Part 1 **The job and you**

Chapter 1 **It's just a difficult job**

When people become stressed or depressed while doing difficult jobs like medicine, they tend to look around the workplace at others who are doing jobs that seem equally hard but appear to be functioning well, and wonder if their difficulties are simply because of the way they are rather than the work they do. They ask: 'Is it me or is it the job?' This chapter outlines the parts of the job that have been found to cause problems. There's no doubt that many aspects of the roles within medicine are very difficult and often upsetting, and it takes an unusual person not to feel stressed at times.

1.1 Health organisations can be a health hazard

There is good evidence that the organisation you work in can make a difference to how much stress you experience: some medical schools, some specialties and some organisations are less stressful than others. For example, a medical school that formed its students into small consistent groups throughout their clinical years showed far fewer stressed students than one which sent students through in groups of over 40. Similarly, one hospital will cause problems to a much greater proportion of its staff than will another: one study comparing hospital staff in a number of organisations found those above threshold for stress on the General Health Questionnaire (GHQ) varied from 17% to 34% depending on the hospital, whilst a study of newly qualified house officers in London's hospitals found mean GHQ levels varied from 8.1 to 15.3 and this was not to do with hospital size or whether it is modern or old. It seems the management of a hospital has an effect.

Teaching hospitals tend to be more difficult places to work than non-teaching, probably because the competition is so much fiercer between colleagues, and the patients are more ill. But also it is clear from these data that there are going to be management issues which make one hospital a good place, with satisfied staff and low turnover, while another has disgruntled and stressed staff, where rumours and insecurity abound, and relationships are difficult. In all organisations, from banks to hospitals or general practices, these effects are passed down the hierarchy and on to customers or patients – and bounce back in the costs of absence, turnover, mistakes, litigation and complaints. Whether you are student, staff or patient, management clearly matters.

1.2 Life in the team

This is equally true at the team level. You will probably recognise that some teams you have worked in have been good places to be, while others have a number of people off sick, experience frequent back-biting and scapegoating, and rarely deal with conflicts openly or fairly. So what are the criteria for a good team? Studies have found that in a good team:

- Its task is defined and its objectives clear.
- There is participation in decision-making by all members, good communication and frequent interaction between them.
- It meets regularly to review its objectives, methods and effectiveness.
- There is a shared commitment to excellence of patient care.
- Its members trust each other and feel safe to speak their minds.
- It has reasonably clear boundaries and is not too large (ideally fewer than 10 people).
- Its members know who leads it and the leadership is good.
- Its meetings are well conducted.

What a pleasure it is to be in one of those teams: you can work harder, be more innovative and be carried during those times when life events might make you less productive. Group processes are powerful influences on individual actions, equally strong for those teams where the criteria are not met. For example, studies have shown:

- General practitioners (GPs) in poor teams are more likely to opt for early retirement.
- The quality of teamwork is the principal influence on whether junior doctors take sick leave.
- The team can compensate for an individual member's errors over time, so a well-established team is likely to make fewer errors overall, and to identify and deal with the underlying causes.

Figure 1.1 GHQ-12 scores for those in good teams compared to poor teams.

- Those in high-quality health care teams are significantly less stressed than those in ineffectively functioning teams or those not in a team – and low stress is related to better patient care.

Some researchers on teams have concluded that, despite all the measures of team function, you really need only to measure the stress levels of its members. Just look at the difference between the stress levels of good teams and poor teams measured on the criteria listed above (Figure 1.1).

Although most health service staff see themselves working in teams, data from the NHS National Staff Surveys show that a large proportion of them work in 'pseudo-teams'; that is, the staff say they are in a team, but it does not meet the criteria for a real team set out above. The surveys show that the fewer criteria that are met, the more those team members make errors and suffer harassment and violence, and the more their organisations show lower quality of care, worse use of resources and higher patient mortality. There are similar findings in primary care. The shift from uni-professional hospital teams, such as a medical firm or a nursing team, to multi-professional groups working within a clinical area to provide a service demands new, more complex teamwork skills which most organisations have not yet managed to develop. So team factors and organisational factors can affect your mental health and always need to be considered.

1.3 Workers of the world

In addition to the sort of organisational and team factors that affect how you feel, there are a number of aspects of a career in medicine which are as

stressful as they are in other walks of life. For example, in surveys from most of the western world, **overload** is always said to be difficult – for students, doctors and every other type of staff, whether in health care or outside it. For doctors, the demands are exacerbated by shift work and, when they are young, by frequent relocations. For them the greatest effect of overload is the conflict it can cause between work and home. You probably need more support from home life at a time like this, but you're probably going to get much less than you need because you spend less time at home. This isn't just a factor for women with children: both male and female doctors report equal work–home conflicts.

