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Scenes from Postgraduate Life

Stress and stress counselling

K.H. Matheson

West Suffolk Hospital, Hardwick Lane, Bury St Edmunds, Suffolk IP33 2QZ, UK.

Summary: This is a report by the 1989 National Association of Clinical Tutors Wyeth Travelling Fellow to the United States of America. The stresses of postgraduate training and attempts to modify these are described, including stress counselling. The significance of stress and the relevance of the findings for postgraduate training in the United Kingdom are considered.

Introduction

During my term as District Clinical Tutor, one of my duties was to be Careers Adviser and Counsellor for the junior doctors in my district. I realised that there was an undercurrent of anxiety and stress that I was not able to deal with. There are numerous papers from the USA on the stresses of postgraduate medical training,[1-10] and I was fortunate to be given the opportunity by the National Association of Clinical Tutors (NACT) to visit North America as their 1989 Wyeth Travelling Fellow to study the stresses and stress counselling.

In the UK we are only now beginning to acknowledge that training is stressful.[11-14] There are lessons to be learned from this study of the American experience as we move towards a more American system as a result of the impending National Health Service (NHS) changes. I visited three Area Health Education Centre (AHEC) affiliated hospitals and one University hospital in North Carolina, three University hospitals in Philadelphia, and one University hospital in Massachusetts and Virginia respectively.

In order to find out about the stresses during postgraduate medical training, I interviewed numerous people including medical students, residents, University and AHEC faculty members (teaching staff), Programme Directors, Chiefs of Service, Associate Deans, and the Dean of the School of Medicine of the University of North Carolina at Chapel Hill. I also met hospital administrators, and other AHEC members such as educationists, clinical psychologists, behavioural scientists, social workers and pharmacists.

Correspondence: K.H. Matheson, M.B., B.S., F.F.A.R.C.S.
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I divide my findings into 2 main groups: these are, firstly, the stressors in the system, in the organization of the training programmes, and personal; and, secondly, the responses of the system, the programme organization and of the person.

Stressors

The System

Medical students have to decide on the choice of specialty very early without the benefit of careers guidance. Their choice is therefore influenced by their debts, their perception of the status of a specialty and its potential earning power.

The most 'angry' residents I found were those in the primary care specialties, which are Family Practice, Internal Medicine, Paediatrics, Obstetrics and Gynaecology. With the exception of Obstetrics and Gynaecology, primary care is perceived as having lower status and is relatively lower paid. The American system of reimbursement rewards procedures rather than consultations.

The most common stressor was difficult patients. American patients are more demanding and expect 'fast food' medicine: as consumers they believe health can be bought and health care rationing is not tolerated. There is an erosion in the traditional relationship between doctor and patient, for medicine is increasingly viewed as a business. Patients are also now more difficult medically particularly the in-patients. The socio-economic cycle of deprivation, hopelessness and substance abuse results in sicker patients: they have more multi-system diseases and more pathology. They are looked after by residents who are less experienced than their British counterparts, and those residents are faced

with additional stresses such as the high incidence of human immunodeficiency virus (HIV) related problems, the need for early discharge as dictated by the Diagnostic Related Groups regulations and the inability of patients to afford the treatment prescribed.

Litigation is a way of life. Residents spend a great deal of their time documenting what has been done or said to their patients, and for quality assurance. Other health professionals can be threatening to a fledgling doctor by their high-handed behaviour, such as the nurses who are paid more than first year residents.

The popularity of medicine as a career has declined in the last decade and it is thought that this has resulted in the selection of less bright students that is now reflected in less able residents who cannot cope so well.

The organization of training programmes

There is a great variation in the way training programmes are organized and this varies with the different specialties and institutions, and with the number of residents on the programme. Residents labelled programmes as abusive, brutal or benign. Although some of the stressors reflect a more aggressive and competitive society, there are many similarities with the British system.

The postgraduate training is short, compressed and intensive: Family Practice, Internal Medicine and Paediatrics are only 3 year programmes. Despite their intensive training, they emerge relatively inexperienced and find the transition from resident to independent practitioner a stressful period, compounded by the lack of business training.

Residents work extremely long hours especially in the surgical specialties when they may work 12–14 hours a day. The day is crammed with rounds and with conferences that have to be fitted into working breakfasts and lunches. The rounds are dreaded in the aggressive 'macho' programmes because the residents are shredded publicly; they claim it is training by shame and guilt. In some hospitals, residents resent having to do work that should be done by others, for example transporting patients to the radiology department, taking blood samples and performing electrocardiograms.

