Editorial

COPING WITH STRESS - A DOCTOR'S PERSPECTIVE

> Do not muse at me, my most worthy friends;
> I have a strange infirmity, which is nothing
> To those that know me.
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> *W. Shakespeare, Macbeth, Act III Scene V*

During the last decade a word has come to feature prominently in the lives of patients and, more recently, in that of the physicians who look after them: stress. To the dyed-in-the-wool physiologist such as Canadian endocrinologist Hans Seyle, this word was coined to refer to a phenomenon akin to that studied in mechanics; one to which experimental animals were subjected in the laboratory, and thereafter their hormonal, behavioural and other responses were assessed - a progression from a state of alarm or arousal to ones of resistance and compensation which, on occasion, led to exhaustion and fatigue.[1] Nowadays this word has taken another populist meaning in the human context, and perhaps a rather different, more sinister, and often pathological, connotation.[2] In the medical context it has come to denote the collective gamut of anxieties and pressures which the individual experiences, both consciously and subconsciously: the pressures of a job, the impetus to seek promotion and success, the desire to avoid failure at all costs, the increasing demands of the post, and more, have all been bundled into the word 'stress'.[3] Lazarus and Folkman[4] define stress as 'a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being.'

Stress does no longer simply denote the pressure itself but has come to refer to the psychological morbidity with which it is often associated, with the ultimate in terms of morbidity and malfunctioning being a 'burn-out', a term originally coined by Freudenberger in 1974 to describe the demoralisation, disillusionment and exhaustion that he had observed in mental health workers. It is now a more universally applied term[5] and has even been elevated to a diagnostic status - ICD-10;Z73 - problems related to life-management difficulty. Its features have been clustered by Maslach and Jackson into three categories: emotional exhaustion, depersonalisation and reduced personal accomplishment with eventual, sometimes catastrophic, changes in inter-personal behaviour, feelings and emotions, thinking processes and general somatic health.[6]

Generation of stress within the medical profession is, as in other instances, likely to be multifactorial. Perhaps its actual seeds are sown much earlier than the graduation day. The impulses which drive teenagers to throw their hats, and the rest of their lives, into the medical ring in the first instance; the selection procedures which they have to endure to enter into the hallowed and respected medical profession, and their gradual nurturing, education and moulding till they actually make the grade, to a varying extent, are all stressors. These life-events have probably not changed too radically over the last century or so. School-leavers who chose medicine for their university career have always had to attain top grades in their end-of-school public examinations; had to convince the universities through their curriculum vitae, or at interviews with the Dean of Admissions or his Committees, that they were rounded individuals with notable achievements in academic, sporting and other extra-curricular activities.

Whether the personality of a particular applicant is suited for the medical experience, and would be able to cope, is a quality that cannot be assessed accurately and reproducibly. For some medical students, their first pre-clinical year at medical school is a year for 'freshers' to let their hair down and savour for the first time a period of freedom of expression in the real world; a time to explore friendships and relationships, away from their families, and perhaps, the rigours of boarding school. Coping with these heady days is a feat in itself - the first stressful milestone in the years to come. Perhaps it is at this stage that some formal psychological assessment, perhaps by structured interviews, should be made. A self-rating questionnaire is another possible option; the version developed by Kellner[7] for clinical work, known as the 'Screening List for Psychosocial Problems', that tests for problems and symptoms, has been extensively validated.

Throughout their undergraduate studies, up to 18% of medical undergraduates seek some form of psychiatric help,[8] ranging from sleep-pattern disturbances to eating problems, alcohol and substance abuse. Financial worries, which are becoming even more prevalent, conflicting feelings of inadequacy due the volume and complexity of the subject material, and the occasional trauma of 'teaching by humiliation', all carry their stress-engendering toll.

The clinical environment to which they are next gradually exposed, both as students and then as young doctors, is yet another developmental step replete with stressors. Patients fall ill during the night as well as during the day and have to be cared for round the clock. Inherent in the job is a life-and-death responsibility; a requirement to empathise with suffering, pain, rejection and worse, and to break bad news. There is a requirement to be able to mend bodies and souls and the general expectation, not least by the patients, to maintain a certain robust, disinterested, unemotional, yet sensitive, compassionate and ever-understanding demeanour. These features are integral to the profession but do sap the physical and mental capabilities, and sometimes make excessive demands on the stamina and reserves of the young doctor.

Climbing the increasingly steep career-ladder, while simultaneously building up a social life and perhaps developing a family or social partnership, also brings further trials, responsibilities, conflicting loyalties and stressful situations.[9-11] Not surprisingly, doctors are thus at a far greater risk of mental health impairment as compared to other professional groups.[12] In Britain, in addition to a National Counselling Scheme for Sick Doctors, the British Medical Association introduced a Stress Counselling Scheme in April 1996. This scheme reportedly averaged around 300 phone contacts per month.[13] In the execution of its statutory duties, the General Medical Council is becoming more regularly involved in health problems of registered medical practitioners, ensuring their obligations to the public - namely that no patient is put at risk - as laid down in the GMC Health Committee (Procedure) Rules (1987).[14]

These doctors have to be identified initially as being ill, and their illness then has to be brought to the attention of those who need to know and who can also assist and ameliorate the situation: the Occupational Health Services or the general practitioner of the ill doctor. Yet there is frequently an innate fear that admitting to illness of this type would mean stigmatisation, loss of respect and beratement by colleagues; a reduced prospect for their career and continued employment, and perhaps a loss of post and salary. Not surprisingly, many prefer to keep quiet about their problems, perhaps self-prescribe and have recourse to a gradually escalating use of pharmacological agents and alcohol. A conspiracy of silence often develops around them, and a blind eye is cast on these situations which gradually become worse, less well-contained and thus less easily managed. The GMC now instructs doctors that to knowingly conceal or fail to

report illnesses in medical colleagues, which are likely to impair their capacity to deal with patients safely, may be a disciplinary offence to which they would be answerable.

Doctors, as a resource and commodity, are scarce and expensively acquired, and every endeavour should be made to ensure that they do fall by the wayside. Sydney Brandon, Emeritus Professor Psychiatry and Postgraduate Dean of the University of Leicester, who assumed the Chair of the National Management Committee of the National Counselling Service for Sick Doctors, states 'When local or national counselling services have been used or refused and the doctor giving rise to concern is still unwilling to seek help, the NCSSD may be called upon....to provide an accessible, confidential and non-coercive counselling service for doctors unable or unwilling to seek treatment....If it (the NCSSD) was being set up today it is unlikely that the words "counselling" or "sick" would be used because the members are not counsellors and many doctors in need of help do not regard themselves as "sick."'[15]

It is an intrinsic aspect of their medical professional duties that doctors are exposed to high levels of stress, and individual resources and occasionally, reserves – no matter how abundant and resilient - may be exceeded, with the risk of mental and physical illness. These professional demands can be tolerated better if a vigilant eye is maintained at all levels of employment, and when required, demands are modified. Stress-coping resources and in-service supportive strategies should also be in place to deal with problems as they arise. The psychological needs of doctors in their professional activities are as real and tangible as those for whom they care, and these should be appreciated and effectively catered for alongside those of the patients. The comments of Richards[16] in his paper entitled 'The Health of Doctors' ring as true today as they did about a decade ago: 'There is a paradox that the (medical) profession's ability to deny its emotions can be a strength when helping others to cope with serious illness and its weakness with coping with its own. For many years the emphasis has rested entirely on the former. Only now doctors are realising that admitting their own humanity may not be so bad after all.'

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