But even overload – having too few staff and too little time to do the job – doesn't always cause stress; the correlation between hours of work and stress are consistently fairly low in medicine. A young doctor who feels well supported by his or her seniors, who has reasonable periods of sleep, and who gets on with the rest of the staff will usually have no problems working reasonably long hours; in fact, he or she will often really enjoy the feeling of competence growing, of being useful and feeling part of a team. For many people, overload is simply an easy and obvious way to label other less tangible causes, and it's true that it will often play an indirect role in stress in that feeling exhausted will always make other problems loom larger, a death become more distressing. As we shall describe later (Chapter 10), there are many factors that lead an individual to feel overloaded but these rarely include simply the number of hours worked.

Other aspects of your role which cause stress in most types of jobs and most organisations include a **lack of clarity** about what is expected of you – so you don't always know when you've done a good job – and a **lack of discretion or control** in how you carry out that job. The reductions in medical autonomy and increases in accountability that have taken place over the last few decades have made many doctors feel that they no longer have control over their work. A greater sense of personal control leads to increased job satisfaction and even better health. The clearer you are about your role and its expected outcome, the happier you are likely to be; and most of us would rather achieve that outcome in the way that suits us best.

Sexism, racism and homophobia exist in all walks of life and medicine is certainly not immune from them. While this might be more subtle when directed towards sexuality or ethnicity, it can still be remarkably open in terms of women. For example, two female first-year postgraduates wrote:

> *My consultant told me that women are unable to make decisions about male patients, especially if they are life and death decisions. He thought they should stick to paediatrics and dermatology.*

My consultant would put his arm round my waist and pull me to him laughing and saying 'how about a hot date', even though other people were around. I found it really embarrassing and didn't know how to handle it. I didn't want to look like a prude but I knew he shouldn't do it.

1.4 And then there's medicine itself

Beyond these stressors common to workers everywhere are others that are particular to medicine, and some of these vary to some extent depending on where you are in your career. However, the following are always difficult for almost everyone at times.

- **Dealing with difficult patients.** Even before people could look up their symptoms on the Internet, it was still difficult to have to deal with patients or patients' relatives who were argumentative, unappreciative, untrusting or just plain abusive.

  Sometime I feel overwhelmed with the total lack of appreciation and even resentment I get from patients. This has got so much worse over the last 20 years as psychiatrists now only get the most psychotic of patients and often have to section people. I guess sometimes the relatives are relieved. (Psychiatrist)

  Then there's the 'heartsink' patient with chronic back pain. You just dread them coming back. You know that whatever medication you suggest won't work, and the demand for yet another specialist referral will lead to the same negative outcome. And you get the blame (again) for not sorting it all out. (GP)

As people increasingly consult the Internet before they talk to you, or come in to see you holding a newspaper cutting about the latest treatment or cure, expectations of what you can provide seem to go up and up. Television programmes such as Casualty or ER don't help as they offer false hopes of miraculous medical interventions. The health care scandals of the last decade have made some people less accepting of your opinion, although the general loss of deference in the population towards authority figures may be more at play here. Generally doctors are still one of the most trusted professions by societies across the world.

- **Death and suffering.** If you ask young doctors to complete a questionnaire and rate a number of known stressors, including dealing with death and suffering, they rate this item very low – 'not a problem to me'. But if you ask them to write about a recent stressful event, young doctors in

particular write most often about this area, especially if the patient was young or in other ways similar to them. For example:

> *A patient with carcinoma of pancreas, otherwise fit, aged 43, developed a massive coagulopathy after total pancreatectomy. He died. I had feelings of total helplessness while giving blood, etc, although management decisions were not left to me. Could not accept defeat and couldn't cope with total failure of our therapies, despite realising medically the gravity of the situation.*

> *A 29 year old woman, recently married, was presumed to have sarcoidosis, but biopsy showed adenocarcinoma with lung metastases. The consultant reckoned she had six weeks to live. The fact that she was young and female made the incident particularly distressing to come to terms with. Also she was just married and had a devoted husband.*

Of course it's upsetting to see someone die at a time when they shouldn't, or to be in pain or distress from something you have done to them, however necessary it was. It is also difficult on those thankfully rare occasions when someone close to you is ill and the boundary between your personal and professional life becomes blurred. For example, a fourth year medical student wrote:

> *Mother was admitted to psychiatric hospital having gone manic again. This time on lithium. Father never takes time off when mum's ill and I had to go. She was managed very badly as a patient as she was a doctor's wife and never really treated by outside doctors. I feel very responsible about helping solve the problem. I had a psychiatry exam too.*

The quotation above highlights another type of patient that doctors find difficult to treat: another doctor or the relatives of a doctor. Traditionally, they are either over-treated or under-treated. We will discuss this further in Chapter 7.

