

STRESS AND GENERAL PRACTICE

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INTRODUCTION

Stress in general practice in the UK is a regular feature of everyday life according to a whole series of research studies¹⁻¹⁴ over recent years. Increasing stress is a feature of society as a whole and general practitioners' ability to deal with stress in themselves may also influence their ability to help others to do the same. Stress is an ambiguous word that is used on different occasions to denote positive or negative strain in a physical or emotional context. Thus it is difficult to agree a common definition, and researchers have often measured the causes and effects of stress on general practitioners or the practice, rather than the quantity of stress that is present. For the purposes of this document, stress is defined³ as the "physical, emotional and mental strain resulting from the mismatch between an individual and his/her environment", which results from a "three way relationship between demands on a person, that person's feelings about those demands and their ability to cope with those demands"¹⁵ Stress is most likely to occur in situations where: demands are high; the amount of control an individual has is low; and, there is limited support or help available for the individual.

This definition captures the essence of stress in general practice as being a dynamic process that changes in quantity and quality in response to internal and external factors. It has been suggested that the nature of the profession facilitates an inflexible response to pressure due to the culture of personal responsibility rather than delegation, and also, the need to provide best care for each patient rather than making trade-offs in a resource constrained environment.¹⁶

Anxiety, depression and burnout, have often been reported together with stress in the literature as they share common causative factors and often co-exist, and so have been included in this document.

Apart from the individual distress caused, stress and other morale issues amongst GPs is a current concern in the UK because of difficulties with recruiting and retaining the workforce needed to meet the targets of a primary care led NHS. A recent survey of GP retirement found that a quarter of professionals planned to retire before the age of 60 with "health, including stress" contributing to 36% of these decisions.¹⁷ Another study in 2001 recently found that 33% of doctors whom retired though ill health did so due to psychiatric illness.⁵³

PREVALENCE: THE FACTS

Around half of general practitioners scored as being "stressed" in a study undertaken in 1994, a similar rate as for hospital consultants and hospital managers, and roughly twice that of the general public (48% GPs scored positively on the *GHQ-28⁹ versus 27% of men and 28% of women in the general population in another study using the *GHQ-30¹⁶).

A study conducted in 1998, which used the GHQ-12 self-report questionnaire to measure psychological symptoms in GPs, reported that 52% of responders scored above the cut-off usually used to detect probable cases of psychiatric morbidity in general population surveys. Again, this is roughly twice that found in the general population.¹⁹

About half of GPs have been categorised as suffering from probable borderline or more severe anxiety (55%⁹ and 41%¹² in separate studies with a score of at least 8 or over using the Hospital Anxiety and Depression (HAD) scale); and a quarter of GPs have been classed as suffering from at least borderline depression (27%⁹ and 26%¹² in separate studies with a score of at least 8 or over using the HAD scale).

* Shortened version of the General Health Questionnaire (GHQ), a survey tool for psychological distress.

A national survey of GP opinion conducted in 2001 by the BMA (to which 23,521 GPs responded) found that 21% of responders considered the amount of work-related stress they experienced to be "excessive and unmanageable", while another 61% considered it "excessive but manageable". In the same survey the 55% of the sample group considered that work impinged on their quality of life to an "unacceptable" extent.²⁰

Burnout describes the syndrome of emotional exhaustion, depersonalisation, low productivity, and feelings of low achievement.¹⁰ A study of British GPs¹⁰ found that significant numbers of GPs in all age groups are affected and that burnout was significantly higher in the UK than the US. The picture emerging of GP morbidity is of professionals who take very little time off work for illness but who, when they are off work, tend to be off for long periods.²¹

Mortality statistics have shown doctors' increased risks from cirrhosis, accidents and poisoning since the nineteenth century. These elevated rates have persisted for cirrhosis (Predicted Mortality Rate (PMR) of male doctors is 203) and suicide (PMRs 162 and 193 for male and female doctors respectively)²². A systematic review²³ of papers reporting suicides in European or North American doctors described the relative risks of suicide among doctors compared with their general populations as being between 1.1 to 3.4 times for male doctors and 2.5 to 5.7 times for female doctors. However, a more recent study reported that although the rate of suicide amongst female doctors in England and Wales was higher than the general population, the rate amongst male doctors was lower. The study also found that general practice, as a specialty, had significantly higher suicide rates than general medicine.²⁴ Further research suggests that more GPs than consultants report suicidal thoughts.⁹ An early study by Sakinhofsky.²⁵ revealed that the wives of GPs were four times more likely to commit suicide than other women. A more recent study has observed that the main stresses for GP spouses were the GPs' detachment from the family; concern about workload; and, communication problems.²⁶

CAUSES OF STRESS IN GENERAL PRACTICE

One of the first studies to look at the causes of stress in general practice in the mid-1980s¹ found that insecurity about work, isolation, poor relationships with other doctors, disillusion with the role of GPs and changing demands were all sources of perceived stress.

