Can doctors self-manage stress?

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The NHS has expressed concern about stress in its workforce and is taking steps to reduce it. This paper reviews the factors associated with stress and burnout throughout a medical career. Clear messages emerge for all doctors and their employers.

INTRODUCTION

Most doctors invest tremendous energy and enthusiasm into their work. Patients and organizations benefit from this commitment. However, there is growing evidence of stress and burnout in doctors. The term stress is used as a short hand for emotional difficulties that can affect the individual.

Sources of stress are external and intrapsychic (Hale and Hudson, 1999). The final common pathway is often the emergence of anxiety and depressive syndromes and refuge in heavy drinking or substance misuse (Birch et al, 1998). Maslach et al (1996) suggest the following useful definition of burnout:

'Burnout is a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with people in some capacity. It represents a loss of resource for the health services as well as having adverse personal consequences for doctors and their patients.'

STUDENTS

Brewin et al (1992) investigated a sample of 75 medical students and showed that those with high levels of self-criticism reported worse relationships with their parents than students who were less self-critical. In a study of 318 medical students (Brewin and Firth-Cozens, 1997), self-criticism in students was a significant predictor of depression in the first postgraduate year. Webb et al (1998) showed that 48% of male and 38% of female second-year medical students exceeded sensible weekly limits of alcohol consumption and there was also a significant prevalence of illicit drug use. However, the lifestyles of medical students and other student groups were similar.

Later in their careers, qualified doctors as a group remain at higher risk of alcoholism compared with other professionals (Harrison and Chick, 1994). Medical schools can take preventative action by the development of appropriate alcohol policies integrated with education (Gray et al, 1998).

QUALIFIED DOCTORS

Preregistration house officers (PRHOs) have traditionally worked extremely long hours and have generally been regarded as very stressed. Firth-Cozens (1987) studied 187 PRHOs and found a 50% prevalence of emotional disturbance, with 28% showing evidence of depression. Overwork was the most stressful aspect of their jobs and, not surprisingly, the more overworked they were, the less favourably they viewed their jobs.

The postgraduate deans and the task forces have attempted to address the issue of junior doctors' working hours. Grainger et al (1996) followed a cohort of PRHOs through to their senior house officer (SHO) years. SHOs appeared more satisfied than they were as PRHOs. The SHOs' hours of work had dropped and there was a decrease in the least satisfying aspects of work with increased seniority, e.g. routine clerking. However, at both points, approximately half the respondents exceeded the critical scores for mental and physical ill health on two scales from the Occupational Stress Indicator (Cooper et al, 1988).

Birch et al (1998) investigated 114 PRHOs and found that of the 93% who drank alcohol, over 60% of both sexes exceeded safe limits. More than 35% of men and 19% of women used cannabis regularly, and 13% of the men and 10% of the women took other recreational drugs. Thirty six per cent of the sample scored abnormally (>4 out of 30) on the General Health Questionnaire (GHQ) (Goldberg, 1972). The transition from medical student to PRHO is often traumatic. Pearce and Blainey (1999) have reported a scheme in which individual PRHOs have a senior nurse mentor on their wards. The study showed that the PRHOs felt supported by the nurses, who were able to teach clinical and non-clinical skills effectively. In addition, the PRHOs' teamworking skills and understanding of the roles of others within the team were improved.

A worrying paper (Lambert et al, 1997) describes a series of cohort studies of British PRHOs and found that only 75% of doctors in 1993 definitely or probably intended to practice in the UK, a decrease of 13% from 1983. However, most respondents were still committed to practising medicine. It is important to ensure that the PRHO year is a supported enjoyable experience as there is evidence that disillusionment during the PRHO year may be perpetuated (Firth-Cozens et al, 1999). It will be

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interesting to see whether the emergence of new PRHO rotations with three 4-month posts, offering medicine, surgery and other specialty experience (including community specialties), will increase doctors' satisfaction with this crucial year.

Hale and Hudson (1992) carried out pioneering work on SHOs based on detailed interviews with 20 doctors. GHQ ratings were abnormal in nearly half of the sample (>3 on the short 12-item version scored as in Firth-Cozens, 1987). In particular, SHOs working long hours in casualty departments spoke of being harassed and verbally abused, with the risk of physical violence by patients and relatives. Little supervision was available.

Doctors who qualified overseas faced particular difficulties and had a sense of forming an 'under-class' within the NHS. The study demonstrated the importance of junior doctor/consultant relationships to personal wellbeing and professional competence. Trainees welcomed consultants who were consistent, praised appropriately, criticized in ways that protected the SHO's self-respect, understood SHOs' professional and private worries, and gave career advice.

