Caring for others can seriously damage your health

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To care for others is a privilege and a source of personal and job satisfaction. However, caregivers must also consider the implications of their work for their own health and welfare.

There is a growing body of evidence to show that responding to the needs of others, while a source of genuine satisfaction, may exact a toll that is not always readily acknowledged or dealt with appropriately. Janoff-Bulman (1985) describes how we function according to a set of basic assumptions, one of which is the 'illusion of invulnerability'. Fired by idealism and altruism, and strengthened by training, those who help others tend to assume they will be able to cope with whatever is asked of them. However, when this illusion is rudely compromised by some inescapable reality, it can be very disarming and threatening to the individual. Denial of the impact of work on their wellbeing and functioning may serve caregivers well until it fails, but then they have to face up to their own vulnerability. This is not easy and is likely to lead to such personnel pushing themselves beyond their limits and displaying a reluctance to seek help.

OCCUPATIONAL STRESS

Occupational stress is defined as the:

'interaction of work conditions with characteristics of the worker such that the demands of work exceed the ability of the worker to cope with them' (Ross and Altmaier, 1994).

Humanitarian, economic and legal influences have encouraged development in this area of research. The last influence is strongly allied to legislative landmarks, including the Health and Safety at Work Act 1974 which enshrines the employer's 'duty of care'.

Unfortunately, the important debate about protecting the welfare of health-care personnel has been bedevilled by numerous factors including poor quality research (e.g. small unselective samples), acrimonious and unedifying disputes about compensation claims and the persistence of a reactionary philosophy reflected in the often heard: 'if you can't stand the heat, get out of the kitchen' and: 'in my day, we just had to get on with it'. This article will highlight a number of studies which make a significant contribution to our understanding of the emotional impact of their work on health-care and emergency personnel.

EMPIRICAL STUDIES

Wall et al (1997) reported detailed findings from over 11 000 health-care workers across 19 NHS hospital trusts (with a response rate of 61–65%). Compared to other employment groups and similar socioeconomic groups, NHS staff were noted to have a higher level of minor psychiatric disorders. More specifically, psychiatric morbidity was highest among managers, doctors, nurses and those in professions allied to medicine. The lowest rates were observed in support occupations, such as administrative and ancillary staff. An interesting finding was that female doctors and managers had significantly higher levels of psychopathology than their male counterparts. In the case of the managers this gender difference did not prevail across all trusts; an observation which implies that inter-trust differences played an aetiological role. This was not the case for the difference between male and female doctors; their difference was evident across all trusts, thereby suggesting the influence of occupational rather than organizational factors.

Several studies have addressed the mental health and stress levels among junior doctors, particularly with regard to their working conditions (e.g. Firth-Cozens, 1987), but less attention has been paid to consultants' welfare. Ramirez and her colleagues (1996) surveyed large samples of consultants in gastroenterology, surgery, radiology and oncology. Credence can be given to their findings in view of a high response rate

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of 78% from the 133 consultants to whom questionnaires were sent.

There were no significant differences among the four specialist groups, and the overall level of psychiatric morbidity was 27%. Job satisfaction appeared to offer some protection against job stress, but psychiatric morbidity and burnout were associated with:

- Feeling overloaded
- The impact of work on home life
- Feeling poorly managed and under-resourced
- Dealing with patients' suffering.

Those consultants who believed they were insufficiently trained in communication and management skills also reported the highest levels of burnout.

Although pre-morbid personality factors may play a role, consultant psychiatrists have been found to have significantly higher levels of severe depression and work-related exhaustion compared with consultant surgeons and physicians (Deary et al, 1996). However, when compared with senior house officers and registrars in psychiatry, consultant psychiatrists display lower levels of burnout (Guthrie et al, 1999). In relation to the identification of stressors, Guthrie's team made two particularly important findings. First, the only work-related stressor which was identified as the most stressful was having to deal with violent patients. Second, many of the stressors were personal rather than work-related. This should remind us of the important effect our personal lives may have on our work performance.

Most health and welfare studies have been conducted on hospital-based personnel. However, the Royal College of General Practitioners also identified the need to consider the impact of work-related stress on its members (Howie, 1993).

In a detailed survey of GPs in the Edinburgh area Howie (1993) highlighted important insights into the pressures on such doctors and how they cope with them — sometimes in a fashion which may distance them from their patients and compromise the doctor–patient relationship. He concluded:

'Professional stress and dissatisfaction is a growing problem, and it is only a step from disengagement from the emotional element of doctor-patient relationships, another way of describing burnout, the most sad and preventable consequence of failing to provide care for carers.'

In a survey of 121 (76% response rate) mental health personnel who work in the community, it was noted that they identified similar stressors to those encountered by hospital-based colleagues, but the impact of their stressors seemed to be more intense and deleterious for the community personnel (Prosser et al, 1996). Community staff had higher levels of burnout and general psychopathology, although there was no difference in job satisfaction.

CRITICAL INCIDENT RESEARCH

The previous surveys focus on the general impact of health care, but there is a relatively new area of research, namely the impact of specific 'critical incidents'. A critical incident is commonly defined as:

'Any event which has a stressful impact sufficient enough to overwhelm the usually effective coping skills of either an individual or a group. Usually such events are powerful, sudden and outwith the range of ordinary human experiences' (Mitchell and Everly, 1995).

Although patient suicide (as a critical incident) did not feature in the study by Guthrie et al (1999), two surveys of trainee psychiatrists (Dewar et al, 1999) and consultant psychiatrists (Alexander et al, 2000) confirm that a patient suicide is a signal event in their careers. Among 167 consultants, 24 (15%) had even considered giving up psychiatry as a career following the suicide of one of their patients. More generally, such events were very distressing and the emotional impact commonly endured for several weeks. Of note is the fact that the impact was experienced in terms of their emotional and physical health, their relationships at home and their functioning at work.