A Medical Audit Advisory Group²⁷ surveyed its constituent general practitioners in 1993 and found that the top ten stressors in descending order of frequency were emergency calls during surgery hours, night calls, time pressure, working after a sleepless night, dealing with problem patients, worrying about patient complaints, interruption of family life, 24 hour responsibility for patients' lives and unrealistically high expectations by others of the doctor's role and partner on holiday.

In the late 1980s, Cooper and others² found that the four most important predictors of job stress were: work-home interface, demands of the job, patients expectations and practice administration. For women doctors, the interference of the job with family life was the most significant predictor of stress whilst for men it was the joint stressors of practice administration and job demands.

More recent surveys by the same authors^{5,6} showed that in 1990, general practitioners reported most stress from night calls (see also later study²⁷), emergencies during surgery hours, and interruption of family life. Females experienced more stress than males from visiting during adverse weather conditions, fear of assault on night visits, finding a locum, the working environment, lack of emotional support at home, and dealing with friends or relatives as patients. Conflict between their work and personal lives seems to have been particularly stressful for female doctors.^{12,15,26} It has been suggested that the fact that female GPs are more likely to self-medicate and less likely to seek formal medical help might be explained by the pressure on female doctors to be seen to be working at least as hard as men.²¹

A recent study²⁸ showed that by 1998 general practitioners were reporting less stress than in 1990 caused by disturbance of home life, interruptions by emergency calls and night visits. However there was an increase in stress due to high expectations of others; adverse publicity by the media; the working environment; dealing with problem patients; worrying about complaints; finding a locum; arranging hospital admissions and dealing with terminal illness. Interestingly women reported considerably less stress in the late 1990s than in 1990 in dividing time between work and family, perhaps indicating that they are beginning to successfully renegotiate or redefine the expectations of others. Perhaps surprisingly, given the increase in nine of the fourteen listed stressors, GP job satisfaction was found to have risen between 1990 and 1998.

The relationship between stress and satisfaction levels has been found by other studies to be an ambiguous one. Women have been found to be more satisfied by their work than men but no less stressed.¹⁹ Increased professional efficacy, in some circumstances, can be maladaptive, increasing future stress and burnout.²⁹

Howie and his colleagues have carried out extensive research studies^{4,5} into occupational stress in general practice, particularly with respect to the timing of consultations and doctors' working styles. Many of the main stressors for general practitioners appear to be created or perpetuated by doctors' own policies⁴: overbooking patients, starting surgeries late, accepting commitments too soon after surgeries are due to finish, making insufficient allowances for extra emergency patients and allowing inappropriate telephone or other interruptions. Higher than average pressure scores occurred⁴ in doctors with fast consultation rates compared to those with slower rates, although there was no overall correlation between feelings of pressure and consultation rate. Evidence from systems with longer consultation times suggest that these are not enough by themselves to ensure high morale.²⁹ What appears to be more important is partnership and practice arrangements. One study suggested that practices, which had equitable and inclusive partner and practice relationships, managed workloads better than practices that were a collection of disparate individuals. Protected time between consultations to tackle problems proactively as a partnership was seen as very important.³⁰

Although recent research still shows that night calls can be detrimental to GP's mental health and also to the quality of patient care,²⁷ there has been a trend for GPs not to cite the provision of emergency care as a cause of stress since the mid-1990s.^{11,12} This is probably due to the changed arrangements for the provision of out of hours care in the UK where many general practitioners are able to delegate a proportion of emergency care to deputising services and GP co-operatives. Research seems to show that it is not the amount of hours but when they are worked that is significant to GP stress levels.^{27,31} At least two studies have found improvements in the health status of doctors coinciding with the increased use of co-operatives.^{32,33}

Another survey³⁴ has noted that a changing trend is the rise of "inappropriate patient demands" coupled with "increasing expectations of what doctors can provide" as a cause of stress, rather than simply an increase in numbers of patient demands. Patients are increasingly active consumers and they demand, and have been encouraged to expect, enhanced services, including extended hours and rapid access while showing less respect and deference to health professionals¹⁶. Spurgeon et al¹¹ found that older general practitioners were more stressed by the new contract demands compared to younger doctors, but younger doctors were more stressed by unrealistic patient demands. Those GPs who considered that job stress was responsible for causing them psychological symptoms of ill-health were those who reported being particularly stressed about the effects of work on their home and social lives.¹¹ Worrying about patients' complaints was an important stressor as was a feeling that the media is becoming more hostile and creating a blame culture.^{16,34} This seems to be at odds with the remarkably sustained high levels of general public satisfaction with GP services.³⁵ GPs also frequently cited both imposed changes from NHS management and perceived loss of autonomy (greater accountability) as having a negative impact on morale.^{16,34}

