. 4).

My research suggests, however, that burnout among junior doctors is experienced and conceptualised as resulting from a combination of work-related stressors *and* issues that an individual faces in her life outside of work. In an anthropological sense, burnout is an emic or locally recognised condition that is not universal. Additionally, whilst training doctors are not the only occupational group to experience burnout, they are a sub-section of a broader population of neoliberal, educated, middle-class Westerners who experience burnout as a culture-bound syndrome.

A ‘culture-bound syndrome’ is a set of symptoms that present themselves within a specific group and were originally included in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), despite having a long history in both anthropology and psychology. Culture-bound syndromes present as clusters of somatic, behavioural, and psychological symptoms broadly recognised by a culture but which may not appear in other populations.

> A culture-bound syndrome is a constellation of symptoms which has been categorised as a dysfunction or disease. It is characterised by one or more of the following:
> (1) It cannot be understood apart from its specific cultural or subcultural context.
> (2) The etiology summarises and symbolises core meanings and behaviour norms of that culture.
> (3) Diagnosis relies on culture-specific technology as well as ideology.
> (4) Successful treatment is accomplished only by participants in that culture. (Ritenbaugh, 1982, p. 351)

Burnout, as junior doctors describe it, satisfies at least the first and second aspects of this definition of a culture-bound syndrome.

Arthur Kleinman (1977) considers how different societies create categories to describe conditions based on the meaning of illnesses within specific cultures. Kleinman refers to the culturally-specific conditions as ‘folk illnesses’ as they were traditionally studied in non-Western societies. However, Cheryl Ritenbaugh (1982) suggests that these syndromes exist in the West and that their meaning should be considered in light of the dominant biomedical model which otherwise tends to obscure the cultural aspects of illness. She argues that a fundamental difference in the function of disease categories does not exist between Western and non-Western societies. Rather, in the West, as researchers, ‘we experience our own culturally derived disease categories as real and have only closely questioned disease categories in other cultures which we cannot intuitively understand’ (ibid., p. 348).

Ritenbaugh is suggesting that Westerners can see the cultural components of illnesses in other societies as they are unusual to the Westerner and thus appear more obvious. In one's own culture, however, these intricacies are somewhat hidden because a category is largely accepted without being questioned to better understand how the category came about and how it plays out in the individual experience. Ritenbaugh writes on obesity in the West as an example of a culture-bound syndrome. In some societies, 'mild-to-moderate obesity is considered to be a sign of beauty and/or health', including in the United States until the 20th Century (Ritenaugh, 1982, p.351). Today, obesity is classified as a serious health problem, even an epidemic. The incidence, prevalence and impact of obesity, in this sense, cannot be understood outside of the cultural context within which it occurs. If interpreted without regard for the context, it may be misconstrued and thus not properly appreciated. Individuals from a cultural context that considers obesity to be a sign of good health would not understand the grand appeal of the weight loss industry that encourages a model that is in complete opposition to the idea that more weight equals greater health.

Obesity makes for an interesting comparison with burnout as a culture-bound syndrome because, as Ritenbaugh suggests, 'the Western separation of mind from body has led to a view of the individual as not responsible for his/her illness' (1982, p. 352). And in the case of obesity, the biomedical model describes the illness as an imbalance between energy spent and energy consumed. This description boils down in more simple terms to be the result of eating too much and exercising too little. 'These terms,' Ritenbaugh argues, 'are the biomedical gloss for the moral failings of gluttony and sloth' which correspond with social themes in the United States around self-control (ibid., p. 352). Burnout, whilst not technically a biomedical category, implies that the individual is not to blame for their suffering—a connotation that is important in a society that places significant value on productivity, strength of character, and resilience. Burnout is a 'gloss' for an individual's own failings of these personality traits. It is also an ambiguous term used to avoid either a psychiatric diagnosis or a moral failing.

In many respects, the symptoms of burnout are similar to those of depression; but due to the stigma associated with the designation of 'depression' and social pressure within the medical community to persist, 'burnout' provides an alternative, perhaps lower stakes category with a decreased risk of having an ongoing impact on an individual's career progress. That is, to say 'I'm distressed' or 'I'm depressed' starts a very different process than if an individual were to say, 'I'm burnt out.' The varying reaction to these phrases is in part because depression is recognised officially and is heavily medicalised, often treated pharmaceutically. The irony here is those junior doctors who describe themselves as 'burned out' intentionally avoid using a medically sanctioned diagnosis in order to avoid stigma, self-incrimination, or derailing their careers.

A junior doctor has a few options when facing the symptoms of burnout: she could admit that she is depressed, exhausted, overworked, and in desperate need of stress leave. This admission would be noted on her record—a fear that my informants overwhelmingly shared due to the threat of retribution they associated with acknowledging their condition. Or the junior doctor could claim she was or is 'burnt out'. The cultural image of the spark or passion that this doctor originally had for medicine has been dimmed or even extinguished for the time being, but the designation avoids treading into symptomology of more severe, explicitly medical conditions. If the junior doctor takes a break—maybe six months out of the workforce or working at reduced hours—she can come back and continue on as though nothing has happened. The junior doctor experienced a period of 'burnout'; the narrative explains absence from medical training in an acceptable non-medical language. An inherent problem does not exist with the individual or the educational structure, and so re-evaluation is not required.

Additionally, claiming to be 'burnt out' implies a faltering of motivation rather than a more severe mental health issue like 'depression' or physical illness like 'chronic fatigue.' Being burnt out, therefore, is an ambiguous claim which may, in some circumstances, work strategically for the junior doctor themselves. Whilst some individuals actually seek out a medicalised diagnosis

and struggle to get the medical system to recognise their condition, doctors who actually have authority over who gets a diagnosis have introduced an intentionally vague category specifically to avoid one. These doctors are aware that sometimes an individual needs a diagnosis not just for medical reasons but also for legal and social ones. And in this case, a diagnosis of a mental health condition may have repercussions professionally that the junior doctor is trying to avoid. 'Burnout' makes an implicit critique of the system of rules and qualifications itself that leaves people feeling exhausted and like they have lost their enthusiasm in medicine while, at the same time, they most carefully avoid certain kinds of diagnoses that will exclude them from career opportunities.

Motivation Maintenance

Lulu is a paediatric registrar in her early-30s. Originally from New Zealand, she now works at a children's hospital in Sydney and lives nearby with her partner. Lulu had recently come back from three months of leave when we talked. "I needed it," she said. "I was really quite, just exhausted basically." Lulu explained that she had finished her exams and then went straight into a more acute training setting. "I just needed to rest… I just needed to have a break and regroup… I'd come through a bit of a tough time personally, and I had a big breakdown."

Lulu told me she felt her lack of a "big support network" in Sydney had contributed to this breakdown. She sensed she could not sit down for another year to study for another set of exams. "I just couldn't face it," she told me.

> And you know, I think people talk about burnout, and you start to see some of that in yourself and that you just… It's not that you don't care about your patients, but it's just, you have to dehumanize them a little bit to be able to cope with the work that you're doing. So yeah, you just need a bit of time to get excited about your job again.

Motivation maintenance is a recurring issue for junior doctors. In particular, when an individual finds themselves struggling to establish and maintain a social network, given how the medical education system is set up and what is required of training doctors, they find that their motivation for continuing in medicine sometimes wanes. Lulu suggested a link between the humanity of patients and a sense of excitement toward one's work. As such, dehumanising is the loss of the ability to perceive medicine as 'exciting'. 'Burnout' is used to describe the feeling of discomfort that comes with this shift in motivations. 'Burnout' may, in this sense, describe junior doctors who came into medicine with ambitions of "helping people" and then discovered that they were beginning to care less about their patients than they wanted to and coping with stress by dehumanising the very people that they had envisioned their work would serve.

Maggie, who was in her mid-30s when we met for her interview, had a much more serious struggle. She suffered from severe mental health issues, which contributed to two suicide attempts since working as a doctor and one whilst she was in medical school. Maggie explained that she has always worked part-time to prevent herself from reaching a point of burnout. "I burn out very fast," she explained when we met for a coffee. I asked Maggie if she could explain what burnout looked like for her.

> Just a combination of agitation and low energy. Like, I'm not calm. My mind is just full of junk, turning things over. But I'm also exhausted and flat and can't concentrate on things. I can't read. I can't… It's like I have my day off, and I get up in the morning, and I don't want to do anything, but I don't want to do nothing, and my head just kind of spins all day.

Maggie, interestingly, did not directly link her suicide attempts with experiences of burnout. Her description of burnout has some characteristics which overlap with fatigue, but she describes specifically a sense of confusion or indecision, of being stuck between action and inactivity. She does not want to do anything but also does not want to do nothing. Her head spins, and she

finds she cannot concentrate. It is almost as though Maggie has lost what it is that motivates her to stay focused and interested in her work. Even on her day off, Maggie describes not being able to find interest in activities she normally would enjoy. Maggie uses a combination of time off and doing activities she enjoys to "bounce back" from an episode of burnout. "Just remind myself, 'Oh yes, there's other things besides work'." Much like Lulu, Maggie uses 'burnout' to describe a period of time during which her motivation for pursuing a medical career has faltered instead of describing this experience as depression in spite of the way her description matches symptoms for the condition. In fact, Maggie suggests that the antidote to 'burnout' is not necessarily to find her motivation to work again but to remind herself that work is not everything. She describes a type of healing process that involves getting away from her day-to-day routine that she is living with medicine rather than getting back in touch with what drove her to do medicine in the first place.

Nick also told me that he feels as though people who choose psychiatry as a training pathway tend to be more aware of burnout. "I think we're more acutely aware of it because that's the nature of what we have to do. We have to be aware and sensitive to those kind of issues." The "kind of issues" that Nick refers to here are mental health-related. He noticed that in psychiatry, like other specialities, the year starts with many trainees, and a large number seem to resign around the middle of the year. Nick did not elaborate on why this may be the case, but the high pressure of specialty training could explain why some decide not to continue. Amongst my informants, the experience of burnout seemed especially concentrated in specialities that were touted as being more competitive and which took longer to progress through, and inevitably, maintaining one's motivation long-term would be more difficult in these particular scenarios.

Nikki felt she "just became cynical and burnt out." She described burnout as "extreme fatigue". She said, "so you're just sort of always tired, and you get used to that… I was getting migraines fairly regularly [when I was burnt out]." Nikki points to having to negotiate the fatigue brought

on by overwork and burnout with finding a degree of motivation to both overcome the burnout itself and continue on in order to progress in their medical career. This motivation can be hard to find when experiencing a period of disinterest and annoyance in what used to be an inspiring and interesting field.