The average on-call rota is 1 in 3 or 4. The residents do not get half days or the day off after 24 hours on call unless they happen to have a night shift system. They claim to work 100–120 hours a week and were not impressed by British junior doctors' supposedly long working hours.[15] To eliminate the 1 in 2 on-call rotas,[16,17] they have accepted cross-cover which means more work when on call and fewer colleagues around for mutual support. Weekend duties tend to be split to avoid more than 24 hours on duty. Even when not on duty, some residents are expected to work Saturday mornings and see their own patients on Sundays.

Training programmes, though excellent educationally, are rigidly structured and inflexible. Residents are told when to take their annual leave of 2–3 weeks, and female residents, when necessary, only take 6–7 weeks maternity leave. The year's time-table is so organized that the unplanned absence of 1 or 2 residents throws extra work on those remaining despite the relatively large numbers of residents in each programme compared with the British system. Locum tenens are not used. Residents complain of exploitation by attending staff who have no interest in teaching yet demand that their patients have resident cover.

Personal

Much of the frustration and anger felt by residents arises from the mismatch between expectations and reality, and from seeing other young professionals overtake them financially and in life-style. When American residents start their training, they tend to be older than their British counterparts because the undergraduate period is longer and also because some students pursue a career with their first degree before entering medical school as mature students. Residency training has been called the period of 'emotional adolescence' and it is said that medical training makes all doctors slow emotional developers.[18]

Residents feel demoralized because of the loss of status and the deteriorating relationship between doctor and patient. They are treated as mere employees by the hospitals which are now run by business corporations. Their pay has been overtaken by the nurses and therefore they feel exploited as cheap labour. They feel helpless at the loss of control over their own time, time-table and time to pursue their own interests and life-styles.

Trying to pay their medical school and college loans is certainly a stressor because the loans can be as much as $100,000 before adding compound interest that is not tax deductible. It is hardly surprising that there is a need to moonlight (working mainly in hospitals where there are no residents) which means they end up being on duty more often than the 1 in 3 or 4 on-call rota. This causes lack of sleep and chronic tiredness.

Most doctors feel they have to maintain the 'superdoc' image even when they feel insecure and vulnerable; and all doctors have to cope with difficult issues such as death, ethics and fears of making mistakes. Residents feel isolated from friends and family because of the long hours at work, and the national computer matching scheme may take them a long way from home.

Female doctors have extra stresses of the biological time-clock, trying to be 'superwoman' as well as 'superdoc' and they have to put up with sexist attitudes, however subtle these may be. Black doctors feel that they have to prove themselves and that their work is more closely scrutinized.

The responses to the stressors

The system

There seems to be little inclination to alter the system to alleviate the stress on doctors, as in the UK.

The organization of training programmes

As mentioned above, the lower status attached to the primary care specialties is one of the reasons that have significantly affected recruitment to the extent that even prestigious Internal Medicine programmes have not been filled.[19] Therefore, market forces have made it necessary to design benign caring programmes to attract residents. Family Practice programmes seem to have made most effort. The so-called 'life-style' and 'high-tech' specialties such as radiology, anaesthesiology, orthopaedics, ophthalmology, dermatology, have become popular. Thus, they are in a better position to pick the more able residents. Surgery remains popular. General surgeons tend to see stressing their residents as part of training. It is well known that there are programmes which boast that none of their residents' marriages survive their training!

It is obviously important where there are many residents in a programme to have an early warning system. Regular, two-way evaluations between trainers and trainees, pick up any changes in a trainee's performance fairly quickly. A preceptor/mentor/personal tutor scheme is being introduced so that there is someone who is non-judgemental to whom a resident can turn. Social events are encouraged so that people get to know each other socially and personally.

Some programmes have been reorganized to prevent overwork and exploitation by limiting the numbers of new patients per resident or team, and patients who get resident cover are selected by their severity of illness and educational value. (Private doctors look after the rest of their own patients.) Some have also introduced night shifts either as an addition or as relief. Some programmes allow residents a degree of control over their time-table, holidays and off duty but with clear guidelines to fit in with their very structured training and to avoid peer abuse. Moonlighting can be legitimized and organized to fit in with the departmental rota, thereby helping to avoid the problem of chronic sleep deprivation.