There has been debate^{36,37} about whether doctors develop mental health problems as a result of working in medicine or because they are more likely to have psychologically vulnerable personalities before selection to medical school. One study³⁶ concluded that the physicians with the least stable childhood's seemed to be the most vulnerable to the occupational hazards of being a doctor; maladaptive personality traits and poor coping styles were already present before entering medical school. Medical students may be motivated to study medicine by unconscious neurotic drives and unresolved conflicts from childhood that attempt to improve their own well-being by healing others. Firth-Cozens³⁷ found that the quality of early relationships that junior doctors had with their parents could predict whether they develop job stress, and their attitudes to their jobs.

Other researchers have noted doctors tendency to compulsivity and perfectionism.³⁸ This may be coupled with a type of personality that is highly self-critical, another factor that has been associated with an increased likelihood of developing stress.³⁹ One important manifestation of this perfectionism is the need to portray a healthy image to both patients and colleagues due to the perception that good health in doctors is linked with medical competence. This is both stressful and a barrier to appropriate self-care.⁴⁰ Another study has found that these worries about confidentiality and image lead to high levels of self prescription and medication amongst GPs; high levels of working when sick and a low use of formal medical services.^{21,41}

A recent survey¹⁴ of stress in the general practice team other than the doctors, found that the top six causes of stress volunteered in descending order of frequency were: patient demands, too much work, patient abuse/aggression, time pressures concerning appointments, GP demands and poor communication. But health visitors have reported different causes of stress from practice employed staff. The top causes of stress - which affected at least two thirds of respondents in a 1994 survey⁴² - were: lack of time, frequent management reorganisations, lack of feedback on effectiveness, day to day bureaucracy, lack of administrative support, lack of consultation about major organisational changes and inadequate computer support systems and training.

SYMPTOMS, SIGNS AND EFFECTS

Experience of stress does not necessarily result in pathological changes or damage. Stress may be contained within the body's normal homeostatic limits. Many symptoms of stress are uncomfortable and reduce the quality of life without causing irreversible damage to the individual. People vary as to the length of time and magnitude of stress needed to cause ill health. But a concurrent illness or co-existing life events may have additive effects, and can increase vulnerability to stress or reduce the ability to cope with stress.⁴³

Some general characteristics of a stressed person at work^{43,44} are: lack of concentration, poor timekeeping, poor productivity, difficulty in comprehending new procedures, lack of co-operation, irritability, aggressiveness, withdrawal behaviour, resentment, increased tendency to make mistakes and resistance to change. The extent and magnitude of the stress or load necessary to reduce an individual doctor's performance or satisfaction levels will depend on the doctor's personality, biographical factors and coping methods.

There is little published work quantifying either the effects of stress on doctors or the results of interventions designed to reduce stress, and most report people's perceptions. In 1970 Mechanic⁴⁵ produced some evidence to show that frustrated doctors are more willing to take undesirable short cuts in treating patients. Grof has demonstrated poor clinical performance in those doctors with negative feelings of tension, lack of time and frustration⁴⁶ as evidenced by having a high prescription rate and with giving little explanation to patients. As part of an 11-year follow-up study of 225 doctors who graduated in 1985, Firth-Cozens investigated the links between stress and lowered clinical care³⁹. Thirty three percent of the sample reported lowered standards of patient care that they saw as having a primarily stress-related cause. When stress symptoms result in mistakes and poor care this can also harm the doctor due to long-lasting feelings of guilt.

The signs of burnout progress through a first stage of feeling exhausted, tense, pressured and guilty whilst being disorganised to the second stage where the sufferer feels frustrated, is hostile, aggressive and quick to anger; he or she becomes increasingly depressed and bored¹⁰. In the third and final stage of burnout a GP may feel hopeless, thinks continually of escape routes, is often late for work, and is forgetful, withdrawn and drained of all interest in others. It has been suggested that depersonalisation (cynicism) is an adaptive coping mechanism that reduces stress by acting as an ego-defence mechanism.²⁹ In this respect it can be viewed as a rational response to overbearing circumstances. Only a minority of GPs under stress continue to deteriorate until they reach the final stages of burnout or absolute fatigue. Most cope as best they are able and continue to keep up acceptable standards of work whilst tolerating the physical and psychological effects of stress.