The Normalisation of Fatigue

32-year-old Georgina, who works on the New South Wales' Central Coast, suggested that seeking support for issues like burnout within the hospital involves risk. "I think I'd have to be feeling pretty bad to risk [it]," she told me when we spoke. I asked what she felt were the dangers when seeking support from people like her JMO manager or Director of Prevocational Education and Training (DPET):

> I feel like you're risking your confidentiality. I feel like medicine's a really small world, and I still don't feel like medicine is that progressive in their views on mental health. But not even just mental health, but the concept of burnout or being tired. It's just not, it's still considered, I think, a bit of a weakness.

Georgina suggests that being burnt out is more like being tired than a mental health issue. In a sense, Georgina is trying to talk about her mental health here without actually being able to. Whilst junior doctors do not have time to sleep and are not encouraged to do so if they wish to do well in their careers, a lack of sleep starts to take its toll emotionally and on an individual's mental health. Burnout is, therefore, a way of grappling with the mind-body relationship in that a failure to care for one's bodily needs produces mental problems which cannot be recognised as mental health issues for the sake of keeping face and preserving professional standing.

Dyrbye, Thomas, and Shanafelt (2006, p. 354) contend, based on their systematic review of psychological distress amongst American and Canadian medical students, that burnout has its genesis in medical school. They argue that current educational processes 'may have an

inadvertent negative effect on students' mental health', suggesting that factors contributing to burnout include workload, academic pressures, concerns relating to finances, sleep deprivation, the fact that they are exposed to the suffering and death of their patients, and 'student abuse'—or bullying and harassment, as it is more commonly referred to in Australia.

Sleep deprivation contributes significantly to the development of burnout. Van Dam and van der Helm (2016, para. 2) suggest that a lack of restful sleep impacts dramatically on a senior businessperson's ability to 'recall simple facts, think through problems and reach clear-cut decisions'. They also struggle to engage, appear uninspired and lack patience with their colleagues. Doctors are impacted in the same way—an outcome which has critical effects not only on the individual themselves, but on the care of their patients. Exhaustion has become normalised for doctors regardless of their seniority and is perhaps even idealised as a virtue in some settings.

An Idiom of Distress

Bree, a 28-year-old General Practice trainee living in rural Australia, found herself on the verge of burnout and needing to take leave. Her GP, however, would not give her a medical certificate for sick leave based solely on stress:

> [The GP] was like, "I can't give you a full sick leave for just being stressed," which is a fair call. I understand that. But it meant that I was still in this awkward situation. And I was like, "okay, what if I… can you grant me a type of study leave or social justice leave or something if I can just go overseas and do a bit of a stint working in Africa or something like that? Just so I can have a sea change, sort of thing." And she was like, "No, you can't do that either." It was like, come on!

This negotiation to try to find an acceptable diagnosis to give her time away without branding her with a stigmatising condition arose because Bree's GP was also bound by the same cultural definitions that the junior doctor was navigating. That is, although 'burnout' is both a prevalent local condition and in the DSM-IV as a recognised diagnostic category, it is not used in the same way as a clinical diagnosis of depression would be, and 'stress' is apparently also not enough to warrant a medical certificate. At the same time, obvious mental health diagnoses which would have justified a medical certificate under Western biomedical categories for work-related leave needed to be avoided because they imply a moral failing or constitutional weakness on the individual's part.

In the end, Bree was told that if she applied for jobs in her area and could prove that she could not get a new position, then she could be granted leave from her training program on that basis. She had to find a justification, a rationale that would allow her to take leave while avoiding a diagnosis that might damage her long-term aspirations. She even considered intentionally stumbling along her career progression to use the system's own competitiveness to leverage some time to recuperate:

> And this was where it was weird for me 'cause I was like, "I wonder if I should just use my least favourite supervisors and submit all my bad assessment reports or, anything bad about me so that I get some leave!" And a dodgy CV so they don't want to employ me so I can get leave.

Bree felt "really backed into a corner" but knew that if she did not take a period of leave, she would get to what she described as "breaking point, like burnout point". Bree's options for self-control were eliminated in this scenario, so much so that she contemplated intentionally failing so that she could have a break from the pace of her medical training.

Burnout presents amongst junior doctors as an *idiom of distress*. Geetha Desai and Santosh Chaturvedi (2017, p. S94) define an 'idiom of distress' as an alternative way of expressing duress

which 'indicate manifestations of distress in relation to personal and cultural meaning.' The physical, bodily symptoms of burnout present as a consequence of 'psychosocial distress and cultural conflicts' when an individual has otherwise found it difficult to seek and attain support for the issue causing the stress. Those treating or providing support to the individual experiencing the distress must understand the cultural context of the individual themselves, much like in the case of a culture-bound syndrome. Burnout poses problems to the individual in this regard. That is, whilst the broader medical community recognise that burnout is a problem amongst doctors, and although it makes sense as a category, 'burnout' is not clinically validated or institutionally recognised. 'Burnout leave' does not exist, and junior doctors cannot get a medical certificate for suffering from burnout. Because a medical certificate is required to validate periods of 'sick leave' under Australian employment conditions, the category of 'burnout' therefore works socially but not institutionally. That is, an individual will not be stigmatised for claiming to be burned out, but she cannot get institutional leave for the condition. Therefore, the category does not work the way it needs to in order to actually fix the problem. Bree's experience highlights that burnout is not medicalised, meaning it cannot be used as a reason to grant a period of sick leave, but the category is accepted socially within the community to the extent that it can be offered as an institutional justification for taking uncompensated time out of one's career progression.

29-year-old Laura grew up in Sydney's Inner West. When we met, she was living and working on the New South Wales' Central Coast, 1.5 hours north of Sydney. Laura seemed distracted and anxious when we sat down over a coffee during a busy cardiology term in her residency year, her pager positioned in plain view on the table next to her coffee. She looked at it periodically throughout our interview. The pager seemed to agitate Laura. She explained that she preferred to return to Sydney during her spare time or days off to catch up with her friends, as it helped to control her stress. As the interview went on, Laura seemed to become more at ease with the

situation and looked at the pager less and less. She opened up about her anxiety and the experience of being on the verge of burnout during her third year of medical school:

> I was living with a flatmate who didn't know it, but she was massively personality disordered and probably a sociopath. She was really weird and really manipulative and just really unpleasant to work with, and at that stage my marks were super bad. My professor had to tell me like, "you're moving out of that house." He was like, "you cannot stay there," because he knew what was going on—it was another med student. So, at that point I… I couldn't perform. I broke up with my boyfriend. It was bad. I think that's probably the closest I've come to a burnout sort of situation.

Laura explained that she was grateful to her professor, who could see what was going on and helped her to get out.

> I think having supportive people around me definitely helped. Getting out of a situation that was precipitating everything and then just doing the necessary, like what had to be done, and then having a holiday… tak[ing] a break.

Laura's situation highlights that burnout arises, not just from medical training but from a junior doctor's life as a whole. Laura's situation at medical school was so demanding that any other disruptive influence in her life had to be eliminated in order to cope—not just her difficult flatmate but also her boyfriend. The problem of work-related stress was not isolated from more general adversity in life. Given the stress of work, anything outside of it can prove to be too much for an individual like Laura to handle and can therefore affect their ability to both perform well in their job and complete their medical training.

Similarly, Tim found that events that occurred outside of work triggered an episode of burnout. Tim used the terms 'burnout' and 'depression' interchangeably in our discussion, which may suggest that they mean the same thing to him. He explained that during his medical degree,

both of his brothers had attempted suicide and eventually succeeded in doing so. He experienced what he described as "reactionary grief", which contributed to the period of burnout. Tim felt on the verge of losing his motivation to do medicine, not because his work life was too stressful or causing him problems, but because he could not simultaneously cope with other situations that were taking place for him in his life outside of work.

Both Laura and Tim's experiences highlight that the cultural context in which burnout presents must be properly understood and recognised. Dealing with work-related issues is one aspect of the problem, but it ignores the contribution of stress that is triggered by situations outside of work in the structural context of a work situation that does not allow people the time to deal with challenging personal circumstances and isolates them from social support networks. In addition, Laura and Tim begin to talk about the rest of their lives *through* their experience of their own motivation to work. They are both dealing with significant, intense conflict and grief, but they measure these feelings in terms of how they might affect their ability to continue in medicine. Laura and Tim feel that they must protect their motivation to keep working rather than looking after their whole person, families, or taking the opportunity to grieve. This motivation is so precious because it has become part of their identity. Laura and Tim actually frame unrelated challenges as dangerous if they may potentially cause 'burnout' and undermine their ability to work.

The Burnout Experience for Women

Miranda was a wife, mother of one (with a second baby on the way) and paediatric trainee when we met. She and her young family lived in a small home on a battleaxe block on the outskirts of Melbourne, where I visited for an interview in late 2018. She had started her paediatric training six or seven years prior and explained that she took longer to finish than the usual six years full-

time due to maternity leave. She had also worked stints part-time. “The first three or four years of paediatric training I found relatively inflexible,” she told me. “Luckily, that was a time when I was just living with my husband, and we didn’t have any extra responsibilities or anything like that.” Miranda spent much of these first few years working and studying. I asked her what she meant by “inflexible”, to which she replied:

> I didn’t really get to… choose when my holidays were or when my weekends off were… I had to be working at least full-time, and I could also be sent to the hospitals… that were far away from where I was living without much, um, sort of choice in the matter.

Miranda and her husband moved around during this time, and she also commuted to work, which she found “challenging at times”, particularly when she was on night shifts—commuting after long shifts overnight was an issue raised by the Australian media during the early phases of this project[33] as well as a problem that other informants mentioned throughout my fieldwork. However, since those early years, Miranda suggested that paediatric training had become more and more flexible, allowing her to work part-time after the birth of her first child whilst retaining her ability to earn a significant income. She was about to take her second period of maternity leave when we spoke.

I asked Miranda what drew her to paediatrics. “I had originally planned to do general practice training,” she explained. “From sort of chatting to people that were a little bit ahead of me when I finished medical school… I thought that would be an area where I could have more work-life balance.” But she was working in paediatrics at the time, which was a requirement of getting onto the general practice training program, and she realised that she had a real passion for child medicine. “I thought paediatric training was less flexible than it actually is,” she told me. “Once I was in, I realised I actually only needed to, you know, work full-time for about three or four

[33] See Denis Campbell’s article in *The Guardian* as an example of this coverage (2017).

years and put my head down and get through exams. And then after that, I would have the flexibility that I was craving."