Medicine is an emotionally demanding job and this is sometimes somewhat swept under the carpet. Some stressors will be chronic and so need to be dealt with by long-term solutions to ease or prevent them happening; others will be one-offs that will not usually be possible to plan for and so will need to be tackled after the event. For example:

- **Making mistakes.** Medicine is clearly made much more difficult with the growth of litigation that is sweeping the western world. All doctors find that if they have to face claims or complaints or discipline, this is one of the most difficult times of all in their careers. However, even if there is no complaint, even if a mistake goes largely or wholly unnoticed, doctors still remember them for most of their lives and most

doctors have at least one of these tucked away in their memories, one that resurfaces from time to time when things get tough. A specialist trainee wrote:

> *I missed the diagnosis of pulmonary embolism and treated the patient as a case of severe pneumonia until the day after. Her condition deteriorated and only then was the diagnosis put right. I felt guilty and lost confidence.*

It's very human to make mistakes, and they are bound to happen in a difficult job like medicine, so often filled with uncertainty and where advances are happening at a rate of knots. But throughout their careers, whether junior or senior, doctors feel great and lasting shame and distress from where things went wrong. How you tackle those mistakes – the way you use them to learn and the way you think about their cause – are important in terms of how you will feel in the future and even how you will develop as a doctor (see Chapters 5 and 6). We will talk about mistakes much more in Chapter 12.

Where emotions run high, as they are bound to do when you deal with such fundamental issues of life and death, blame can sometimes ricochet around when things go wrong. In reality, it's rarely down to one person or another, and almost always involves systems issues. Nevertheless, one of the most stressful aspects of mistakes is where you get the blame for something you feel was not at all your fault. For example:

> *I was blamed for a mistake about a patient's medication as I'd taken the message from the consultant in the path lab and he'd got it wrong.*

At a time like that, getting support from a senior is particularly important:

> *My consultant sat me down and reassured me what the situation was and how it wouldn't lead to litigation. She relieved all my anxiety.*

Consultants rarely understand just how important they are to junior doctors and how much every word they say of blame or praise has an enormous effect on confidence and is remembered for years. GP trainers play the same role in a primary care setting. It is all too easy for them to forget how stressful and lonely it can be on a house call, when the visiting doctor is exposed to clinical and, on occasions, physical risk. Good supportive backup on the phone, with supportive de-brief sessions, can make all the difference.

- **Complaints and litigation.** Perhaps the most stressful happening of all for doctors occurs when a serious complaint takes place, especially if they have to face litigation or the long drawn-out process of coming before a disciplinary body. At times like this they say they feel utterly alone, isolated from colleagues and patient alike, and suicides are sadly

not uncommon. Even after they have been fully exonerated by the disciplinary agency – and this is increasing as these organisations take every complaint much more seriously than they used to do – they often continue to feel demolished by the experience and uncertain in their judgments. One senior doctor said: 'I find I check everything over and over now and often go to colleagues to make sure I'm right. I know I'm sending for far more tests than I used to do as well.'

More trivial complaints, even when embedded in a patient's letter of thanks and appreciation, still raise irritation or anger in most doctors who tend to ignore the good points and see the small complaint as an attack upon their competence or dedication. Learning to see the positive, to recognise the good things you do and to deal with the inevitable stress by learning relaxation or meditation and by getting support beyond your family are all essential strategies at a time like this (see Chapter 5). Remember that colleagues, lawyers and medical defence societies can all support you, but get counselling or other professional help if you are feeling really low.

- **A colleague's under-performance.** Another associated stress is where you become aware that a member of your team may be under-performing. They may turn up late for work, not answer the phone or bleep, refuse to come in when you need help with an urgent case, or fail to do any teaching. You know that you have a responsibility for patient safety, as well as a wider professional requirement to express concerns; but you know too that saying something risks the team's cohesion, and also potentially your own reputation and future references.

  We were puzzled by the erratic behaviour of a GP colleague, and struggled to know what to do. He came in late quite a bit and seemed distracted. I can't say that the patient care he gave was dangerous or particularly odd, but something wasn't quite right. In the end we had to talk it through with him. It turned out he had financial problems.

1.5 Things change

Beyond these core issues for doctors there are others which appear at particular points in careers. For example, **students and young doctors** report finding senior doctors difficult to deal with and bullying has been reported as widespread in the past.

He shouted at me and threw a packet of X-rays in my face in front of lots of colleagues, just because my consultant has asked me to get a scan arranged.

I took a day off sick and my consultant told me off saying that in her career she had never taken a day off sick!

My GP Trainer always seemed to want to pick on me. However much I knew, it was never enough. We used to meet up with the nursing and office staff at coffee time, and he would delight in exposing my ignorance to the assembled team.