The effects of stress on a practice may be seen as increased errors such as in prescribing, disloyalty, increased staff turnover, limited team working, increased numbers of patients' complaints, poor time-keeping and sickness absence, resistance to change or the adoption of new technology or systems, and disruption in the practice organisation even resulting in a practice partnership split. Staff may be less motivated or effective. GPs may have little energy or capacity to listen or empathise with patients, and communication between doctors and patients may be poor. Research has shown a statistically significant lowering in "perceived depth of relationship" with their GP in consultation sessions surrounding nights on call. These sessions were found to be characterised by anticipatory or hangover stress.²⁷ Stressed GPs may develop problems in their relationships with their partners and family at home, becoming uncommunicative at home or work, and more withdrawn and isolated.²⁶

Doctors commonly use alcohol as a common coping method for stress, which causes more stress and affects well being and performance. A 1998 report from the BMA⁴⁷ stated that as many as seven per cent of doctors were addicted to alcohol and / or other chemical substances, with about half of those being addicted to alcohol alone. A further study reported that 23% of GPs had increased their drinking in response to stress.⁴⁸

Effects of stress on the practice organisation have been described¹⁴ as mistakes, arguments or angry outbursts, poor relationships with patients and staff, increased staff sickness and turnover, and accidents, in decreasing order of frequency. It has been suggested that it is practice arrangements that both exacerbate and fail to recognise morale problems.³⁰

INTERVENTIONS AND SOLUTIONS

Most GPs and practices have an ad hoc approach to containing stress, but few have agreed, applied and monitored policies on stress management.¹⁴ Interventions to reduce stress in general practice are pitched at individual and organisational levels: for instance, changes in lifestyle, support from others, or improved practice management,^{30,49,50} such as longer booking intervals for patient consultations.⁵¹ There is some evidence for the benefits of relaxation and cognitive behavioural skills.⁵⁰ A systematic review of stress management strategies in general practice³¹ concluded that there is little evidence of a preferred mode of intervention, and that availability of expertise, individual preference, and cost-effectiveness should determine choice.

A recent report by the BMA suggested that work-related stress amongst doctors must be addressed by reducing demands (by flexible employment practices and organisational climates discouraging excessive working hours); increasing job control (by increasing staff participation in decision making); and, increasing support to the individual (by ensuring good career and staff development strategies and promoting formal and informal social support).⁵² Some of these views are echoed in a separate study which identifies work stress in general practice as being a symptom of a malfunctioning professional reward system.¹⁶ Where GPs would previously accept any professional hardships due to the respect, deference, autonomy and job security offered by the profession, these rewards have now been replaced by greater accountability, a growing blame culture and greater consumer expectation by patients. A new compact would require organisations to take a highly participative approach with high quality appraisal, personal development, and other modern human resource management techniques.

A 1995 study, involving in-depth interviews with 29 general practitioners³⁴, found that general practitioners with high stress levels do not necessarily have low morale, and that there is a close positive correlation between levels of job satisfaction and morale. Others have demonstrated the protective effect of job satisfaction against stress.⁵⁴

Many are calling for comprehensive occupational health services and confidential counselling services for NHS staff.^{13,14,55,56,57} One study found that only 11% of GPs reported that there was an occupational health service available for their use. The same study found that 95% of consultants had access to occupational health services.²¹ Despite a reluctance of doctors to seek help^{21,40} 77% of GPs indicated that they would like to see a special service devoted to doctors' health-related problems and stress.⁴⁸ These services would have to be backed by a changed culture of worker-friendly health policies throughout the NHS, which would improve the working environment and encourage staff to take up such services readily. Additionally, doctors must be encouraged to assume greater responsibility towards their own health. Research has found that most GPs do not follow the BMA guidelines on self-care ("Ethical responsibilities of doctors towards themselves and their families") which encourage doctors to rely on other health professionals for the diagnosis, management and medication of illness.^{3,8,21} These guidelines should be promoted widely and monitored.²¹

It would seem that stress has become endemic in general practice. Although there are many contributory factors, it would appear that the position of GPs as independent contractors with a public duty has inherent pressures. Professional isolation, individual responsibility coupled with increasing accountability, and a lack of administrative infrastructure and support can cause overwhelming demands.⁵⁸ It is hoped that the new GP contract (being negotiated at the time of writing) will help to ease some of these pressures by giving GPs more control over their working priorities. GPs will be contracted to their practice or primary care trust rather than to the NHS and will have the option of drawing a salary. They will be able to choose to stop having 24-hour responsibility for their patients. They will also be able to choose the level of service they wish to provide, with the resources provided, and with financial rewards for achieving their own targets and continuing to improve the quality of the services they provide. A supporting local infrastructure, more flexible service provision and improved career pathways may alleviate some of the cultural stress present in general practice.