Many women I interviewed spoke about the desire to pursue a training program that would provide them with the flexibility to which Miranda refers. Finding a balance between work and life outside of work was a high priority for many women training doctors. In the 2013 *National Mental Health Survey of Doctors* conducted and published by Beyond Blue, the authors reported that women were more likely to face issues relating to the balance of work and home life than their male colleagues, particularly during childbearing years. Likewise, throughout medical school, women report anxiety higher than their male peers (Dyrbye et al., 2006) and were reported to more commonly experience depression (Zoccolillo et al., 1986). The latter research, published in 1986, may have come when women were still new to the profession, facing difficulties that their male colleagues did not, including the discrimination that Susan, the senior surgeon I spoke with, described. Rich and colleagues (2016) argue that women still face discrimination at work and find it particularly difficult to balance their work and other commitments.

The term 'work-life balance' was coined in 1986 but did not come into more common use for some time afterwards (Lockwood, 2003). The concept is now advocated by human resource professionals as the 'win-win solution' to issues of decreased productivity and higher rates of absenteeism in the workforce. However, Doris Ruth Eikof (2007, para. 2) suggests that:

> The work-life balance debate seems to centre on a number of questionable assumptions and perceptions: that work is experienced as negative, with long working hours a particular problem; that "life" can be equated with caring responsibilities, most particularly childcare, with the result that women are the primary target of work-life balance provisions; and that work and life are separable and in need of being separated.

According to Rich and colleagues, women often spoke of having to choose general practice as a specialty to have a career 'more conducive to a work-life balance' (2016, p. 1). My interviewees for this project, such as Miranda and others who I discuss throughout this section, support this observation. Female informants in their mid- to late-20s and even into their 30s suggested that they have often considered going into general practice rather than pursuing a medical specialty that is of greater interest to them as general medicine would provide a better "quality of life" and sense of stability that they may not otherwise find in medicine. Several women informants explained that they had chosen paediatrics as their specialty because they felt it was a more child-friendly field of medicine. Whilst Miranda chose paediatrics because she enjoyed the speciality and found that, after a few years of hard work, the paediatric training program gave her the flexibility she desired, this did not always prove to be the case for other participants who had pursued paediatric medicine.

Imagining the 'Split Dream'

Many women I interviewed experienced burnout as they navigated their professional life as a training doctor, with their life at home. Often, 'life at home' includes being a mother—or working toward becoming a mother at a later stage—wherein they face the pressure of their 'biological clock ticking' as they progress through their training and career, and encounter difficulties 'juggling' varying responsibilities with their training in order to achieve what Tanya Sharon (2016) describes as the 'split dream'.[34]

[34] Whilst bullying and harassment are of great concern to women in medicine and do indeed contribute to rates of burnout in this demographic, this section does not touch on this. See Chapter 5 for a discussion around how women experience bullying and harassment in the medical profession.

Tanya Sharon (2016) hypothesises that women face different challenges when progressing toward 'adult identities' (p. 162). She suggests that women who have ambitions of both successful careers and families may make adulthood more abstract or intangible. Sharon quotes Levinson's 1996 book, entitled *The Seasons of a Woman's Life*, which shows that women construct a 'split dream' to combine the aspects of their future lives. Although this book has been criticised as being outdated, the concept of a split dream is relevant to my informants who shared that they considered making career-defining decisions such as going into general practice training in order to have both a career and family.

Annabel explained that she had originally decided that medicine was completely out of the question as she wanted a more "balanced" lifestyle. She had originally studied physiotherapy with the intention of working part-time and having a family.

> So, I think for me really, I'm not the kind of person who wanted to do med ever until I started it. And I'm not the kind of person who has always wanted to do surgery. But unfortunately, everything I keep telling myself that I'll never want to do, I end up doing.

She laughed as she said this and described herself observing her peers during her science degree who were desperately wanting to do medicine. "I just looked at them," she said, "and I was like, you poor souls. You don't know what you're getting yourself into. Look at it. It's such a horrible life. You'll never have children. You'll never know your children. You'll never have a good work-life balance." Once she decided to do medicine, Annabel told herself that she would compromise and do general practice training. She felt this trajectory would give her a good quality of life and still allow her to pursue other interests, such as having children—the 'split dream' if you will. However, during the first practical term of her third year of medicine, Annabel was placed with a female supervisor who inspired her in many ways.

> I just happened to be with Professor Smith, who was this ridiculously overachieving, amazing trauma surgeon, orthopaedic surgeon, who has [four] kids and a family and this

> perfect balance. And she's also a chef, and she does… anyway… and there's me in third-year med being like, I want that. I want *that*. Dammit.

Annabel went on to describe the first surgery she ever saw her professor perform. "She was doing spinal surgery. And it blew my mind." Annabel was scrubbed into the theatre. "I had my hands in there. And the spinal cord was just there right in front of you, and the vertebrae that they were taking out and fixing… I just lost it… mind blown." Whilst she knew how difficult it would be to become a surgeon, particularly as a woman wanting a family, Annabel had decided that she wanted to embark on this career path. She felt inspired watching a fellow female reach this goal.

Yet, during our interview, Annabel also expressed concerns over being able to time having children within the sequence of training to become a surgeon. She explained that when she and her partner decide to have children would depend on whether she is offered a particular job, whether she passes the exam required to get onto the surgical training program, and whether she actually is accepted on to the program. "It takes nine months to cook one," she said about pregnancy. "So, for me, that weighs on my mind. And then the fact that you have a biological clock. A lot of people freeze their eggs. People in my position are talking about that all the time." Annabel was one of many female informants who I interviewed that mentioned feeling the pressure of their 'biological clock ticking'. Catherine Aponte (2019) attributes the origin of this metaphor to writer, Richard Cohen, in the late 1970s. Since its emergence, the 'biological clock' image has been described as capturing 'the interconnections and fissures between social and physiological domains regarding women's bodies and reproduction' (Friese et al., 2006, p. 1551). That is, the discourse around this concept focuses on the way that organised paid labour impacts and, in many respects, competes with a woman's most fertile years. The metaphor was widely used by the 1980s as a way of stereotyping the identity of a 'largely Caucasian, educated, upper-

middle-class… woman', which may begin to explain why the notion of the biological clock was at the forefront of my female informants' minds.

As women have taken on paid work and have had increasing access to reproductive technologies to assist in family planning, some have postponed childbearing until an age that they feel is better suited to their own personal and professional preferences. Consequently, professional women—in this case, those who have pursued a career in medicine—find themselves worrying about whether they have left pregnancy too late. Research from the UK suggests that fertility in women begins to drop off after the age of 30. At this stage, many women start reassessing their desire to have children if they do not yet find themselves in the position to pursue their childrearing plans (Iacovou & Tavares, 2011). Some women, of course, do not wish to have children at all; but the majority of the women who I interviewed for this project expressed this desire and explained that they had thought deeply about how they might go about having children alongside a career in medicine.

Early on in my interview with 31-year-old Bella, an emergency medicine training doctor based at a Sydney metropolitan hospital, she mentioned that she would like to reduce her work hours for a while so that she could focus on studying for her exams. She explained that she and her boyfriend, Carlos, were planning to move in together shortly, which she hoped would give some order to her life. "You know when you find that your life is a bit disordered, it takes away from other aspects?" she said. "So, I'm like, 'Okay, just need some order. We need to move in together. I need structure." Bella suggested that having some order whilst she studies for her exams would allow her to focus on other things in the future, such as having a family. But she felt she could not do both at this stage. "That's life, isn't it?!" she considered, "…and this is why I decided to start studying because I was like, 'Well, I might have children. I don't know how to deal with children. So, let's get these exams done, and then we can just relax a bit.'" Female trainees tended to raise the prospect of having children, regardless of when exactly that might

occur, during our interviews, and so potential motherhood must sit in the back of their minds. Much like Bella, many young female training doctors begin to plan for and think about having children well before they intend to actually do so. Both Annabel's and Bella's stories demonstrate that the planning for children heavily impacts upon decisions surrounding choice of specialty, when to sit important exams, and when might be the best time to join a training program. Their experiences also suggest that the pressure of a 'ticking biological clock' may force them to consider these aspects of their future well before they are ready to pursue them.

Additionally, the question arises around whether a woman will have children at all. A young doctor may have previously thought she would at some point have children, but after years of training, knowing she has many years left before becoming a fully qualified specialist, the plan for children may become less of a focus. In other cases, as a woman moves closer to the end of her fertile years, Heckhausen, Wrosch and Fleeson (2001) suggest that her goal for having a family becomes dominant compared to other aspects of her life. This shift in focus may explain why informants considered pursuing a career in general practice, although it may not have been their most preferred area of medicine. General practice has long been perceived as providing a more balanced lifestyle for the doctor themselves. Bishan, for example, explained that he feels his colleagues who have chosen general practice training have more hobbies and participate in leisure activities more frequently as their schedules provide a degree of flexibility that other specialities, such as surgery which Bishan himself hoped to pursue, do not. "I have some friends that very much picked their specialty based on what they thought was more [conducive] in terms of lifestyle and family," Bishan explained. "I think surgery probably exists at one end of the spectrum where you do embrace the lifestyle."

Bishan suggests here that if junior doctors are after a particular way of life that does not involve medicine "24 hours a day, 7 days a week" which surgery is renowned for (and rightly so given the long hours and on-call that surgeons and surgical trainees do), then they should consider a

specialty that will allow for this lifestyle. Many of my informants described the notion that medicine itself is a "lifestyle choice"—some felt that it made up a large part of their identity, and others explained that whilst they love their work, it is not the only factor they consider a part of who they are. More commonly, women referred to trying to find this balance between medicine and life outside of work, which often included their children or aspiration to have children at some point in the future. Interestingly, the men who mentioned wanting to find a balance between their work and home life, and who had decided to become general practitioners, already had children, including Jason and Thomas who have been introduced in previous chapters.

Damini was a 24-year-old woman who was in the twelfth week of her internship when we met. She grew up in Sydney but was working on the central coast of NSW after completing her undergraduate degree near Newcastle. Damini told me about how she had grown up wanting to be an astronaut. However, after realising that career path was not feasible, she decided to do medicine instead. "I had to settle for being a doctor," she said, laughing at the irony of this statement. Damini finds science and the human body "the most fascinating thing" she has ever learned about; she wanted to follow a career that would be challenging and have a degree of job security. So far, in her first twelve weeks, she had found the experience particularly stressful, "but also incredibly rewarding," she explained. "Sending patients home is the best bit."

