

STRESS IN HOSPITAL DOCTORS: WHAT CAN BE DONE?

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THE PROBLEM

Whereas doctors in the U.K. now enjoy better physical health than others from the same social group, their mortality rates for suicide, cirrhosis of the liver and road traffic accidents are some two or three times greater¹. Underlying psychological factors play a prominent part in this increased mortality, and we are beginning now to examine and understand these factors. In particular we are indebted to Firth-Cozens^{2,3,4} for her careful follow-up of a cohort of North of England medical students into house officer year and beyond. The rate of emotional disturbance as measured by the General Health Questionnaire increased from 31.2% in fourth year medical students to 50% in the house officer year. Moreover the rate of clinical depression, using the SCL 90 depression subscale, was a high 28%. When this finding was further analysed it was found that the prevalence of clinical depression was much higher amongst women house officers, reaching a rate of 46%. This is three times the rate found amongst women in community surveys⁵. Surveys in other parts of the world confirm the high rates of depression amongst junior hospital doctors and the particular high rates in women. Hsu and Marshall⁶ sampled almost 2,000 Canadian junior hospital doctors and found a rate of depression of 23%, with single women being four times more likely to be depressed than married men.

CAUSES OF STRESS:- EXTERNAL FACTORS

The junior doctors in Firth-Cozens study³ were asked to rate factors causing stress. Table 1 ranks these factors in order of perceived stressfulness.

ASPECT OF JOB	LEVEL
Overwork	2.47
Talking to distressed relatives	2.25
Effects on personal life	2.19
Serious treatment failure	2.18
Having too few skills	1.86
Making decisions	1.83
Dealing with death	1.70
Inflicting pain	1.67
Relations with consultants	1.61
Financial problems	1.45
Relations with nursing staff	1.25
Relations with peers	1.16

Table 1 – Factors related as stressful by junior doctors in rank of stressfulness (FIRTH-COZENS 1987)

Most reviews of causes of stress in junior doctors highlight the effect of long hours on-call and sleeplessness⁷. In addition to the cognitive impairment of excessive work, affective changes in the direction of increased depression and increased anger occur. It is clear that disruption of social and intimate relationships due to being on call contribute to mood changes, and conversely good social and close relationships act as a buffer against the effects of stress⁷. Doctors habitually respond to stress by working even harder and their most frequent coping mechanism is "to do nothing and hope it will blow over"⁸. This sets up a circular effect of increased social isolation, stress, and more work, a pattern which persists into later career stages.

The high rate of depression in women house officers was investigated by Firth-Cozens in a separate study⁴. Table 2 ranks sex-related factors in perceived level of stressfulness.

ASPECT	LEVEL
1. Conflicts between career and personal life	2.45
2. Sexual harassment at work	1.92
3. Prejudice from patients	1.77
4. Sexual discrimination by senior doctors	1.36
5. Sexual stereotyping	1.22
6. Lack of senior female role models	0.66

Table 2 – Sex-Related Factors Rated as Stressful by Women House Officers in Order of Stressfulness (FIRTH-COZENS 1990)

The survey showed that sexual harassment, although rare, was perceived as being stressful when it occurred. The main stressor in frequency and severity was conflict between career and personal life. It is unfortunate that medicine is rigidly organised and makes combining family life and a career difficult, a fact of medical life that begins to bite in the house officer year.

How do external stressors continue to affect the junior doctor as his career progresses? An American study⁹ has delineated changes in reported stressfulness of various factors in a group of 243 interns from postgraduate year one to postgraduate year four as indicated in Table 3.

The gradual decrease in levels of stress experienced by doctors as they progress from house officer to consultant has been confirmed by King and colleagues in a large study¹⁰ of medical staff at a London teaching hospital. However, there are not yet any studies of causes of stress in consultants in this country. Table 4 represents some of the external stressors acting upon a consultant. To the pressures of patient, relative, peer and family can be added the new stresses of audit and the market place. The consultant needs to perform a continuous juggling act to keep these pressures in balance.