In the health-care domain, however, the group most likely to be confronted regularly by such incidents are ambulance personnel, who provide an accident and emergency service, and staff of trauma units.

A surprising gap in the literature is the impact on ambulance personnel of their recurrent exposure to critical incidents. Such individuals deal with more incidents of this kind than do the police and fire services combined. Rodgers, in two detailed publications (Rodgers, 1998a,b), documented the fact that ambulance personnel have significantly higher levels of early retirement through ill health than other health-care groups. The most frequent causes of early retirement on medical grounds were musculoskeletal and mental disorders. Alcohol problems were also more commonly reported in ambulance personnel than in other health-care workers.

The psychological health of such personnel was first studied by James and Wright (1991).

They emphasized that ambulance personnel gain a rather unusual view of society usually when its members are suffering pain, dying, bleeding and/or disfigured. Moreover, these personnel are themselves exposed to certain personal risks in the fashion of toxic and otherwise dangerous agents, and physical assaults by members of the public. Replies from over 350 ambulance personnel (representing a 69% response from the service) revealed that the principal sources of stress were:

- Organizational/managerial aspects of their work
- New, unfamiliar and difficult duties
- Work overload
- Interpersonal relations.

More recently, a study of Scottish ambulance personnel has pursued further, by means of a detailed questionnaire, standardized measures of general psychopathology, burnout and post-traumatic reactions, and by semi-structured interviews, the specific effect of critical incidents. Alexander and Klein (2001) surveyed 110 ambulance personnel (a response rate of 69%) of the Scottish Ambulance Service who provide an accident and emergency service. Almost a third of them in each case displayed significant levels of general psychopathology (32%) and post-traumatic reactions (30%) in relation to a specific critical incident (nominated by themselves). Twenty-seven per cent of these workers reported that these adverse post-traumatic reactions endured for at least several weeks.

This circumstance raises the possibility of cumulative effects from the serial exposure to such incidents. Their investigation of this led to an important finding; one which challenges the aphorism, commonly heard in the emergency services and in trauma units, to the effect that the 'more you do, the easier it gets'. For 12% of these ambulance personnel, the opposite was true: the more critical incidents with which they had to deal, ultimately the more difficult it became to cope appropriately. (This finding is consistent with an earlier observation by Alexander and Atcheson (1998) from a study of almost 300 surgeons and nurses in hospital trauma units, to the effect that it was the senior nurses and surgeons rather than their less experienced colleagues, who reported that their trauma work had caused them emotional problems.)

The survey by Alexander and Klein (2001) also confirmed that burnout was associated with longer service, less recovery time (between critical incidents) and more frequent exposure to such incidents.

A more recent study of post-traumatic stress disorder and other psychopathological symptoms in 56 ambulance workers also found significantly high levels of symptoms in over two-thirds of them (Clohessy and Ehlers, 2001).

MODULATING AND EXACERBATING FACTORS

Many research studies confirm high levels of job satisfaction among those who provide care for others. However, the 'job satisfaction' described usually relates to the intrinsic features of the job (e.g. relieving suffering), rather than extrinsic factors (e.g. the way the service is organized and managed). The former type of satisfaction appears to offer employees some protection against the otherwise deleterious impact of their work (Ramirez et al, 1996). Unfortunately, the extrinsic factors may themselves constitute a source of stress and may exacerbate the effect of other stressors.

Peer support is also commonly described as a protective factor (McCammon, 1996) but a disconcerting finding from the survey by Alexander and Klein (2001) was that ambulance personnel would not always take advantage of help available to them because of reported fears about a lack of confidentiality (64%), and because of concerns about career prospects being damaged by admitting to needing help after critical incidents (46%).

Another disturbing but consistent trend in these studies was the pejorative comments made about the managerial style and organizational climate with which health care and emergency personnel had to contend. James and Wright (1991) noted that it was less often the medical aspects of their work which troubled ambulance personnel; rather, it was extrinsic factors, such as not being consulted by supervisors and inadequate support from management. Seventy-three per cent of the personnel surveyed by Alexander and Klein (2001) reported that the ambulance service was 'never concerned' about the welfare of its staff after critical incidents. One of the major stressors identified by the consultant staff in the study by Ramirez et al (1996) was, as reported above, the feeling that they were poorly managed and resourced.

Observations such as these underscore Felton's comments following a detailed review of burnout in health-care workers:

'Burnout is a professional occupational disease manifest in the many specialties of health care and will be a disorder as long as human values and worth are disregarded by inept policy makers and managers of human resources.' (Felton, 1998)

CONCLUSIONS

To provide care for others is intrinsically rewarding, but such an endeavour may lead to problems of mental health and adjustment for a significant proportion of staff. Stressors may be intrinsic (e.g. distasteful and critical incidents), or they may be extrinsic (e.g. factors relating to the organization and management of the services). The services can do little about the intrinsic stressors but they have a responsibility to ameliorate the impact of these stressors by creating a 'climate of care' for their own employees. Research of this kind offers an opportunity to develop a more proactive approach to stress-related problems than currently appears to be practised. **HM**

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KEY POINTS

- Health-care personnel have rewarding jobs but they are subject to mental health and emotional problems associated with their work.
- Such personnel may be reluctant to admit when they are having difficulties in coping with the demands of their work.
- Recurrent exposure to critical incidents and other stressors may have a cumulative effect.
- Organizational and managerial practices and philosophy are potent sources of occupational stress, but they also provide an excellent opportunity to improve the welfare of caregivers.