Damini has decided that she would like to do physicians' training. However, this decision only came after she seriously considered undertaking general practice training in order to facilitate having a family as well. Whilst Damini did not have a boyfriend when she and I met, she very much hoped that within the next ten years, she would be in a position with a partner to have children. "I spend a lot of time worrying about physician training and how hard it would be," she expressed. "Ultimately, I do want to have kids one day, and I'm turning 25 this year, so I have sort of… in the next ten years, I will be having kids. And for a while, that in and of itself was a

reason why I wanted to do general practice." The worry of whether a career in her preferred speciality would be able to accommodate family life almost caused Damini, at the age of 25 when she still feels as though she is a decade away from having a family, to choose a different specialty pathway altogether. She went on, however, to say:

> But then I just sort of went, no. Like, I've worked really hard on my career. I don't want to go down a path that isn't going to be fulfilling long term. Yes, it might be difficult now, but ultimately, this is what I want. So, it's worth it. Another 10 years of hard work is worth it.

Her decision to undertake the specialty she is more passionate about stems from a desire to have a rewarding career in the future. Damini felt that pursuing an alternative option, even if it may be more suited to family life, was not worth sacrificing the satisfying career she feels that she will have by becoming a physician. Perhaps pursuing the specialty that she is really passionate about may, in fact, provide Damini with a degree of protection against 'burning out'.

Gemma, a 35-year-old trainee who was married with two young children at the time we met, explained that she was "trying to combine having children and training at the same time, which is challenging." The most difficult aspect to date had been meeting the expectation as a junior doctor to complete extracurricular activities, including voluntary work, to ensure the development of a competitive CV. "For example, volunteering to teach medical students, volunteering to be a member on various hospital committees. They're all expectations that are in the preferred criteria for jobs that you apply for," Gemma described.

Gemma explained that the issue she finds with completing these different elements of CV criteria is that they usually do not fall within normal working hours. "When you have small children, [it's] really challenging because you have to choose to pay for babysitting to go and do unpaid work basically in order to be competitive," she said. This dilemma makes it difficult for women, or indeed men who take on caring responsibilities, to compete with their peers who do

not have children or who are not the primary caregiver of their children or others, such as elderly parents or disabled relatives. Gemma suggested too that these extracurricular activities do not give an individual an advantage when applying for jobs or training programs: "it's basically a baseline expectation that you would do that stuff if you want to be a senior registrar," she expressed. If even the baseline expectation is difficult for women with caregiving responsibilities to achieve, women are at a severe disadvantage in terms of taking on speciality training in any area that does not provide them with some sort of support to level the playing field. The problem is that a refusal or inability to meet the baseline expectation can be interpreted as 'not wanting to be a senior registrar' or rather, not being committed enough to the training program.

Gemma was a paediatric trainee and, much like Miranda, suggested that paediatrics was a more family-friendly speciality. Any speciality which was supportive of women having children, which would include taking maternity leave and working part-time or flexible rosters, would facilitate an individual achieving the 'split dream'. Gemma had undertaken a senior residency year in adult general medicine before trying out paediatrics as an SRMO and choosing it as her specialty. She became a paediatric registrar in 2014, and between then and 2018, when we met, Gemma had worked both full- and part-time, having taken two stints of maternity leave. She described the difference between working full- and part-time as "huge!" She worked two ten-hour shifts in the paediatric emergency department[35] as a part-time staff member, which she described as "fantastic for family life." Full-time, however, was very challenging,

[35] Many senior consultants who I came across throughout the course of this research project and in my career in the health service more broadly have suggested that emergency medicine in Australia can be particularly 'family friendly' based on the shift work. However, few informants discussed this option in interviews, and most of the registrars whom I interviewed that were undertaking emergency medicine training worked full time.

> Because you don't have time. Well, you certainly don't have time if you have children to do any extra-curricular stuff to build your CV, and just the practicalities of getting to and from [work]… like if you're commuting an hour a day, and there's no hospital parking. All of those things that add up to an extremely long working day and are difficult [for] time management.

The other difficulty that Gemma described with paediatrics was that at least fifty percent of the terms she was required to complete involved night shifts. Night shifts were one aspect of her work that Miranda too found difficult to negotiate, particularly having to commute to and from late shifts. Gemma explained that she felt "lucky that [her] husband doesn't have a full-on job" as his flexible work assisted her to fulfil the night shift requirements of her role. "So that has been something that's allowed me to do [these terms]," she said. Gemma wondered how other women who do not have a husband to take on the childcare responsibilities overnight would be able to complete these shifts. This example demonstrates that women with children who have partners that also work are actually disadvantaged when it comes, not only to building up their CV so that they can compete for coveted training positions but also to meeting the basic requirements of a specialty training program.

The Importance of Other Relationships

Sochos, Bowers, and Kinman (2012) argue that social support plays a significant role in preventing or dealing with burnout. And yet, where training doctors experience issues relating to time pressure in the clinical environment and difficulties with personal confidence, they receive little support from their seniors and co-workers. In contrast, burnout and stress levels were lower amongst married medical students, as opposed to their peers who were single (Dyrbye et al., 2006). In a study by Coombs (1982), interviews showed that medical students gained emotional support from their spouses, and consequently, stress levels decreased in the year following marriage. Coombs' research is around four decades old, when individuals married

and had children younger, before current demographic trends. This factor may explain how significant psychological distress at work affects young doctors today, who are simultaneously emerging adults and who no longer have the emotional support of a spouse as those who trained before them more often had.

Relationships may support one's motivation, which may assist in making the motivation itself more durable amid challenging experiences. Burnout is not simply caused by a lack of emotional resource or energy. Instead, the particular type of moral exhaustion that is labelled 'burnout' makes it difficult to remind oneself why they persist. Motivation is not an individual trait; it is partially the product of one's social network. And one reason emerging adulthood is so tough is because an individual has not yet built the social network that she might need to help her, which might be more fully formed in 'adulthood'.

Much like Gemma, Annabel described the value in having a supportive partner whilst studying medicine and training to become a doctor:

> It's great. The support that you get from having that kind of relationship. I don't think I could do everything that I'm doing without it. So, I think that it's super important. Which I don't entirely know how people do it so independently. They must be amazing people. I think we've been together so long now that we definitely rely on each other for all that [support]. But it makes it easy. Because you spread the stress over two people. And it's like half the stress instantly.

She and her partner, Michael, had been together seven years. They had recently bought a house together and shared two dogs. When we met for our interview in 2018, Annabel explained that whilst marriage was likely, they had decided to spend their money on buying a house in the first instance rather than a wedding, so marriage was a little further off. Toward the end of 2019, however, Annabel and Michael married and, in August 2020, Annabel gave birth to their first child. So, whilst Annabel, during our interview, described an imagined path throughout the next

few years, the actuality looked quite different. Marriage and a family came sooner than Annabel had anticipated.

Women were not the only informants who found having a partner advantageous both from a practically supportive point-of-view and in relation to the state of their mental health throughout their medical careers. Tim was a 27-year-old intern at a hospital on Sydney's Northern Beaches when we met. He had studied medicine as a postgraduate student after completing a bachelor's degree in medical sciences. At school, Tim had achieved good academic results, and as he wanted to help people, he felt that medicine would be a very satisfying career. "I just feel like it fits with my personality," he explained.

I asked Tim if he could describe a typical weekend or day off, and he immediately mentioned his partner. "So, I've got a partner who I see every weekend." He went on to explain that on the weekends or whenever he has a day off at the same time as his partner, who was also studying medicine, they would spend time together. "You know, go to the movies, any events happening in Sydney we'll do," he said. He also explained that she was the person that he would go to when he was struggling with work or when his mental health was suffering. "I talk to my partner… I like the fact that I can talk to her about my day really simply, but I think I do transgress and talk about it too much." When Tim says he can talk to his partner "really simply", he is referring to the fact that she understands what he is going through as she is in the same field. "I, on the whole, am happy that she's in medicine," he told me, both because he felt it was a good fit for her as a career choice and because he liked the fact that she understood his own workday.

Several female informants expressed that they found having a supportive partner particularly useful in order to progress through their medical training as their partner could take care of the children whilst they worked and studied. Evelyn, for example, was born and raised in Vietnam and came to Australia for her final two years of schooling. She studied medicine as a second career after working in information technology for six years. Originally not particularly

interested in medicine herself, Evelyn's husband had encouraged her to pursue a medical career, and after several years of persisting, Evelyn finally agreed to sit the entry examination and was successful the second time that she applied.

Evelyn had three children whilst studying medicine. After her third year of study and on the birth of her third child, she decided to take a year off. "I never take a year off any other time," she said. "I took two weeks between leaving work and going back to uni [to study medicine]." She and her husband then decided to move from Sydney to a regional city in New South Wales, where she completed her final year of medicine and has since stayed on for her internship year. "I am still finishing my internship," Evelyn explained when we met for our interview. "Well, I took my internship in two years because I was pregnant with my fourth." She laughed as she said this. "So, I did one term of internship and then took maternity leave off."

Evelyn described coming back to work full-time after her maternity leave as "tough." But at the same time, she said, "I have a very good husband, so the kids stay at home with dad instead of childcare." She explained that her husband does not work, and so it has worked well for them to have him take care of the children whilst she earns the primary income. Evelyn really enjoys her work and finds that it renews her momentum. "The kids drain [my] energy," she confessed. "[But] going to work is a relief. [It's] recharging… You get your mind stimulated." She finds that after a satisfying day at work, she feels excited to go home and spend time with her children. And in a similar way, having her husband and children to go home to helps her get through more difficult days. "Whenever I feel a bit blue at work, I get home [and] look forward to the kids." Evelyn has found that having a large family is "complementary" to her career in medicine, despite it being logistically challenging, and has found that having her husband as a stay-at-home dad crucial in finding this balance. Evelyn demonstrates the situation that many doctors in a previous generation would have faced. That is, Evelyn's situation is quite traditional for division of labour in a household, albeit with genders reversed. And whilst this division of labour

may work in a regional town where the cost of living is less, it may not be possible in a more expensive metropolitan city.