REFERENCES

- 1 Branthwaite A, Ross A. Satisfaction and job stress in general practice. *Fam Pract* 1988; 5 (2) : 83-93.
- 2 Cooper CL, Rout U, Faragher B. Mental health, job satisfaction, and job stress among general practitioners. *BMJ* 1989; 298: 366-70.
- 3 Richards C. *The health of doctors*. King's Fund, London. 1989.
- 4 Howie J, Porter A, Heaney D, Hopton J. Long to short consultation ratio: a proxy measure of quality of care for general practice. *Br J Gen Pract* 1991; 41: 48-54.
- 5 Howie JG, Hopton JL, Heaney DJ, Porter AMD. Attitudes to medical care, the organisation of work, and stress among general practitioners. *Br J Gen Pract* 1992; 42: 181-5.
- 6 Sutherland VJ, Cooper CL. Job stress, satisfaction and mental health among general practitioners before and after introduction of new contract. *BMJ* 1992; 304: 1545-8.
- 7 Sutherland VJ, Cooper C. Identifying distress among general practitioners: predictors psychological ill - health and job dissatisfaction. *Soc Sci Med* 1993; 37(5): 575-81.
- 8 Chambers R. Health and lifestyle of general practitioners and teachers. *Occup Med* 1992; 42: 69-78.
- 9 Caplan RP. Stress, anxiety and depression in hospital consultants, general practitioner and senior health service managers. *BMJ* 1994; 309: 1261-3.
- 10 Kirwan M, Armstrong D. Investigation of burnout in a sample of British general practitioners. *Br J Gen Pract* 1995; 45: 259-60.
- 11 Spurgeon P, Barwell F, Maxwell R. Types of work stress and implications for the role of general practitioners. *Health Services Management Research* 1995; 8(3): 186-97.
- 12 Chambers R, Campbell I. Anxiety and depression in general practitioners: associations with type of practice, fundholding, gender and other personal characteristics. *Fam Pract* 1996; 13 (2): 170-3.
- 13 Williams S, Michie S, Pattani S. *Improving the health of the NHS workforce*. Report of the Partnership on the health of the NHS workforce. The Nuffield Trust, 1998.
- 14 Chambers R, George V, McNeill A, Campbell I. Health at work in the general practice. *Br J Gen Pract* 1998; 48: 1501-4.
- 15 Bynoe G. Stress in women doctors. *Br J Hosp Med* 1994; 51(6): 267-8.
- 16 Edwards N, Kornacki MJ, Silversin J. Unhappy doctors: what are the causes and what can be done? *BMJ* 2002; 324: 835-8.
- 17 Mathie T, McKinlay D. *A General Practitioner Retirement Survey in the North West Region*. NHS Executive, London 1999.
- 18 Huppert FA, Whittingham JE. Longitudinal changes in mental state and personality measures. In: Cox BD, Huppert FA, Whichelow MJ (eds). *The health and lifestyle survey: seven years on*. Aldershot, Dartmouth 1993.
- 19 Appleton K, House A, Dowell A. A survey of job satisfaction, sources of stress and psychological symptoms among general practitioners in Leeds. *Br J Gen Pract* 1998; 48: 1059-63.
- 20 British Medical Association. *National Survey of GP Opinion*. BMA, London 2001.
- 21 Forsythe M, Calnan M, Wall B. Doctors as patients: postal survey examining consultants and general practitioners adherence to guidelines. *BMJ* 1999; 319: 605-8.
- 22 Office of Population Censuses and Surveys. *Occupational Health Decennial Supplement for England and Wales*. London: HMSO, 1995.
- 23 Lindeman S, Laara E, Hakko H, Lonnqvist J. A systematic review on gender-specific suicide mortality in medical doctors. *Br J Psych* 1996; 168: 274-9.
- 24 Hawton K, Clements A, Sakarovitch C, Simkin S, Deeks JJ. Suicide in doctors: a study of risk according to gender, seniority and specialty in medical practitioners in England and Wales, 1979-1995. *Journal of Epidemiol Community Health* 2001; 55: 296-300.
- 25 Sakinhofsky I. Suicide in doctors and their wives. *BMJ* 1980; 281: 386-7.
- 26 Rout U. Stress among general practitioners and their spouses: a qualitative study. *Br J Gen Pract* 1996; 46: 157-60.
- 27 French DP, McKinley RK, Hastings A. GP stress and patient dissatisfaction with nights on call: an exploratory study. *Scand J Prim Health Care* 2001; 19: 170-3.
- 28 Sibbald B, Enzer I, Cooper C, Rout U, Sutherland V. GP job satisfaction in 1987, 1990 and 1998: lessons for the future? *Family Practice* 2000; 17: 364-71.
- 29 McManus IC, Winder BC, Gordon D. The causal links between stress and burnout in a longitudinal study of UK doctors. *Lancet* 2002; 359: 2089-90.
- 30 Huby G, Gerry M, McKinstry B, Porter M, Shaw J, Wrate R. Morale among general practitioners: qualitative study exploring relations between partnership arrangements, personal style, and workload. *BMJ* 2002; 325: 140-4.
- 31 Firth-Cozens J, Moss F. Hours, sleep, teamwork, and stress. *BMJ* 1998; 317: 1335-6.

