Stress and coping in accident and emergency senior house officers

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OBJECTIVE: To identify levels of psychological distress in accident and emergency (A&E) senior house officers (SHOs).

METHODS: Questionnaire survey given to SHOs at training sessions.

MEASURES: General Health Questionnaire (GHQ) and the Brief COPE.

RESULTS: Over half of the 37 respondents (51%; 95% CI: 36% to 67%) scored over the threshold for psychological distress on the GHQ. This is considerably higher than for other groups of doctors and for other professional groups. Correlational analysis revealed that the coping style Venting was significantly related to greater anxiety (r=0.34; p<0.05) and depression (r=0.33; p<0.05), while the coping style Active was significantly related to lower anxiety (r=−0.38; p<0.05), somatic complaints (r=−0.46; p<0.001) and years since qualification (r=0.40; p<0.05).

CONCLUSIONS: Replicating findings from a study of stress in A&E consultants, this study shows higher levels of overt psychological distress among A&E SHOs than among other groups of doctors. An intervention to improve coping strategies may be useful for this group of doctors.
A&E departments generally have an activity focus and have to prioritise availability highly, making the work less susceptible to planning. To allocate specific time into SHOs’ and others schedules for development of coping skills even for research purposes may be alien to the culture and call for interested and positive leadership from consultants and managers. However, given that the government aims to recruit 183 new A&E consultants by 2004 to increase capacity the A&E A&E consultants that there is already an acknowledged difficulty in recruitment and retention of doctors to the specialty, attention to aspects of psychological working conditions in A&E may be essential to meet these targets for recruitment.

ACKNOWLEDGEMENTS
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REFERENCES
7. Corver C. You want to measure coping but your protocol’s too long: consider the Brief COPE. Int J Behav Med 1997;4:92–100.

DISCUSSION
Over half of the respondents (51%) scored over the threshold for psychological distress. Although it may not be possible to generalise these results to medical staff at other levels working in A&E, this supports the conclusions of the recent survey of A&E consultants that there is a greater prevalence of psychological distress among doctors working in A&E than in other doctors and other professionals. Furthermore, SHOs constitute the largest proportion of medical staff in an A&E department and therefore it is possible that these high levels of stress may have an impact on the functioning of the department as a whole.

The sample is representative of A&E doctors working in an inner city area and may only be generalisable to hospitals in similar highly populated urban areas. Further studies would be important to identify levels of psychological distress in A&E staff in other areas of the country.

The respondents used a range of coping styles, some of which were associated with more stress than others. In particular, Active coping (that is, problem solving, planning, positive reframing) was related to lower scores on the GHQ, suggesting that it is a useful strategy to reduce or prevent stress; while Venting (that is, expressing negative feelings) was related to higher scores, suggesting it is unhelpful. One possible explanation for this is that problem solving and planning can change the sources of stress, while Venting entails focusing on the emotions aroused by the stressors that may impede adjustment to stressors by preventing planning and problem solving. Alternatively, it may be that only the psychologically robust respondents had the emotional resources to engage in problem solving behaviours. It is unclear how much stress and psychological strain fluctuate and this study considers only one time point during the six month rotation. It would be useful to carry out assessments at different time points, to identify whether any factors over the course of six months lead to increase or decrease of stress levels. Years since qualification were positively related to Active coping. It could therefore be argued that coping strategies improve with experience or that only doctors with those coping mechanisms opt to stay in A&E. To separate the two would require a longer cohort follow up study. However, an intervention may help doctors develop adaptive coping strategies earlier in their careers and may be more efficient than existing processes.

From these results, it could be argued that a helpful intervention would be one that aims to channel emotions resulting from negative experiences constructively into finding solutions. This could involve group sessions such as “Balint Groups”, in which events or experiences are brought to the group by the doctors and a facilitator helps the group to examine personal responses and think of positive responses and solutions.

### Table 1 Correlations between GHQ, coping styles, and years since qualification (using Pearson’s r)

<table>
<thead>
<tr>
<th>Coping strategy</th>
<th>GHQ 28</th>
<th>Anxiety</th>
<th>Depression</th>
<th>Somatic complaints</th>
<th>Social functioning</th>
<th>Years since qualification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance misuse</td>
<td>0.20</td>
<td>0.35*</td>
<td>0.25</td>
<td>0.08</td>
<td>-0.06</td>
<td>-0.21</td>
</tr>
<tr>
<td>Turn to religion</td>
<td>0.02</td>
<td>-0.17</td>
<td>0.16</td>
<td>-0.02</td>
<td>0.24</td>
<td>0.39*</td>
</tr>
<tr>
<td>Humour</td>
<td>-0.16</td>
<td>-0.03</td>
<td>-0.13</td>
<td>-0.19</td>
<td>-0.18</td>
<td>-0.38*</td>
</tr>
<tr>
<td>Behavioural disengagement</td>
<td>-0.14</td>
<td>-0.23</td>
<td>0.01</td>
<td>-0.05</td>
<td>-0.13</td>
<td>-0.09</td>
</tr>
<tr>
<td>Seeking support</td>
<td>-0.17</td>
<td>0.08</td>
<td>-0.28</td>
<td>-0.23</td>
<td>-0.18</td>
<td>0.04</td>
</tr>
<tr>
<td>Active</td>
<td>-0.48*</td>
<td>-0.38*</td>
<td>-0.29</td>
<td>-0.46**</td>
<td>-0.31</td>
<td>0.40*</td>
</tr>
<tr>
<td>Venting</td>
<td>0.29</td>
<td>0.34*</td>
<td>0.33*</td>
<td>0.08</td>
<td>0.25</td>
<td>-0.03</td>
</tr>
<tr>
<td>Denial/blame</td>
<td>0.04</td>
<td>0.15</td>
<td>-0.05</td>
<td>-0.17</td>
<td>0.21</td>
<td>-0.17</td>
</tr>
<tr>
<td>Acceptance</td>
<td>-0.28</td>
<td>-0.16</td>
<td>-0.18</td>
<td>-0.35*</td>
<td>-0.11</td>
<td>0.24</td>
</tr>
<tr>
<td>Years since qualification</td>
<td>0.30</td>
<td>0.26</td>
<td>0.05</td>
<td>0.21</td>
<td>0.38*</td>
<td>–</td>
</tr>
</tbody>
</table>

*p<0.05, **p<0.001.

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