The women I spoke with who had managed to avoid burnout and who had found this socially constructed notion of 'work-life balance' between their life at work and their life at home had not done so single-handedly. In order to successfully 'have it all,' these women had relied on their partners for motivation support and for childrearing. The 'balance' for which these women strove was not individualised. It was not something that they could create themselves; 'work-life balance' in the context of the 'split dream' was, in fact, a team effort and relied heavily on having a supportive partner who was willing to take on a large portion of the traditionally female-centric responsibilities in the home. Evelyn highlights that, in fact, separating the role of having children from the role of caring for them may allow women to perform at a different level in spite of the 'split dream'.

Implications for Women

Tania was 27 years old when we met; she had recently given birth to her first child. She and her fiancé lived in New South Wales' Hunter Valley. Tania was on six months of maternity leave at the time of our interview but was still studying for her provisional paediatric examinations. She had stopped doing her usual 13-hour night shifts at 35-weeks gestation and had gone on leave at 38.5 weeks. However, as a compromise for not doing night shifts past 35 weeks, Tania had been required to work ten weekends in a row between the 28th and 38th weeks of her pregnancy. She explained that as her husband worked 11-days per fortnight, they had spent very little time together for those ten weeks. "We just didn't see each other basically for like ten weeks of my pregnancy," she said, "But like, that's just how it goes."

Tania was worried that her training would mean that she and her family would have to move several times in the coming few years, which would be disruptive once her child was at school. She had decided fairly early on in her internship that she wanted to pursue paediatric training but had also been made aware of the sacrifice this choice, 'paeds' as it is commonly called in the field, would involve. "We have a careers night when we're PGY2s," Tania explained.

> Like, all the specialties come and talk, but at the time, I knew I wanted to do paeds. And the paeds reg[istrar] who came and spoke was like, 'be prepared to move six months out of every twelve.' So, we'll have six months at a home hospital… and then the other six months we're expected to go away.

Tania suggested that she foresaw only two ways of fulfilling this requirement: the first was to move her whole family every six months; and the second would be to have a long-distance relationship without seeing her children or partner very often. Both options would end up being quite costly as the second would involve frequent travel home to visit.

I asked if Tania and her fiancé had a plan for these periods. She explained that whilst on maternity leave, she was studying with the intention of taking her written and clinical examinations within the year. She was planning to go back to work full-time at the end of her maternity leave to complete some of her required basic training. Once her basic training was out of the way, Tania hoped that she and her fiancé would be able to have a second baby. This would mean that she could take another stint of maternity leave, which would give her fiancé the opportunity to have a period of secure employment under his belt, which would look good on his CV given they otherwise have to move around so frequently. She was hoping that after her maternity leave, she might be able to negotiate doing twelve months of training away from home in one block to avoid moving back and forth several times.

Tania's experience suggests that navigating a career in medicine with a young family and a partner who works in another industry requires detailed, long-term planning for which Tania

felt solely responsible. She highlights that time in training is important to develop sound knowledge and clinical experience, which in turn come with increased respect in the workplace. And so balancing family life with the time it takes to build this knowledge and respect is another complicated element for women pursuing medical careers. In addition, Tania and women doctors in a similar position must deal with the competing demands of their partner's career, along with the expenses and upheaval of moving the family to undertake required rotations in different locations. Despite paediatrics being perceived by some junior doctors as a more suitable option for those wishing to embark on medical training whilst childrearing, the women who I interviewed that had chosen this pathway had found themselves confronting the same challenges that those in other specialities. Whilst women like Miranda felt that the hard work at the beginning of the training program was worth it for the flexibility afforded later on, others, such as Tania and Gemma, found that having children during the earlier years of the program was difficult and meant that they were constantly negotiating the various aspects of work, study, and family life. Regardless of at which point in their careers they had children, all three informants show that the planning of childrearing and the responsibilities that come with this are felt heavily by the women themselves.

Lebares and colleagues (2018) suggest that gender is not commonly considered in the discourse around burnout and its prevention. They examined the burnout experiences of general surgery residents in the United States and documented that in surgical training, 'gender differences are seen in reports of stereotype bias, perceived social support, and unequal professional expectations' (ibid, p. 800). Additionally, they note that women in medicine tend to be held at different social standards to their male counterparts, which results in 'proven inequity in promotion, retention and compensation' (ibid., p. 800). Linzer and Harwood (2018) consider how the expectations of female and male physicians by patients of differing genders contribute to high burnout amongst female doctors. They found that 'female patients tend to seek more empathic listening and longer visits, especially with female physicians' (ibid., p. 963). Yet,

female physicians are not necessarily given more time to consult these patients and thus do not meet the social expectations of the doctor spending more time with their patient. As a result, many women in the medical profession reduce their workload to part-time to assist in decreasing work-related stress, and Linzer and Harwood suggest that this issue may contribute in part to high rates of burnout amongst female doctors.

Empathic concern and a love for their work and for helping patients are invaluable contributions that women make to the medical workforce. Additionally, women physicians very often record better patient outcomes than their male counterparts. Rotenstein and Jena (2018) cite recent research that shows lower mortality and readmissions for patients treated by women. Society's best interest, therefore, is to find ways to encourage increased participation by women in medicine. Linzer and Harwood's research suggests that addressing aspects of individuals' lives that may contribute to burnout would be beneficial, not just for the women who face these issues themselves but also for patient care and satisfaction. Whilst Linzer and Harwood highlight changes such as increasing visit times for patients, improving staff awareness of gender differences, and training for doctors in patient expectations, I suggest that we consider the broader picture. That is, we should look at how these women's lives play out both at work *and at home* during their medical training. If their concerns such as the 'biological clock' are taken into account, and they are given the help and support they need in order to find success in a specialty for which they are truly passionate, women might have more chance of achieving the 'split dream' to which they aspire whilst also reducing their risk of burnout.

Conclusion

Interviews for this project were designed to find out about participants' life outside of work. Yet, subjects in their responses overwhelmingly focussed on the various aspects of doctoring: medical education and training, work, interactions with colleagues, and career aspirations. My

informants explained that they see medicine as largely a "lifestyle choice" or as a way of life. That is, an individual pursues a career in medicine knowing that their entire life—both at work and at home—will be heavily influenced or affected by their profession, for better or for worse. My informants demonstrated an entangling of their own identity with being a doctor. From the very beginning of fieldwork interviews, when asked to tell me about themselves, these junior doctors predominantly began with a description of their professional activities. They would tell me about their stage in their training, what their role involved in the hospital or medical practice in which they worked, and about their career-related aspirations. In part, this focus on professional identity and activity was my informants' reaction to their assumptions about the general topic of my research. But in fact, this focus on medicine indicates a broader underlying pattern. When a junior doctor is asked to describe themselves, they respond by saying, "I'm a doctor." 'Work life' for a medical doctor does not just constitute a 9-to-5 job after which they 'switch off' to enjoy leisure activities or time with their families. Instead, work and 'being a doctor' makes up an individual's own personal identity—often their *sole* identity.

Because the identity of these doctors is so tightly bound to the practice of doctoring, problems related to the medical hierarchy and bullying and harassment have especially dire consequences for the victims. These individuals cannot separate who they are from their work and the interactions that they have within their workplaces. Difficult experiences, therefore, tend to lead junior doctors to question their importance within and personal contribution to their patients and hospitals. They may also question whether they are suitable for the profession. When a social role fundamental to the core of one's identity is brought into question, motivation becomes difficult to maintain. Cynicism and pessimism creep in, and the junior doctor finds it difficult to maintain the high levels of productivity that the medical profession, especially under tight management regimes, demands. In fact, in many cases, they struggle to keep working at all. Burnout occurs as a result of these compounding issues and can only be understood within a specific cultural context. Burnout is not a disorder of mental health as such; instead, it is a local

way of talking about when one's resources chronically but consistently fall just short to meet the demands placed on the junior doctor and their own standards. They can no longer maintain the motivation given that they are so obviously being exploited in the present for a future promise that they will have it better. If people are operating on the margin of their capacity with only a future of relief to look forward to, burnout is inevitable.

Culturally constructed ideas of motherhood have also contributed to the burnout experience for women. And the gender disparity within this experience highlights the significant role that stressors in life outside of work, or rather, *at home*, play in the development of 'burnout'. The difficulties of reconciling their careers with families that many of my female informants talked about are not because of biology. Whilst a woman may need to be near her child for the medically recommended six months of exclusive breastfeeding, even that is not a biological imperative, and lots of ways to meet this need exist without extended periods of maternity leave. So, whilst women do have some specific needs that men do not, it is actually a construction of the social environment to suppose that implications of burnout for women are inevitable. Women have been led to believe, for example, that the 'biological clock' is their problem alone, when in fact 'male factor' infertility makes up 40-50% of all fertility issues globally (Kumar & Singh, 2015). And whilst supporting women in their medical careers by having on-site childcare centres or facilities for breastfeeding mothers to pump are crucial, my research demonstrates that helping both men and women to share childrearing responsibilities and have flexible careers will free up women to have other goals. The current Western construction of motherhood and indeed the 'split dream' is in conflict with the way we train doctors in Australia. And narratives like Evelyn's show that women, their partners, and their families do better when the responsibility for the 'split dream' is in fact shared.

Junior doctors experiencing burnout today, such as the informants who I consider throughout this chapter, have grappled with a lack of support for their distress. Whilst their presentation of

'symptoms' often fits within the biomedical model of 'depression', this category is not necessarily accepted by the profession as it suggests that the individual is not fit to do his or her job. And so 'burnout' has been created as a new kind of category. 'Burnout' is oftentimes a more socially acceptable reason for taking a leave of absence than other categories which imply a lack of resilience or strength. It also demonstrates the junior doctor's own moral intentions. The term provides a way of talking about workplace inadequacies or mental health struggles without undermining the individual's professional identity. And in a sense, 'burnout' is a morally favoured condition. The very fact that individuals are working so hard that they reach the point of burning out demonstrates their moral intentions and shows a sign of commitment in spite of this dedication actually hurting them.

Conclusion: "I'm a doctor"

'The only thing that makes life possible is permanent, intolerable uncertainty: not knowing what comes next.'

– Ursula K. Le Guin, The Left Hand of Darkness

Whilst junior doctor suicides in Australia are not a recent phenomenon, this project came into being due to the increased media coverage they received in the mid-2010s. Prior research had focussed predominantly on what was happening *at work* in order to ameliorate the immediate work environment, which is appropriate; however, it has largely overlooked that junior medical officers, or JMOs, are individuals with lives outside of work and has not considered what these training doctors might be experiencing. The individual narratives of over fifty training doctors across the country informed my investigation into the most influential factors affecting these doctors who found themselves emotionally challenged to inform how we might offer advice to address this problem more holistically than focussing solely on at-work initiatives.