I found the psychosocial supports interesting. Residents have 'bitch' sessions with the chief resident. Some specialties, in particular family practice and paediatrics, have tried using support groups as a means of mutual support and they serve as a way to allow residents to let off steam and socialise. However, support groups met with variable success. Half or one day retreats are becoming popular; these retreats are semi-social events that occur once or twice a year outside the hospital and may include spouses; the residents learn about stress management, time management, business management and interpersonal relationships. Stress and business management can be incorporated into the curriculum. Some programmes had either a designated or informal counsellor who tended to be a clinical psychologist, though it was not uncommon to find that the residents did not know whether there was such a person. They usually sought the help of a friendly clinical psychologist, social worker or senior colleague if they needed to. (There is still a stigma attached to seeing a psychiatrist and to do so may also blight future career prospects.) In fact, an enlightened and sympathetic senior colleague could fill the role of stress counsellor adequately.

Personal response

Modification of the individual's response to stress is the function of stress counselling, and there are several practical techniques that can be used. It is important to identify and encourage support systems such as spouses, friends, family, sports and hobbies. It has been recognized that spouses and partners may need support too. Stress management consists of identifying priorities, goals and problems, then learning to come to terms with the problems and circumstances. People can be induced to take a more objective long term view of their situation, and to understand their own reactions to stress. Time management is using time efficiently by listing activities in terms of priority, and by identifying, then eliminating time wasting strategies. Relaxation techniques, for example exercise, yoga, biofeedback and meditation, can be used to reduce stress.

Discussion

Although some of the stressors are peculiar to the USA, others are similar to those in the UK, such as demoralization, long working hours, unhelpful administrators and difficult patients. Compared with his American counterpart, the British junior doctor faces a long training period during which there are frequent job hunts and moves, he encounters more variable quality of training, and

he has to pass the 2 to 3 part postgraduate examinations. Our long training in a military-style pyramid system means that there will be 'stuck doctors'[20] and that women are at a disadvantage.

Whilst stress is inherent in medicine, it has to be realized that not all stress is bad, as the stress curve in Figure 1 illustrates.[21] Stress which increases productivity is good stress or eustress, as opposed to bad stress or distress which occurs when stress is increased beyond point A and which decreases productivity, causes fatigue and exhausts any reserve for coping with further stress; that is 'burn-out'. Some people are more susceptible to stress because of their 'pre-morbid' personalities. Eventually distress and 'burn-out' may cause physical ill-health or psychiatric problems. In the USA this is referred to as the impaired physician.

Trainers should learn to recognize stress in their trainees by their changes in performance clinically and at examinations, by changes in personality, life-style or habits. Special attention should be given to the 'odd-ball' and to the loner.

How well an individual copes depends on his personality, environment and physical well-being. Different specialties appear to attract different personality types and these may vary in their perceptions of stress and their ability to cope with it. Although most doctors appear to cope, coping can either be positive or negative (maladaptive).

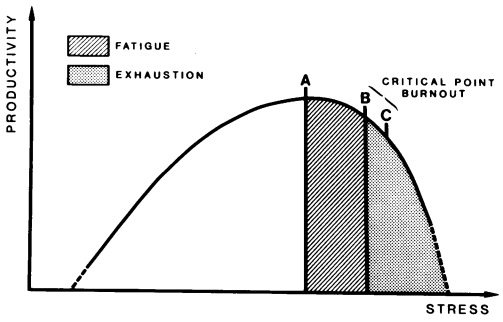

Figure 1 The stress curve.

The problem is that prolonged stress induces maladaptive coping mechanisms that may become permanent features of professional behaviour; doctors may become aloof and distance themselves from their patients or even regard them as enemies; they may indulge in flights of omnipotence or authoritarianism, or resort to workaholism or isolation.[2,22] Senior doctors do not always make good role models in these respects. Marital and family conflict can arise as a result of maladaptive behaviour. Positive coping can be encouraged by the methods available to the stress counsellor.

My findings have particular relevance to us in the UK today as the impending NHS changes move us towards the American system with greater emphasis on profit and business efficiency. There is justifiably great concern, not only about patient care, but also about the future and the cost of postgraduate training and career structures. Our juniors are increasingly vociferous about their training and conditions of service. The principles of the methods our American colleagues have incorporated into their training programme organization to reduce stress can be applied to our system to give us a basis to help our juniors cope with their stresses. It is time for the medical profession to cease regarding the difficult stressful time during training as an 'initiation rite' and to stop ignoring the vulnerability of the youngest and newest members of our profession. As trainers we should be able to recognize stress and be in a position to provide stress counselling as part of careers counselling.

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