Such systematic ritual humiliation used to be common practice in many medical teaching settings. That it has not disappeared entirely is a cause for concern, and a reminder that everyone has a responsibility to challenge behaviour that is not acceptable.

In addition, both students and young doctors face examinations and the constant exposure of being evaluated by others and this is never an easy passage. And then there is the new challenge of getting the job they really want in a world where medicine changes regularly from being over- or under-supplied.

Change in itself is at best a challenge and more often very stressful. Although once medicine pottered on with very few drastic changes happening, over the last 20 years successive governments have radically altered the way the health service is organised and how the professions work within it. For doctors this has resulted in a gradual reduction in autonomy. **Senior hospital doctors** used to be the least stressed, but now their levels have risen considerably as the constraints have grown and their roles, particularly in hospitals rather than in general practice, have become more demanding. In addition to those factors we've discussed above, hospital consultants list the following as increasingly stressful:

- Constant change driven from the top;
- Targets that are often meaningless clinically;
- Breakdown of the firm structure;
- Not knowing their junior staff now there is a shift system (tough for the juniors too!);
- Lack of autonomy;
- Bullying managers;
- Too much paperwork;
- The fear of litigation.

GPs, particularly those in partnerships, also face major external pressures which mirror those for senior consultants. The audit culture, with its emphasis on meeting targets and the need to supply endless data on clinical and organisational activity, wears doctors (and their practice managers) down.

I used to think that my job was to meet the needs of my patients. Now it seems that my role is to furnish the Office of National Statistics with endless information of increasingly limited value.

Struggling with the need to meet ever changing targets, I am spending much longer in the surgery building, as well as taking paperwork home. As the Senior Partner in a small practice, I worry that the practice income is now falling and that I may have to make some staff redundant.

One wider challenge to all doctors remains that of the change in the nature of politics, as health care, its costs and organisation, increasingly appears at the centre of the political debate. The emergence of new national strategies and initiatives, such as 'delivery units', and the need for managers and clinicians alike to dance to their political masters' tunes, leave many doctors dismayed and demoralised. In the UK, the historic role of GPs as 'gate keepers' – the expert generalists who guided their individual patients through the system to seek their optimal care and treatment – has to some degree been replaced by a rationing role for the benefit of the wider population. Consultants also feel this pressure to divide their loyalties, aware that the patient in front of them may receive 'second best' treatment for reasons of cost, and knowing that this thought is also in the patient's mind. The mutual respect and trust they both seek is put at risk when talk of rationing and the need to balance budgets takes over.

I struggle with how to face the patient's family. They want to know that everything possible is being done, and I want that too. How do I explain that the best chemo option is not on the protocol and that the local Primary Care Trust won't pay for it?

1.6 Conclusion

It is clear from the above that the context and the time in which you work, and the policies that are introduced or in place at different points are all going to affect both what you see as stressful and your stress levels. To some extent this is going to make it harder for older doctors who have been trained differently and who have had to make many more changes during their careers, than for young doctors who may have fewer expectations and whose new training may make it easier, for example, to work with the patient rather than simply for the patient.

You may feel now that a chapter full of difficulties, as this has been, is enough to distress anyone, but we hope this isn't the case. Rather, it is usually a relief to find that the things you were experiencing as stressful are shared by thousands of others. The good news is that stress levels are clearly changeable to some extent by changing the context in which you work. Ways to handle the distress caused will be discussed in more detail in Part 2.

Bibliography

British Medical Association. *Stress and the Medical Profession*. 1992, BMA, London.

Carter AJ, West MA. Sharing the burden: teamwork in health care settings. In Firth-Cozens, J & Payne, R (eds) *Stress in Health Professionals: Psychological and Organizational Causes and Interventions*. 1999, J. Wiley & Son Ltd, Chichester.

Editorial. The doctor is unwell. *The Lancet* 1993;**342**:1249–50.

Firth-Cozens J. Depression in doctors. In Katona, C & Robertson, MM (eds), *Depression and Physical Illness*. 1997 (pp. 95–111), Wiley, Chichester.

Firth-Cozens J. A perspective on stress and depression. In Cox J, et al. (eds) *Understanding Doctors' Performance*. 2005, Radcliffe Publishing, Oxford.

Firth-Cozens J & Payne R. *Stress in Health Professionals: Psychological and Organizational Causes and Interventions.* J. Wiley & Son Ltd. Wiley's are at Chichester.

Gabe J, et al. *Challenging Medicine*. 1994, Routledge, London.

Harrison, J and van Zwanenberg, T. *GP Tomorrow*. 2002, Radcliffe Publishing, Oxford.

Smith R. Why are doctors so unhappy? *BMJ* 2001;**322**:1073–4.