What has already been done to address these issues?

Medical organisations nationally, including representative bodies, unions, colleges, and local health districts, know the mental health issues amongst the junior doctor cohort and the impact these have on the workforce more broadly and on patient outcomes. As a consequence, departments, faculties, and administrative teams specifically focusing on wellbeing have been set up to implement strategies to improve the junior doctor experience and reduce the risk of suicide in this population. Regulatory bodies are understandably concerned about the increase in mental health issues within this cohort of trainees. Major bodies such as the Australian

Medical Association and organisations including medical colleges and universities, have developed awareness campaigns and introduced health and wellbeing programs to equip young doctors and medical students with skills in resilience and self-care. Support networks, including 24/7 hotlines, have also been provided. Whether these specific examples have succeeded is not the focus here; instead, they provide an understanding of the recent response to the increase in media coverage of junior doctor suicides. Moreover, the persistence of the problem despite widespread awareness and the presence of these programs points to a more entrenched source for these stresses, something that is not obvious to the participants who advocate for programs that are demonstrably inadequate. The fact that junior doctors remain anxious and overworked, bullying persists, and many individuals feel on the edge of "burnout" in spite of mindfulness programs and awareness campaigns suggests that they are structural features of the current medical education system and not individual responses to an otherwise healthy training program.

New South Wales Health (NSW Health)

JMO Wellbeing & Support Plan

In June 2017, NSW Health hosted a forum for junior doctors to express their concerns about wellbeing. The forum also heard from representatives of the AMA, Australian Salaried Medical Officers' Federation (ASMOF), medical colleges, student associations, deans of medical schools, local health districts, and academic experts. Based on the discussions which took place as a part of the forum, NSW Health published the JMO Wellbeing & Support Plan later that year (NSW Health, 2017). The plan aims to 'improve the ways we work to better support the health and wellbeing of our junior medical workforce and provide greater assistance to our junior doctors when burnout and other mental health issues do arise' (2017, p. 6).

Because of this plan, recommendations were made to change how mandatory reporting was handled and to conduct a closer review of how rostering occurred and the policies surrounding safe working hours and parental leave. The plan suggested that the length of training contracts be expanded to cover the entire period of one's specialty training, which would provide a degree of job security. A review of recruitment practices was recommended, and the Ministry of Health advised that they would work with other agencies to develop local support programs, as well as partnering with the Black Dog Institute 'to pilot prevention, intervention and postvention initiatives in NSW Health among the medical workforce…' (2017, p. 8).

The plan suggests that others feel the impacts of burnout and mental health issues amongst junior doctors as these lead to 'an increase in unprofessional behaviour, lower patient satisfaction and increases in major medical errors' (2017, p. 9). The report highlights the broader cost to the Australian health care system due to higher rates of absenteeism and reduced overall productivity.

Royal Australasian College of Surgeons (RACS)

'Training in Professional Skills' (TIPS) Course

I met with Gabby, a representative of the Royal Australasian College of Surgeons (RACS), toward the end of 2018 during my fieldwork in Melbourne, so I have used RACS as an example in this thesis but recognise that their approach may not necessarily represent all the Australasian medical colleges. Gabby explained that RACS identified a gap in their training curriculum in 2012 and have since developed a two-day course focused on communication and teamwork. The communication component includes the development of practical skills taught in a patient-surgeon simulation scenario. "Part of that conversation is to sort of learn about empathy versus sympathy to avoid burnout," Gabby said. "And how you can maintain professional distance but still care and have compassion." She went on to explain this aspect of

the course contributes to supporting junior doctors in their roles and assists in preventing burnout in this group. This approach suggests that RACS consider caring too much as the source of "burnout". Psychological distancing is therefore treated as the coping mechanism or desired outcome.

The second day of this course focuses on teamwork. Gabby explained that whilst good team communication has been proven to have a positive effect on patient outcomes, she also felt this would influence the functioning of teams and would lead to a "much more satisfied" workforce. "We don't have the evidence yet," she said. "But [we have seen] a positive impact on how teams function and therefore how people finish their day… and working in a more supported environment et cetera." When I spoke to Gabby, these modules were approximately 90% finished, but the content was still confidential as they were not completed. She explained that the College had developed a set of videos to accompany the modules, which provide practical ways of managing both internal and external stressors. This specific module also covers how a young surgeon might manage and respond to an adverse event—information that would be useful in an otherwise stressful situation.

Other e-learning online modules being developed by RACS covered finding a "balance" between work and life outside of work—which suggests an assumption that the problem is not just a case of being overworked—, the importance of relationships and tips around how to build new relationships, and decision-making, mindfulness, and situational awareness. They also look at conflict management and team dynamics—"the idea of not just leadership but 'followership' and what makes a team," Gabby explained. She went on to tell me they are trying to "start a conversation" around "practicing positivity and working on our perceptions, how to balance negativity and avoiding some of that, kind of, pitting specialty [against] specialty… that kind of banter, [which] can be kind of damaging ongoing." This approach demonstrates that RACS has identified a 'cultural' issue within surgery and surgical training. Whilst they attempt to develop

courses that address these issues, this attitude continues to place the onus of solving the problem on the individual, feeding directly into the neoliberal dilemma that situates responsibility on the individual, as I have described in this thesis. Even the workshops that focus on group dynamics only include team dynamics, rather than addressing the larger social and organisational structures that drive many of the dynamics that make medical training so difficult and discouraging.

Gabby described a shift taking place, particularly within the surgical training space, where people are more recently realising that the technical aspects of surgery are relatively easy to teach, whereas teaching professionalism, communication, and skills that impact behavioural and environmental change in the workplace is more difficult. She felt that medical students who have done prior degrees in the humanities, for example, responded well to this non-technical material and "you start seeing a more well-rounded physician coming out" of medical school, she said. "It's really exciting to see the College supporting this and driving it forward," Gabby explained.

'Operating with Respect' Course

RACS developed and initiated an action plan in 2015 entitled, 'Building Respect, Improving Patient Safety'. This plan sought to investigate bullying and harassment within surgery as a specialty (Royal Australasian College of Surgeons, 2015). Gabby explained this action plan has since driven a lot of the education that the College is now undertaking. An e-learning module was developed to set a standard for acceptable and unacceptable behaviour, and how to respond to it. Following the success of this module, which was measured by the fact that 97-98% of all fellows, trainees, and International Medical Graduates participated as a part of their professional development, Gabby explained that in April 2018, a one-day course was launched called 'Operating with Respect' which is aimed predominantly at senior surgeons.

> A very difficult course to develop 'cause it's aimed at senior surgeons essentially who have been told that they have to do the course, and then the pushback you're getting is, well, "The College thinks we're all bullies. They're making us do this course." So, we were very much on the back foot when we started developing the course.

And of course, the senior surgeons that Gabby mentions here are right in that they are being made to do a course aimed at bullies. Bu the fact of the matter is that many of these senior surgeons are bullying their junior staff members. And so many bullies exist within the system largely because they are being trained to be bullies by having to work within coercive, bureaucratic institutions.

Gabby said that they brought together experts in the field, including psychologists, representatives from the College's Employee Assistance Program, and an ex-Commissioner for Human Rights, to develop the course material. Over about 14 months, this group met every three to four weeks, she said, to develop the course which was based on several guiding principles. The first principle was building respect. "So how to build respectful environments, building resilience and how to respond to your stressors," Gabby explained. Another significant portion of the course looks at speaking up. Gabby described this as "identifying when unacceptable behaviour occurs" and "instilling this idea that you have a responsibility to speak up when you see something happening." Those participating in the course practice having a low-level intervention conversation, which Gabby calls a "coffee conversation". "[We] train up messengers to deliver, you know, this sort of behaviour's been reported, and I'm just letting you know that this behaviour's been reported and perhaps just take a moment to think about that," she said.

This concept has the potential to assist in uncovering inappropriate behaviour and dealing with it in a non-confrontational way. As Gabby said, "I think there's some real learning happening around how [surgeons] can contribute to fostering a respectful working environment. And how

your behaviour might be perceived in a different way even though that's not what you intended." But the problem here lies in the fact that encouraging someone to "take a moment to think about" their behaviour has no actual implications or consequences for the individual. And again, the problem is individualised rather than being dealt with at the macro, institutional level.

Gabby suggested that the next thing she feels the College needs to think about is how to engage hospitals and jurisdictions to give similar training to other members of staff, in addition to surgeons. "But, you know, they do function within a hierarchy," she said, "and they are the top. At least we're starting somewhere." The idea here is that targeting the doctors at the top of the hierarchical ladder may increase the impact of these campaigns if the effect can trickle down from senior to junior doctors. In addition, RACS has adopted a reflective self-assessment exercise for stress to give their training doctors "an indication of where they're sitting on the stress scale," Gabby explained. Like most Local Health Districts and public hospitals, the College provides support to their trainees through their own Employee Assistance Program, which is a confidential counselling service provided free-of-charge, and by encouraging anyone experiencing distress to contact Beyond Blue.

JDocs Framework

RACS has also developed the JDocs Framework: an extensive document outlining the skills, tasks, and behaviours that junior doctors should achieve in the first few post-graduate years to prepare them for a career in surgery. The framework essentially gives junior doctors at postgraduate years one to three a clear idea of what to expect in their training, from whom, and when. However, the framework stresses early on in the document and continues to do so throughout that junior doctors are responsible for their own career progression—namely 'self-directed learning'. The JDocs Framework provides a guide to both training doctors and their supervisors about where they should expect to be at specific times in the early years of their training, which sets expectations from the outset.

Whilst setting these expectations may be useful, it again places the responsibility to address any issue on to the individual junior doctor rather than examining or modifying the broader structures at play. And as with the other interventions, the focus remains predominantly on the workplace, ignoring that medical training takes place whilst life outside of work continues. Remembering that on top of this, as this thesis has explored, junior doctors must sit several exams, instigate and participate in extracurricular activities or projects, and network with others in their respective field to progress their career.

Onwards

Themes that came out of informant interviews and participant observation highlight the complexity of the problem facing training doctors in Australia. Implementing changes in working hours and enforcing lunch breaks address important issues in the workplace but do little to address the broader issues at play. To unpack these intricacies and to provide a fundamental background to the outcomes of my research, this thesis first outlines how an individual becomes a doctor in Australia. I place this process within the context of the Australian health care system. The neoliberalisation of this system, which I call the neoliberal dilemma, has meant that any attempt to help individuals deal with issues relating to their mental health and wellbeing has put the onus back on them, rather than altering or redressing the structural forces that produce the distress in the first place.