- 32 Heaney D, Gorman D, Porter M. Self-recorded stress levels for general practitioners before and after forming an out-of-hours primary care centre. *Br J Gen Pract* 1998; 48: 1077-8.
- 33 Fletcher J, Pickard D, Rose J, Stewart-Brown S, Wilkinson E, Brogan C, Lawrence D. Do out-of-hours co-operatives improve general practitioners' health? *Br J Gen Pract* 2000; 50:815-6.
- 34 Hayter P, Peckham S, Robinson R. *Morale in general practice*. University of Southampton: Institute for Health Policy Studies 1996.
- 35 Cabinet Office. *Monitoring Satisfaction: Trends from 1998-2002*. Cabinet Office, London 2002.
- 36 Vaillant G, Sobowale N, McArthur C. Some psychologic vulnerabilities of physicians. *New Eng J Med* 1972; 287 (8): 372-5.
- 37 Firth Cozens J. The role of early family experiences in the perception of organisational stress: Fusing clinical and organisational perspectives. *J Occupational and Organisational Psychology* 1992; 65: 61-75.
- 38 Gabbard GO. The role of compulsiveness in the normal physician. *JAMA* 1985; 254 (20): 2926-9.
- 39 Firth Cozens J. Predicting stress in general practitioners: 10 year follow-up postal survey. *BMJ* 1997; 315: 34-5.
- 40 Thompson WT, Cupples ME, Sibbett CH, Skan DI, Bradley T. Challenge of culture, conscience, and contract to general practitioners' care of their own health: qualitative study. *BMJ* 2001; 323: 728-31.
- 41 Chambers R, Belcher J. Self-reported health care over the past ten years: a survey of general practitioners. *Br J Gen Pract* 1992; 42: 153-6.
- 42 Durdle T. *First national membership survey, Health Visitors' Association*. Health Visitors' Association, 1995.
- 43 Chambers R, Davies M. *What stress in primary care!* Royal College of General Practitioners, London, 1999.
- 44 Cox T. *Stress research and stress management: putting theory to work*. HSE Contract Research Report No 61/1993. Suffolk: Health and Safety Executive, 1993.
- 45 Mechanic D. Practice orientations among general medical practitioners in England and Wales. *Med Care* 1970; 8: 15-25.
- 46 Grol R, Mokkink H, Smits A, Van Eijk J, Beek M, Mesker P, Mesker-Niesten J. Work satisfaction of general practitioners and the quality of patient care. *Fam Pract* 1985; 2(3): 128-35.
- 47 British Medical Association. *The Misuse of Alcohol and other Drugs by Doctors*. BMA, London, 1998.
- 48 McKeivitt C, Morgan M, Simpson J, Holland W. *Doctors' health and needs for services*. Nuffield Provincial Hospitals Trust, London 1995.
- 49 Myerson S. Doctors' methods of dealing with 'on going' stress in general practice. *Med Sci Res* 1991; 19 : 267-9.
- 50 Sims J. The evaluation of stress management strategies in general practice: an evidence-led approach. *Br J Gen Pract* 1997; 47 : 577-82.
- 51 Wilson A, McDonald P, Hayes L, Cooney J. Longer booking intervals in general practice: effects on doctors' stress and arousal. *Br J Gen Pract* 1991; 41 : 184-7.
- 52 British Medical Association. *Work-related stress among senior doctors*. BMA, London, 2000.
- 53 Pantani S, Constantinovici N, Williams S. Who retires early from the NHS because of ill health and what does it cost? A national cross sectional study *BMJ* 2001; 322: 208-9.
- 54 Ramirez AJ, Graham J, Richards MA, Cull A, Gregory WM. Mental health of hospital consultants: the effects of stress and satisfaction at work. *Lancet* 1996; 347: 724-8.
- 55 McKeivitt C, Morgan M, Holland WW. *Protecting and promoting doctors' health: the work environment and counselling services in three sites*. Nuffield Provincial Hospitals Trust, London 1996.
- 56 Chambers R. *Occupational health services for GPs- a national model*. Royal College of General Practitioners, London 1997.
- 57 Chambers R, Smith G. Occupational healthcare services for the NHS workforce – what can we do better? *Clinician in Management* 2001; 10: 85-90.
- 58 Firth-Cozens J, Greenhalgh J. Doctors' perceptions of the links between stress and lowered clinical care. *Social Science and Medicine* 1997; 7: 1017-22.