Event/Stressor	Postgrad. Year 1	Postgrad. Year 4
Change in Geographic Location	88.0%	16.2%
Difficulty Adjusting to Work	35.4%	17.6%
Increased Family Conflict	17.3%	13.2%
Decreased Social Interaction	48.6%	23.5%
Change in Eating Habits	23.9%	8.8%
Change in Sleeping Habit	52.7%	8.6%
Self Doubt About Speciality	28.8%	17.0%
Conflict with Colleagues	3.7%	9.7%
Conflict with Superiors	7.0%	11.8%
Concern about Future	27.2%	39.7%

Table 3 – Changes in Sources of Stress in Interns (TAYLOR et al 1987)

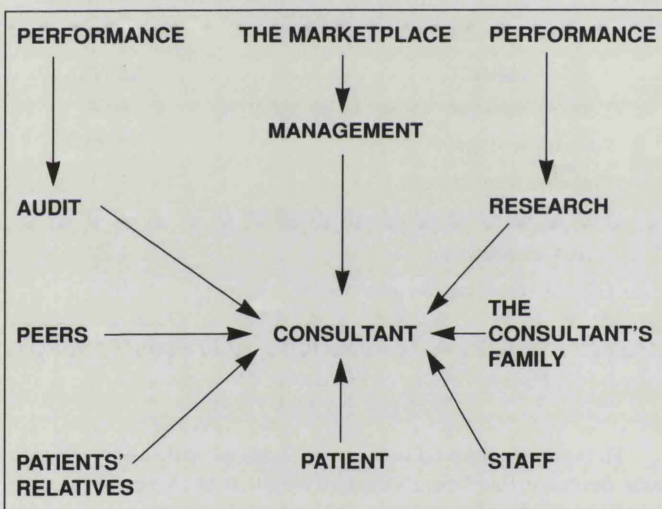


Table 4 – External Stresses on a Consultant

CAUSES OF STRESS:- INTERNAL FACTORS

In addition to experiencing stresses from outside ourselves, doctors are also driven by stresses which arise from inside. These can be described from a psychoanalytic point of view in terms of internal anxieties, inherent motivations and personality traits.

Internal anxieties can be divided into persecutory and depressive anxieties. The psychoanalyst Donald Winnicott¹¹ has described four archaic internal persecutory anxieties which he calls primitive terrors. These are:- going to pieces; falling forever; having no relationship to the body; having no orientation. We allude to these terrors in our everyday speech, eg. "I feel shattered, my heart was broken, I felt pushed over the edge, I lost my grip, I didn't know where I was." As doctors we are in daily contact with patients who are

disintegrating physically or mentally and such external stresses threaten to ignite these primitive persecutory anxieties within ourselves. In addition actual external threats (coroners' courts, criticism from patient or relative, management disapproval) can also trigger internal persecutory anxieties.

Depressive anxieties relate to fears of damaging others and result in reactive wishes to repair others. As doctors we are allowed to do powerful things to patients eg. we can cut them up, we can fill them with potentially poisonous substances, control their minds with electricity and so on. If the patients does not then get well we may be left with feelings of depressive anxiety and guilt. We may then hate the patient for making us feel anxious and guilty and if we are not able to feel hatred and forgive ourselves for it we may be left with even more unconscious or conscious guilt. The seeds are in this way sown for a descent into guilty depression and illness.

We should not lose sight of the fact that doctors are not a homogenous group and that we have different motivations for entering medicine, often derived from our childhood experiences. One study of medical students¹² estimated that only 32% had predominantly mature motives for entering medicine, designated as primary motivation towards sciences or working with others. The remaining 68% were more or less conflicted with unresolved neurotic reasons for choosing medicine. These can be divided into needs to give, and needs to be given¹³. An American psychoanalyst, Karl Menninger has described doctors who as children had their belief in parental omnipotence suddenly and catastrophically shaken by the illness of a parent or by the parents' failure to rescue an ill or damaged child. The doctor-to-be becomes identified with an omnipotent doctor figure who will save the family from catastrophe.

There has been interest in the psychoanalytic literature in the idea that the medical carer, in common with helping professionals in general, may choose medicine to remedy early emotional neglect. The uncared-for part of the doctor is located firmly within the patient and is looked after in its displaced situations by the adult, non-neurotic part of the doctor who is now freed from internal conflict. An unfortunate corollary of this defensive displacement is that the doctor needs a constant supply of patients to ensure that the needy part of self is looked after. If we go on holiday or if we fail to look after our patients then we are at risk of taking back into ourselves our own need. We are familiar with the infuriating habit we have of becoming ill on holiday!

Looking after others and not ourselves can easily become compulsive. One American study¹⁴ of a large number of doctors across nine specialities found that being needed by their patient was their greatest source of satisfaction. Clearly there is then an onus upon the patient to be a good and grateful patient and to be helped. If patients are not gratified, or remain unwell, we may be pulled into a therapeutic furore to get the patients well at all costs, or we may take on more patients to satisfy our need to be helpful. Along with the need to help goes a denial of personal vulnerability, which is seen as a threat to the doctor's grandiose omnipotence and to a sense of professional competence. A survey of house officers¹⁵ reported that 24% felt they would be letting everyone down if they themselves were ill. Finally, displacement of need can lead to an emotional detachment on the part of the doctor. Medical education often encourages such detachment, but this defence can spread into personal life including the doctor's marriage. Doctors are often described by spouses as emotionally cold and controlling,

unable to experience pleasure and not spending enough interactive time with their children.