Junior doctors are often within a liminal developmental phase whilst completing their training, called emerging adulthood by some developmental psychologists. However, delayed development throughout emerging adulthood is not a demographic problem as such; it is an economic problem focused on reaching a set of culturally defined financial goals. The three case studies that I presented in chapter three demonstrated how those training doctors who identified as adults had also developed, over time, a set of alternate identities that bolstered

their resilience to the difficulties they faced at work and in their training. Whilst these alternate identities provided resilience for these individuals, they fed into the notion that each individual must help themselves to survive the onerous medical education system.

The thesis then investigated the theme of uncertainty raised by informants. Made of several layers, this doubt encompasses fears, including regarding what one's future may look like, both professionally and personally. The ambiguities that junior doctors face throughout their training leaves them without a clearly defined path toward their end goals. The stakes are high as these junior doctors focus heavily on their career aspirations—finishing their training and qualifying as a consultant—from the very beginning when they take their first position as an intern. Additionally, whilst they imagine themselves pursuing interests in their personal lives which informants suggested included getting married or having children, they felt these goals were largely out of reach or so far in the future that they could not find hope in these prospects. Rather than the issue being simply that junior doctors are also emerging adults, the intergenerational change more globally has made the image of adulthood as a particular economic status or secure material wellbeing less attainable. That is, emerging adulthood is no longer just a liminal development phase through which an individual must pass to reach social adulthood but instead, it is the *new* adulthood that looks very different to prior images of adulthood because of the way that economic conditions have changed. When even a doctor cannot afford to buy a home, a mid-twentieth century concept of the material wellbeing that adulthood would normatively include is increasingly out of reach.

Trainees also described uncertainty in night shifts where they were often particularly tenuous and unsupported by senior staff. In these shifts, their expertise and lack of experience felt especially exposed, and they sensed an increased likelihood that something might go horribly wrong. This issue, along with problems relating to the traditional medical hierarchy and bullying in medicine, highlights some cracks in the system which need to be directly addressed to

improve working conditions for junior doctors nationally. Increased staffing levels would mean that the responsibility of junior doctors overnight could be shared, which would alleviate some of the uncertainty and isolation these doctors feel leading into their night shifts. A well-supported junior doctor would be more confident and less anxious, better positioned to make important clinical decisions and provide greater teaching opportunities to these doctors. The change would improve patient care overall.

The traditions of hierarchy and bullying and harassment in medicine and medical education also came up in interviews; they contribute to both the derailment of one's medical identity and to burnout. Burnout is more complicated than it appears on the surface, and chapter six explores its history to provide some explanation as to why the term has become so prevalent amongst training doctors. Burnout actually demonstrates the need to understand the socio-cultural group in which the term is used to best comprehend why it is a problem. Informants adopted the notion of "burnout" in order to "demedicalise" the discussion of exhaustion and depression to avoid stigmatising their diagnoses and to describe a period during which time they found it nearly impossible to maintain their motivation.

Junior doctors place so much importance on the medical identity which they develop for themselves, having thrown so much of their own focus and self into becoming a doctor, that they have no alternate identities to fall back on when they inevitably face challenges at work or in their life outside of work, or when they find themselves "burned out". This one-track focus prevents the development of 'resilience'—which has become a crucial concern in the area of mental health and wellbeing, despite appearing at times to be tokenistic or a 'buzzword'. That is, the very concept of 'resilience' implies that the problem lies in worker frailty or lack of toughness. And thus, the solution is more resilience rather than actually addressing the fact that the job itself is too difficult or that the workplace needs to better support their workers. The issue here is that an individual's willingness to continue working despite the demands placed on

them is turned into a virtue and held in high esteem which undermines any responsibility placed on the industry to improve working standards for this group.

However, if the individual has time to pursue other interests and nurture relationships both at and outside of work, they develop a sense of identity resilience which may bolster them when times get tough, or if they are bullied by someone they previously had great respect for or looked up to. The stories of my informants, Annabel, Bella, Evelyn, Gemma and Damini, presented in Chapter 6, also demonstrate the work required to cultivate alternate identities, specifically as parents.

The neoliberal dilemma has placed all the burden of fixing the problem on to individuals without addressing the structural issues that cause distress which is also the case when suggesting that the solution to the problems that JMOs face is to build alternate identities. We have not yet addressed organisationally that these issues were previously framed in individual terms—that is, how can we act on the individual doctors, rather than the broader structures, to fix their mental health? The answer to this question does not stop at the promotion of self-directed learning, how individuals can prevent bullying and harassment, or even how they might develop alternate identities to build resilience to protect them against difficult scenarios they may face throughout their careers. It is no longer enough to run mindfulness workshops, social games of barefoot bowls, and give out prizes to 'wellbeing champions' in hospitals or training organisations. I recognize that the sentiment behind these initiatives is well-meaning, and we should not just *stop* delivering them, but over time, training doctors feel these become tokenistic. In the end, JMOs disengage from these enterprises.

Instead, the medical education system should consider the complex lives that junior doctors lead and change how it trains its junior doctors. Increasing the publication of information such as JDocs will provide direction to individuals as they move from university into the clinical environment. This guidance helps to mitigate the anxiety surrounding the doctors' professional

futures and supports these significant transitional phases. But these documents must be careful to not solely place the responsibility of wellness on to each individual trainee. We must look at the bigger picture by holding both the public health care system and the private training colleges accountable for disseminating clear information on how to progress through a career in their field. Whilst the colleges play an important role in making teaching hospitals responsible for their treatment of junior doctors, they also contribute to the problem in many ways by charging exorbitant fees for exams, making trainees regularly move to complete rotations in different hospitals, and sometimes, but not always, providing a clear pathway from internship or residency on to a training program. Trainees thus leave medical school feeling more overwhelmed than when they began—a feeling which is reinforced throughout their career. Training colleges should work alongside local teaching hospitals, for example, to take steps to consolidate rotations so that trainees do not have to move around as much. Extending trainee contracts and improving interhospital networking particularly when designing rotations, may also provide a sense of stability for registrars.

Individual responsibility along with the complicated layers of bureaucracy, not only within the hospitals themselves but also at the college level, make navigating the system nearly impossible and make it hard for the training doctor to not feel individually responsible for their mental health struggles. The configuration of medical education in Australia might suit some young people in their early 20s, for example, those who come from wealthy families or have no other commitments and so may afford to relocate for month-long rotations and work long hours and have the financial means to pay for the onerous exams and courses. It may even work well for a young person with a partner at home to prepare meals and ensure the junior doctor is well-looked after from a personal point of view. However, most training doctors today have graduated with a postgraduate medical degree, having studied previously, and are thus older. They are in relationships, sometimes with other training doctors who are just as busy, stressed, and overworked as they are. These trainees rent their homes and feel that the ‘adult’ social goals

of homeownership or being established in their communities to provide them with a sense of stability are far out of reach. They may want to have children but worry they will not have the time to care for them or that pregnancy or childcare will not align with their training pathways. Many of these doctors decide that pursuing their ideal specialty is not worth the effort and become general practitioners instead, which has flow-on effects to the specialty of general practice itself. That is, general practice has come to be considered by many as a "backup plan" or "fallback option" and so is not as highly regarded as other, more competitive specialties.

We must start by addressing the fundamental way we train doctors. We need to re-design the training pathway to reflect the junior doctor of today, to ensure that it fits appropriately into the life of a young person in the 2020s, rather than making these young people fit an outdated training model which serves no one. We need to understand the lived experiences of our doctors and incorporate this understanding into the re-development of medical training. Doctors require a multifaceted education system that provides space for them to be cared for and to care for themselves. By letting only a few training doctors progress toward more seniority at a time, the higher status is preserved, which allows those at the top to monopolise prestige and privilege. The language of psychology and the training discourse are used to mask what is a tiered expertise model. Many of my informants realise that they are being exploited by the hospitals they serve, but they cannot actually articulate their condition. They end up with a fragmented understanding of their own circumstances, so they bear the load and retroactively justify their own exploitation. At the core of this problem is the fact that an educational program is grafted onto a tiered labour system and hierarchy of privilege. And to date, every proposed solution focuses on an individualist approach. My research demonstrates that individual lived experiences are a part of the overarching systemic structure. And whilst the organisation of Australian medical education is problematic and unbearable for those working within it, it is doing what it was designed to do—it provides less expensive clinical staff to fill workforce needs

whilst convincing these training doctors that they will one day be rewarded as senior clinicians for the long, arduous hours they work and the education they undertake as juniors.

We also need to invest in professionals to support these doctors. A generalised assistance telephone line with operators that have no real understanding of what is required to become a doctor will not provide the help that trainees need. Many of my informants explained that they now avoided these services, such as the Employee Assistance Programs provided by their employers, as they felt the majority of their consultation involved explaining the roles of resident or registrar rather than actually addressing their problems. Even though Employee Assistance Programs claim to be confidential, my informants worried that these services would report back to their employers about their mental health status, and this would go on their record permanently. They demonstrated concern that any sort of record of their mental health status may inhibit their chances of succeeding in their medical careers. They worried that their employers or training colleges might see them as inept or not strong enough to continue in the field.

In the director of training's role, we see an overlap of fundamentally different functions, such as performance evaluation, pastoral care, and work direction, amongst others. These functions are often at odds with one another and so are not as effective as they could be if they were separated and performed by several individuals. Separating these roles would decrease the amount of overall authority that one individual holds and may also reduce the risk of bullying occurring as a consequence of one person having such significant power over junior staff. We should also recognise that directors of training and senior consultants have heavy teaching and clinical workloads, so it makes sense to redistribute some of these tasks. Instead of leaving pastoral care up to the busy consultants or senior registrars in a department, health services should employ and train staff whose profession is caring for doctors.