USEFUL RESOURCES

Allibone A and Ashley-Miller M. *Taking Care of Doctors' Health: reducing avoidable stress and improving services for doctors who fall ill*. Nuffield Provincial Hospitals Trust, London, 1996. ISBN 090057495X.

British Medical Association. *The ethical responsibilities of doctors towards themselves and their families*. BMA, London, 1995. This can also be viewed at:

<http://www.bma.org.uk/ap.nsf/Content/Ethical+responsibilities+involved+in+treating+doctor-patients>.

British Medical Association. *Stress and the Medical Profession*. BMA, London, 1992. ISBN 0727907581.

British Medical Association. *Work-related Stress Among Senior Doctors*. BMA, London, 2000.

Butler G and Hope T. *Manage Your Mind*. Oxford University Press, Oxford, 1995. ISBN 0192623834.

Chambers R, Schwartz A. *Beating Stress in the NHS*. Radcliffe Medical Press, Oxford, 2002. ISBN 1857759273.

Davies M, Chambers R. *What Stress in Primary Care: a once in a lifetime programme that will help you control stress in your practice*. Royal College of General Practitioners, London, 1999. 085084245X.

Earnshaw J, Cooper C. *Stress and Employer Liability (2nd ed.)*. Institute of Personnel and Development, London, 2001. ISBN 0852926154.

Elliott-Binns C, Bingham L. *Managing Stress in the Primary Care Team*. Blackwell Scientific Publications, Oxford, 1993. ISBN 063203565X.

Firth-Cozens J, Payne R. *Stress in Health Professionals: psychological and organisational causes and interventions*. John Wiley, Chichester, 1999. ISBN 0471998761.

Grainger C. *Stress Survival Guide*. BMJ Publishing Group, London, 1994. ISBN 0727908790.

Hambly K, Muir A. *Stress Management in Primary Care*. Butterworth-Heinemann, London, 1997. ISBN 0750627379.

Hare B. *Be Assertive*. Vermilion, London, 1996. ISBN 0091813964.

Haslam, D. *Not Another Guide to Stress in General Practice! (2nd ed)*. Radcliffe Medical Press, Oxford, 2000. ISBN 1857754468.

Holland, J. *A Doctor's Dilemma: stress and the role of carer*. 1995. ISBN 1853433136.

Kompier M and Levi L. *Stress at Work: causes, effects and prevention*. European Foundation for the Improvement of Living and Working Conditions, Dublin, 1994. ISBN 9282685942.

Looker T, Gregson O. *Stresswise. A Practical Guide for Dealing With Stress*. Hodder and Stoughton, London, 1989. ISBN 0 340503718.

Maslach C and Leiter M. *The Truth About Burnout: how organisations cause personal stress and what to do about it*. Jossey-Bass, San Francisco, 1997. ISBN 0787908746.

Medical Television Productions Ltd. *Stress in General Practice (Video)*. Pfizer Ltd. 1995.

Open University, *Handling Stress Groupwork*. Open University, Milton Keynes, 1998. ISBN 0749247029.

Rout U and Rout J. *Stress and General Practitioners*. Kluwer Academic, London, 1993. ISBN 0792388151.

Rout U. *Understanding Stress in Doctors Families*. Ashgate, Aldershot, 2000. ISBN 1859725910.

Royal College of General Practitioners GP Stress Fellowship. *Database of Activities and Initiatives in the UK Associated With Reducing GPs' Stress or Improving GPs' Well-being*. RCGP, London, 1997.

CONTACTS

Organisations which help general practitioners with problems of stress and other mental ill-health problems are given below. Local schemes may also be available through the appropriate primary care organisation. However the College strongly urges every general practitioner to register as a patient with another general practitioner in whom they have confidence, and to use the general practice service.