WHAT CAN BE DONE

It is helpful, even if somewhat simplistic, to think of a stress continuum between mental health and serious psychiatric illness. Progress down the slippery slope to illness can be prevented and hopefully reversed by a series of measures ranging from lectures to raise awareness of the problem to individual specialist treatment as described in Table 5.

The Stress Continuum	Task	Intervention
Mental Health	Raising Awareness	Lectures
Recurrent Acute Stress	Teaching Stress Techniques	Stress Management Workshops
Chronic Stress (Burn Out)	Individual Stress Counselling	Ongoing Peer Groups Individual Counselling
Illness eg. alcoholism depression	Individual Treatment	Individual Psychotherapy or Specialist Referral

Table 5 – Possibilities for Intervention

Raising the awareness of the problem amongst doctors must be a primary task. Awareness may lead to a gradual change in medical culture so that an admission of emotional stress is seen as acceptable and healthy and not as "weakness" or professional incompetence. Changing the climate of medical education is an important aspect of this task, and medical students should be taught about the stresses of being a doctor before learning about them at first hand.

There are a whole range of techniques that can be learned which will enable the doctor to reduce and manage stress levels. Amongst these are:- attention to sleep, diet and exercise; efficient time management with programmed breaks; attention to personal relationships and especially intimate relationships; understanding our internal drives; being aware of our own stress signals; problem-solving techniques; relaxation techniques. All these may be taught in stress management workshops which optimally take several sessions but which can be compressed into a single day. In the Northern Region the Regional Department of Psychotherapy offer such stress management workshops. Table 6 summarises some tips on personal stress management.

As described, it is the most junior doctors who are most frequently under the greatest stress, and this group should be a priority for education and for provision of counselling facilities. Several surveys of doctors^{15,16} have indicated that if doctors are to use counselling services, such services need to be accessible and confidential. In the Northern Region a pilot study has begun of a service for pre-registration house officers, House Concern, run by a senior registrar in psychotherapy. Individual house officers have been informed of a 24 hour answering service, with a quick follow-up response leading to individual counselling. In addition, groups of house officers are being encouraged to organise small group meetings with their senior registrar as facilitator.

Avoid Self Medication
Use Physical Activity
Learn A Relaxation Technique
Know Your Own Stress Triggers
Get Enough Sleep and Rest
Don't Work if You're Ill
Manage Time and Delegate
Allow Time for Personal Relationships
Plan Ahead by Saying No Now

Table 6 – Stress Reduction: Some Tips

It seems that junior hospital doctors are less cohesive than was the case in the past. One factor may be the reduction in time spent together, in the past doctors were more likely to have special facilities and privileges which kept them together as a group eg. a doctor's mess. Meeting as a group to plan ways to reduce stress can counteract feelings of isolation and helplessness amongst junior doctors. Consultants can in particular play an important role in supporting junior staff as illustrated in Table 7.

INDIVIDUALS

- Set Aside Time to Discuss Problems
- Set Achievable Goals
- Give Both Positive and Negative Feedback
- Discuss How to Improve Weaknesses
- Discuss Future Career Plans
- Discuss Relations with Patients and Relatives
- Discuss Disagreements
- Help with Reading and Exams

GROUP

- Encourage Juniors to Meet Regularly
- Encourage Gripe Sessions
- Provide Climate in Which Doctors Can Seek Help

Table 7 – How Consultants Can Help Junior Staff

Finally it is important that management recognises the existence and importance of stress in doctors and represents this recognition in business plans. In the Northern Region the Regional Medical Committee has been concerned to promote such awareness and has agreed that there needs to be designated consultant time to lead and organise initiatives to combat stress in hospital doctors, and has supported the creation of a five-session consultant psychotherapist post with these objectives. If we can only look after ourselves half as well as we look after our patients, then we will really be making progress with this difficult problem.

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PRACTICE NOTE

Sir – I was talking to general practitioners about the management of heart failure recently, and they were asking about the initiation of ACE inhibitors in general practice. As you are probably aware, ACE inhibitors are now prime treatment for congestive cardiomyopathy or cardiac failure generally. Unfortunately, until now, the drug needed to be started in hospital because of the risk of hypotension. Both Enalapril and Captopril are now accepted for initial treatment in general practice rather than hospital.

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Editorial note: On the facing page there is a scheme for managing heart failure in general practice. This has been kindly supplied by MSD.