The answer to the complex problems facing junior doctors involves implementing a long-overdue redesign of the medical training pathway as a collaborative exercise with all interested parties (health districts, colleges, and other professional bodies). A restructure would ultimately improve the transitions from medical school to internship, from residency to specialty training, and from training to consultancy. A pilot program could take place to test alternative ways of selecting individuals to enter specialty training, such as a lottery based on medical school results or performance during internship and residency, rather than placing such onus on an overinflated CV. It would make sense for the health care system to also introduce additional professional roles such as a medical scribe, for example, who undertake a shorter university degree than medicine itself and who are employed to write up notes during ward rounds, do discharge summaries and other clerical-type work that is currently being done by interns and residents. This plan would mean that junior staff are more available to do clinical work, which not only contributes to their education but may even alleviate some of the overwork these young doctors experience. However, in implementing such a strategy, it would be necessary to consider how this would then affect the overall education and training of junior doctors, given they would no longer undertake the recording of the work that they have previously been responsible for and which makes up an important part of their training. Perhaps future research could consider the outcomes both on junior doctors and on the broader health care system (including the quality of patient care) of the newly created role of 'Assistant in Medicine' which was implemented as a result of the COVID-19 pandemic and a significant increase in workforce need as an example of how this may or may not work.

Alternatively, we could increase hospital or department incentive to focus on the proper treatment of training doctors by placing the responsibility on the performance of hospitals or departments and the teaching they provide. This approach would encompass Key Performance Indicators for senior staff members around behaviour that are reported on by the JMOs themselves, turning the hierarchy on its head. Providing retentive contracts to trainees so that

hospitals invest in these individuals knowing they will be a part of the team for the long term may also help in redressing some of the deeply embedded structural issues such as bullying and harassment.

The Australian government and health care systems should also provide proper pastoral care for our training doctors. Until the Australian medical training system address these underlying root causes, health services will not support their trainees adequately, leading to continued mental health problems, lost work, and undermining of the training system itself. Patients will inevitably be collateral damage. And struggling junior doctors will continue to go unnoticed until they feel they have such chronic unmet needs and accumulated stress that they are faced with a choice between continuing, leaving medicine, or something worse. A medical system that does not care adequately for those who provide care will always lurch from one crisis to another, mistaking structural problems for individual tragedy.

Appendices

Appendix 1: Glossary of Acronyms

Medicine and medical education are renowned for their use of acronyms. I have therefore included a glossary of acronyms to make it somewhat easier to decipher this often-foreign language. This glossary does not by any means include all acronyms adopted with the medical industry—only those used throughout this thesis.

Acronym	Meaning
ABC	Australian Broadcasting Corporation
ACEM	Australasian College for Emergency Medicine
AHPRA	Australian Health Practitioner Regulation Agency
AMA	Australian Medical Association
AMC	Australian Medical Council
AMSA	Australian Medical Students' Association
ASMOF	Australian Salaried Medical Officers' Federation
ASSET	Australia and New Zealand Surgical Skills Education and
AT	Advanced Trainee
ATAR	Australian Tertiary Admission Ranking
AUD	Australian Dollars
BPT	Basic Physicians Training/Trainee
CCrISP	Care of the Critically Ill Surgical Patient
CEO	Chief Executive Officer
CICM	College of Intensive Care Medicine of Australia and New
CLEAR	Critical Literature Evaluation and Research
CMO	Career Medical Officer
CPD	Continuing Professional Development
CV	Curriculum Vitae
DPET	Director of Prevocational Education and Training
DSM-IV	Diagnostic and Statistical Manual of Mental Disorder
ED	Emergency Department
EMST	Early Management of Severe Trauma

GAMSAT	Graduate Medical School Admissions Test
GP	General Practitioner
GPA	Grade Point Average
HETI	Health Education and Training Institute
HR	Human Resources
ICU	Intensive Care Unit
JMO	Junior Medical Officer
MBA	Medical Board of Australia
MBBS	Bachelor of Medicine/Bachelor of Surgery
MD	Doctor of Medicine
MOA	Markers of Adulthood
NHS	National Health Service
NSW	New South Wales
PGY	Postgraduate Year
PMCV	Postgraduate Medical Council of Victoria
Pre-SET	General Surgery Research fellowship Program
PT	Provisional Trainee
RACS	Royal Australasian College of Surgeons
RMO	Resident Medical Officer
RMOA	Resident Medical Officer Association
SET	Surgical Education and Training
SRMO	Senior Resident Medical Officer
TIPS	Training in Professional Skills
UCAT	University Clinical Aptitude Test
UK	United Kingdom
US	United States
VMO	Visiting Medical Officer
WHO	World Health Organisation
WRAPEM	Wellness, Resilience and Performance in Emergency

Appendix 2 of this thesis has been removed as it may contain sensitive/confidential content

Appendix 3: Approved Recruitment Notice

MACQUARIE University
SYDNEY·AUSTRALIA

Are you a junior doctor or trainee working in an Australian hospital? Perhaps you work with or educate junior doctors or trainees?

If so, we want to hear from you!

We are conducting a research project considering changes in the lives of junior doctors and trainees in Australia.

We are asking interested junior doctors and trainees as well as those who work with or educate junior doctors or trainees to participate in a one-on-one interview which will run for approximately 45-60 minutes. We will ask you about your experience as a junior doctor or trainee, which aspects you find most rewarding and most challenging, and how you balance your workload with your life outside of work.

This research is part of my doctorate at Macquarie University.

As a token of gratitude for your time, you will be given a $25 Coles/Myer gift card.

For further details or to express interest in participating in this project, please contact:
Lara McGirr (PhD Candidate, Dept. of Anthropology, Macquarie University).
Email: [redacted]
Phone:

The Macquarie University Ethics Committee (Human Research) has approved the ethical aspects of this research.
Ethics Reference No. 5201800092

Appendix 4: Participant Information and Consent Form

Department of Anthropology
Faculty of Arts
MACQUARIE UNIVERSITY NSW 2109

Phone: +61 (0)2 9850 8077
Fax: +61 (0)2 9850 9391
Email : greg.downey@mq.edu.au

MACQUARIE University
SYDNEY·AUSTRALIA

Participant Information & Consent Form

You are invited to participate in a study considering changes in the lives of junior and training doctors in Australia.

Chief Investigator:
Prof. Greg Downey (Dept. of Anthropology, Macquarie University)
Email: greg.downey@mq.edu.au

Co-Investigator:
Lara McGirr (PhD Candidate, Dept. of Anthropology, Macquarie University)
Email: [redacted]

In order to participate in this project, the co-investigator will conduct an interview with you. This interview will take place in a public space such as a café or restaurant. Interviews will vary in length, and you are free to end the interview at any time.

The interview will be recorded. The audio recording will be used for transcription purposes only and will be stored in a secure location to which only the investigator and co-investigator will have access.

Participation in this project is **entirely voluntary,** and you are not obliged to answer all questions during the interview. You are also free to withdraw from the project at any time. The results of this research will be used by the co-investigator to submit a thesis to fulfil the requirements of a Doctor of Philosophy at Macquarie University.

I _____ (name of participant) volunteer and give consent to participate in the above-mentioned research project. The project has been explained to me and I understand that any information I provide will be used as data unless I request otherwise.

Please choose:

- ☐ I wish for a pseudonym to be used in order to protect my identity.
  OR
- ☐ I wish to have my responses/opinions associated with my name and/or organisation – please provide your (or the organisation's) name as you wish it to appear in the project:
  _____

Signature of Participant	Date

The Macquarie University Ethics Committee (Human Research) has approved the ethical aspects of this research. If you have any complaints or reservations about any ethical aspect of your participation in this research, you may contact the Committee through the Research Ethics Officer (email: ethics@mq.edu.au). Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.

If you experience any distress during or because of the interview, please contact Lifeline 24/7 on 13 11 14 or visit https://www.lifeline.org.au/Get-Help/Online-Services/crisis-chat.

Appendix 5: Participant Profiles

Pseudonym	Age at Interview	Sex	Level of Training/ Position at Time of Interview
Amy	25	F	Resident Medical Officer (PGY2)
Annabel	29	F	Resident Medical Officer (PGY2)
Anne	28	F	Provisional Trainee - Emergency Medicine
Anthony	32	M	Resident Medical Officer (PGY2)
Arham	26	M	Resident Medical Officer (PGY2)
Bella	31	F	Advanced Trainee - Emergency Medicine
Bill	Not Disclosed	M	Registrar - General Practice (PGY4)
Bree	28	F	Registrar - General Practice (PGY5)
Caitlyn	26	F	Registrar (PGY3)
Caroline	Not Disclosed	F	JMO Manager
Damini	24	F	Intern (PGY1)
Danielle	24	F	Intern (PGY1)
Danika	24	F	Intern (PGY1)
Evelyn	Not Disclosed	F	Intern (PGY2)
Gemma	36	F	Advanced Trainee - Paediatrics
Georgina	32	F	Resident Medical Officer (PGY2)
Hannah	25	F	Intern (PGY1)
Harry	28	M	Resident Medical Officer (PGY2)

Jasmin	30	F	Advanced Trainee - Emergency Medicine (PGY6)
Jason	39	M	Resident Medical Officer (PGY3) Registrar - General Practice Registrar - Aerospace Medicine
Jenny	27	F	Resident Medical Officer (PGY2)
Jessica	23	F	Intern (PGY1)
Jiang	28	M	Basic Physician Trainee - Year 2
John	25	M	Resident Medical Officer (PGY2)
Kate	29	F	Registrar (PGY5)
Kavya	23	F	Intern (PGY1)
Laura	30	F	Resident Medical Officer (PGY2)
Lilian	24	F	Resident Medical Officer (PGY2)
Lulu	31	F	Advanced Trainee - Paediatrics
Maggie	35	F	Career Medical Officer (PGY6)
Matt	26	M	Intern (PGY1)
Maureen	Not Disclosed	F	Director of Prevocational Education & Training (DPET)
Mia	29	F	Unaccredited Trainee - Research Fellow (PGY3)
Michael	27	M	Intern (PGY1)
Minh	28	F	Intern (PGY1)
Miranda	Not Disclosed	F	Advanced Trainee - Paediatrics (PGY7)
Natalia	25	F	Intern (PGY1)

Nick	26	M	Resident Medical Officer (PGY2)
Nikki	36	F	Advanced Trainee - Paediatrics
Ricky	Not Disclosed	M	Senior Consultant
Rosemary	69	F	Senior Midwife
Seo Ah	31	F	Advanced Trainee - Oncology
Tania	27	F	Advanced Trainee - Paediatrics
Thomas	34	M	Resident Medical Officer (PGY2)
Tim	27	M	Intern (PGY1)
Vicky	50	F	Advanced Training - Physicians
Vince	Not Disclosed	M	Resident Medical Officer (PGY2)
Vivienne	24	F	Intern (PGY1)
Yichen	27	M	Registrar - General Medicine
Zara	32	F	Resident Medical Officer (PGY2)

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