BMA Stress Counselling Service: Service provided by the BMA to members and their families. Provides telephone access to a 24-hour confidential counselling service for all personal, emotional, work or study related problems. Tel: 0645 200169.

British Doctors and Dentists Group: A support group of recovering medical and dental drug and alcohol users. Students are also welcomed. It will support the sick doctor or dentist, giving confidential help and advice through a local recovering doctor or dentist. National contact (via the Medical Council on Alcohol): 0207 487 4445.

British Association for Counselling: For lists of names of qualified counsellors contact: 1 Regent Place, Rugby, Warwickshire CV21 2PJ. Tel: 0870 443 5252.

British Confederation of Psychotherapists: For a directory of details of registered psychotherapists. 37 Mapesbury Road, London, NW2 4HJ. Tel: 0208 830 5173.

Centre for Stress Management: The Centre for Stress Management is an international training centre and consultancy which runs modular courses in stress management, stress counselling, psychotherapy and coaching suitable for professionals wishing to gain more knowledge and skills practice in these subjects. Contact: Centre for Stress Management, 156 Westcombe Hill, Blackheath, London, England, SE3 7DH. Tel: 0208 318 5653.

COPE: A confidential counselling scheme for GPs in the Avon area. It gives GPs direct access to GP helpers, psychologists, counsellors and psychiatrists. A list of GPs, psychologists, counsellors and psychiatrists who have agreed to be available to other colleagues can be found at: http://www.primhe.org/resources/support/avon_cope.htm

Counselling in Primary Care Trust: Promoting, supporting and developing counselling, psychotherapy and the use of counselling skills in primary care. Contact: 1st floor, Majestic House, High Street, Staines, TW18 4DG. Tel: 01784 441782.

Doctors Support Line: This highly confidential service, set up in October 2002, offers a service where callers speak directly to doctors instead of counsellors. The Doctors' Support Network and Primary Care Mental Health and Education (PriMHE) set up the line with an initial three year funding from the Department of Health. It is manned for 36 hours a week by trained volunteer doctors. The Doctors Support Line is usually open Mon-Fri from 6pm until 10pm (11pm on Tuesdays). In addition, on Tuesday 9am to 2pm and Sunday 10am until 10pm. Tel: 0870 765 0001. Visit their website at: <http://www.doctorssupport.org/>.

Doctors' Support Network: The Doctor's Support Network (DSN) is a warm, friendly self-help group for doctors who have been troubled at some stage in their lives. This includes stress, severe mental distress, burnout, depression, manic depression, psychoses, and eating disorders. The group believes that contact with and support from other doctors who have had similar experiences helps recovery. All doctors are welcome to join and the group can be contacted by phoning: 07071 223372.

GP Care: Counselling support for GPs in various localities. These are confidential self-referral services delivered locally by qualified, professional counsellors offering telephone and one-to-one counselling. Contact: Dovedale Counselling Ltd, 2 Dovedale Studios, 465 Battersea Park Road, London, SW11 4LR. Tel: 0207 228 6768.

Health at Work in the NHS: HAWNHS is a ten-year initiative with the strategic aim to 'ensure that as an employer, the NHS promotes healthy workplaces and thereby contributes to the health and well-being of its employees'. Useful guidance on workplace health can be found at: http://www.hawnhs.hda-online.org.uk/primary_care/index.html. Tel: 020 7413 1873.

National Association for Staff Support (NASS): Contact: 9 Caradon Close, Woking, Surrey, GU21 3DU.

National Counselling Service for Sick Doctors: A confidential independent advisory service for sick doctors which is supported by the medical Royal Colleges, the Joint Consultants Committee, the BMA, and other professional bodies. A network of advisers return calls from sick doctors or those worried about a sick doctor. The advisers refer sick doctors onto Counsellors as appropriate. The national contact point is staffed 24-hours a day, 7 days a week. Tel: 0870 241 0535.

National Depression Care Training Centre: National training courses for primary care nurses / teams in the recognition and management of depression. Tel: 01604 735500 ext 2640/2712.

Sick Doctors Trust: A confidential intervention and advisory service for alcohol and drug addicted doctors, run by doctors for doctors. Supported by expert advisers throughout the UK. Advice regarding treatment and support groups available. Contact: 24 hour helpline 01252 345163. All calls are received by the national co-ordinator or a nominated member of the APP and responded to within 12 hours.

Information Sheets can be obtained through the Information Services Section of the RCGP, or can be downloaded from the RCGP's Web site at:
http://www.rcgp.org.uk/rcgp/information/publications/information/infosheets_index.asp