JENNY FIRTH-COZENS

Why I study…

stress in doctors

ON the face of it there seemed to be very good reasons back in 1983 to start a study of doctors. Although a clinician, I was working at the Social and Applied Psychology Unit at the University of Sheffield, and the MRC and ESRC funded us to conduct research on occupational issues. In those days the MRC only funded research scientists for a maximum of two three-year contracts, and I was reaching the end of my second year. I wanted a topic that would make my PhD, but also one which would nicely last another four years. Of such reasons is great science made!

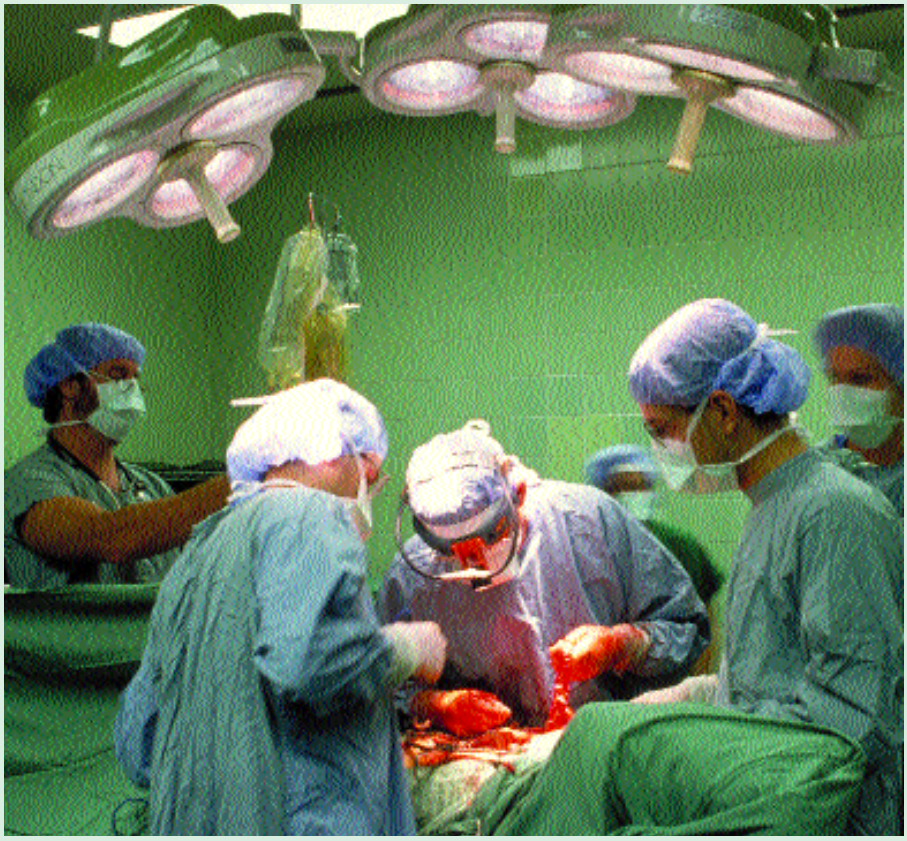
My theoretical interests at the time – arising out of the question from psychotherapy clients of 'Why me?' – were around why some people in the same jobs became stressed or depressed while others didn't. What did they carry with them from their family experiences or personalities that seemed to predispose them to suffer in most or certain workplaces? I needed a population whose working environment was fairly consistent who would become stressful and, above all, who would be relatively easy to follow up over the three years.

While I thought about this I read some of the work of Elizabeth Bedell Thomas at the Johns Hopkins Hospital in Baltimore. She had followed up a cohort of male medical students over 40 years to study the predictors of premature death. They had used a checklist of adjectives about family relationships and had found that cold distant fathers predicted early death from both cancer and suicide (Thomas & Duszynski, 1974). I found this very interesting so I went to see her, almost 90 by then and still active in her work. Clearly a way of avoiding premature death oneself, I thought.

The month I returned, two young doctors from the local teaching hospital visited me. They were clearly emotional and angry, and they told me that two of their new graduates, in their first weeks at work, had killed themselves. No one on either team had mentioned it at all afterwards. 'You're funded to do work on these things,' they said with a hint of accusation. 'Why don't you look at doctors?' A group that really fitted the bill, I thought. 'Don't touch doctors!' I was advised. 'They never answer anything about themselves.'

Actually, a search showed that very few people in this country had ever tried to research stress in doctors, so in 1983 I began a longitudinal study. I caught them first in their fourth year at Sheffield, Leeds and Manchester (where I knew the professors of psychiatry), and followed them up in their first postgraduate year when I expected stress levels to be particularly high. The aim was to see what predicted stress and depression at that time. On both occasions I asked them various things about their role, satisfaction, stress, depression, family relationships, self-criticism and empathy. I chose the last two because I felt that these would be pretty awful traits if you were a doctor, since medicine was clearly not organised at that time to allow one to discuss blame or to be affected by one's experiences. In fact, self-criticism in particular has predicted stress and depression as strongly as working conditions over many years. In a climate of ever stronger accountability, high self-criticism may become an even more serious problem, while low self-criticism – responsible for poor relationships with patients – may run counter to initiatives like clinical governance (Firth-Cozens 1999,2001).

Longitudinal studies are wonderful: you can endlessly explore questions such as 'Why are surgeons so cheerful all the time?' and 'Why are psychiatrists so



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unhappy?' The study is still continuing and they've just turned 40, now mainly consultants or senior general practitioners. A number of others are now also following cohorts which allow snapshots of change over the years: for example, Pamela Baldwin and Rob Wrate's study in Edinburgh, and Chris McManus's covering most of Britain.

My study has led to work with Chris Brewin on family influences on self-criticism; to my studying the links between stress and accidents in medicine; and from that to risk in general, its links to teamworking and assessment. This in turn has given the research an international platform and led to my involvement in various national policy groups such as that producing the recent *An Organisation with a Memory* with the government's Chief Medical Officer.

I enjoy all this enormously but also believe passionately that we cannot hope that clinical governance will raise quality unless we look after the people who deliver health care – doctors in particular but nurses too – and I emphasise the importance of psychologists in helping to bring this about.

So those were the obvious reasons for my study: theoretical interest, local doctors telling me to do it, never been done before in this country, just the right amount of time left on my contract, a group that could always be followed.

However, when I had been on the conference bandwagon for a couple of years reporting the early findings someone who knew my family said: 'I suppose you're studying that because your husband dropped out of medicine at Sheffield?' This had happened before I met him and before he became a journalist, but the coincidence was too great for a one-time psychotherapist to totally deny.

Thinking more widely along these lines I recalled that our family has suffered a long list of dreadful medical blunders, some saved only by desperate ferocity on my part, and all caused by doctors not listening to what I was telling them. I remembered a paper (Paris & Frank, 1983) showing that doctors were more likely to have come from families with serious health problems and lawyers from families with legal problems. Well, medical stress and risk researchers have a relevant history too!

The reasons for my research were clearly as personal as they were practical: I do think that doctors have an enormously difficult job and I want to make it better for them. But I want to do this for their patients too. If I can contribute in any way to making their lives more tolerable so that they will have the time and inclination to listen more closely to their patients' stories, and make their decisions more carefully, then I will feel some some small sense of success. As you see from the papers every day, things are moving. But I need to live as long as Elizabeth Thomas if I want to see real change!

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