Firth-Cozens et al (1999) carried out a longitudinal study of 314 medical students, followed up as PRHOs and again 7 years later. They found that stress levels were highest in the laboratory-based specialties and psychiatry and lowest in surgeons and anaesthetists. Self-criticism scores in students were highly related to stress levels at follow up. Over 32% of the sample expressed some dissatisfaction with their career choice and 11% did not see themselves continuing in medicine, with no difference between the sexes in respect of stress or specialty satisfaction. There was also dissatisfaction with the availability of career counselling.

Clear correlations emerged between dissatisfaction at PRHO level and later dissatisfaction. The trainees requested more career counselling at medical school and subsequently. They also wanted flexible career structures, allowing for specialty change and time out of medicine, without detriment to careers.

A sample of 171 SHOs working in accident and emergency medicine (Williams et al, 1997) has demonstrated that SHOs with higher distress scores have significantly lower confidence in carrying out clinical and practical tasks. Intensity of workload, communication difficulties and worrying about misdiagnoses were common stressors.

Paice (1998) surveyed 1 316 SHOs and found that the acquisition of experience has more to do with working in a well organized, well supervised educational environment, than with working long hours or doing without sleep. In most specialties, the closer that the post came to delivering the *New Deal* (Department of Health, 1991) the higher the SHOs rated the experience. High ratings for experience were associated with high ratings for induction, consultant supervision, objective setting and number of hours of formal education per week. The quality of consultant supervision was the most important determinant of satisfaction with the post.

McKee and Black (1993) showed that much of the work of junior doctors at night can be reduced by producing guidelines on the need to operate at night, transferring tasks to other professionals and reducing the number of sites at which services are provided.

CAREER GRADE DOCTORS

Caplan (1994) surveyed 81 hospital consultants, 322 GPs and 121 senior hospital managers in the NHS. Of all 389 subjects, 47% scored positively for depression on the GHQ. GPs were more often depressed with suicidal thinking than managers or consultants. Ramirez et al (1996) surveyed 1 133 consultants and found similar psychiatric morbidity. Three sources of stress were associated with burnout and psychiatric morbidity:

1. Feeling overloaded and its effects on home life
2. Feeling poorly managed and resourced
3. Dealing with patients' suffering.

Burnout was also associated with low satisfaction in domains of relationships with patients, relatives and staff, professional status and esteem, and intellectual simulation. Also, being 55 years old or less and being single were independent risk factors. Burnout was more prevalent among consultants who felt insufficiently trained in communication and management skills.

A study of 1 817 GPs (Cooper et al, 1989) showed that female GPs had more positive signs of mental wellbeing compared with other normative groups, but male doctors showed higher anxiety scores, had less job satisfaction and drank more alcohol than their female counterparts. The four job stressors most predictive of high levels of job dissatisfaction and stress in GPs were:

1. Demands of the job and patients expectations
2. Interference with family life
3. Constant interruptions at work and home
4. Practice administration.

The authors argued for the provision of counselling services for GPs. A recent survey among consultants in North Thames (Allen et al, 1999) has produced wide ranging recommendations for ways that employing authorities, postgraduate deans and consultants themselves can work to reduce stress.

CAN DOCTORS SELF-MANAGE STRESS?

The traditional ways in which some doctors have self-managed stress, i.e. self prescribing, alcohol and drug abuse, and covering up for problems in themselves and others, are inappropriate. There are ways in which doctors can manage stress and these are set out below. Additionally, NHS management, both at trust and regional and national levels can work to implement policies to improve working lives of their employees. A recent consultation paper (Department of Health, 1999) is a welcome step in this direction.

All doctors

- Tell your employer if your working conditions/hours are unacceptably stressful

- Remember the effects of drugs/alcohol abuse on performance
- Seek advice when you feel uncertain
- Protect time for your professional development
- Recognize the benefits of interprofessional working
- Ask for career counselling when you contemplate a career move
- Develop good working relationships with local managers
- Protect time for life outside medicine.

Additional responsibilities for career grade staff

- Provide regular supervision and support for your trainees.

NHS employers

- Implement the recommendations in *Improving Working Lives in the NHS* (Department of Health, 1999)
- Ensure that you have effective occupational health services, skilled in dealing with emotional problems
- Be aware of organizational factors which increase stress in your workforce and reduce them
- Facilitate flexible/portfolio working for staff who need it
- Ensure that doctors' personal development plans include sufficient time for management and educational responsibilities. HM

The author would like to thank Dr Elisabeth Paice, Dean Director, TPMDE North Thames, for her helpful comments on this paper and Karen Fergus for her assistance with the manuscript.
Conflict of interest: none.

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KEY POINTS

- If your job is unduly stressful take positive action.
- Use career counselling and/or mentorship schemes throughout your career.
- Recognize the benefits of interprofessional working.
- Protect time for life outside medicine.