Protecting and promoting doctors' health: the work environment and counselling services in three sites

Project Report
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Contents

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Summary

This study investigates the extent to which current structures and services ensure that working environments protect and promote doctors' health. It focuses on two main areas of importance for doctors' health: the working environment for junior hospital doctors; and the needs for, and provision of, counselling services for both hospital doctors and general practitioners.

AIMS OF THE PROJECT

1. To identify the extent to which good practices are being adopted locally in terms of the work environment for junior hospital staff:

    - Do current standards of accommodation, catering, recreational and other facilities attained in three districts (inner city, urban and rural) meet existing guidelines?
    - Are there mechanisms by which the provision of facilities can be reviewed, complaints made and consultation take place; and how do such mechanisms operate?
    - What is the role of the occupational health service in the promotion of doctors' health and provision of services?

2. To identify current availability and acceptability of counselling services for hospital doctors and general practitioners, methods of dissemination and level of use.

METHODS

Case studies were undertaken in three contrasting areas: inner city London, a centre in the south west of England serving an urban and rural population, and a city in the north of England. Visits were made to each centre and interviews were conducted with a range of medical and managerial staff employed by one hospital trust, and with primary care staff, including local medical council representatives and health commission employees.

KEY FINDINGS

- All three areas studied are complying with 'New Deal' hours but it was noted that the problem of intensity of work has not been satisfactorily addressed.
- There are variations in the standard of accommodation attained, though in the study areas these appeared to be generally satisfactory.
- Dissatisfaction was widely expressed with arrangements for out-of-hours catering.
- On site recreational facilities are becoming less common. This and changing work patterns suggest that traditional forms of peer support among hospital doctors may be diminishing.
- There are local arrangements for consultation and complaints which also vary, but it was commonly suggested that these may not always be apparent to junior doctors.
- Responsibility for the health of hospital doctors falls within the remit of a number of different individuals and agencies, including managers, senior medical staff and occupational health staff, but there appears to be no overall strategy. While responsibility for the implementation of the 'New Deal' conditions lies with local managers, the regional task forces were established to oversee that implementation. With the task forces due to end their work, there will no longer be a mechanism to ensure that policy is implemented. This may well continue to depend on the perceptions, priorities and abilities of local personnel and the quality of the relationships between interested groups of staff.
- Formal counselling services are provided in two of the trusts visited and for GPs in one area. Provision of such services does not fall within the remit of any one agency. Their establishment therefore depends on perception of local need and the ability of individuals to take action.
- A number of opportunities to reduce stress among GPs were identified, such as fostering the development of local networks to provide peer support and participation in educational activities. The effectiveness of such opportunities, however, remains untested.

RECOMMENDATIONS

1. The Nuffield Provincial Hospitals Trust Working Party on doctors' health has proposed a strategy to oversee responses to the broad health needs of doctors. There appears to be a need to co-ordinate the activities of the many interest groups, but if the working party's proposal is to be advanced, wider consultation is needed to invite comment and create support from all interest groups. These include Royal Colleges and Faculties, NHS Management Executive, trust executives, junior doctors' representatives, consultants,

representatives, and current service providers.

2. Mechanisms should be established to ensure that local counselling (and other) services for doctors are monitored and evaluated and that the results of such research are systematically disseminated, especially to primary care staff in health commissions, local medical councils and hospital trusts.

3. Research (or a systematic review of available research) into the impact of the 'New Deal' on junior doctors' health is needed to improve efforts to reorganise workloads.

4. Where traditional structures for informal support among hospital doctors are diminishing, reflected in changing working patterns, decreasing importance of mess life and loss of recreational facilities, trust managers and others with responsibilities for doctors' pastoral welfare should ensure that new forms are created.

5. The study areas identified a number of new opportunities to provide peer support and to promote psychological health among GPs, arising out of local reorganisation of primary care. There is a need to investigate their existence and development nationally and to evaluate their effectiveness.

1 Introduction

This report presents the findings of the third in a series of projects examining aspects of doctors' health, which has been carried out by a research team from the Department of Public Health Medicine, United Medical and Dental Schools of Guy's and St Thomas's, with funding from The Nuffield Provincial Hospitals Trust. The initial project, 'The Provision of Medical Services to Sick Doctors',[1] examined the provision of medical and advisory services based on interviews with senior managers and health professionals in eight health authority districts. This identified major attitudinal and organisational barriers to the uptake of services, including problems of the stigma of illness, professional loyalty, the tradition of self-treatment and informal consultations, and perceptions of the confidentiality of services. It also described problems of a lack of knowledge of existing services and the ambiguous position of managers in relation to doctors' health. A second study, 'Doctors' Health and Needs for Services',[2] involved a survey of all doctors working in three hospital trusts and GPs in two FHSAs, and focused directly on doctors' own experiences and responses to ill health. High levels of stress were reported, especially among GPs, of whom 73% rated their jobs as 'often' or 'always' stressful, compared with 62% of hospital consultants and 43% of junior hospital doctors. This confirmed other reports of doctors' high levels of stress and psychiatric morbidity (which may be increasing and/or increasingly admitted).[3,4] The study also indicated that doctors were less likely to take short periods of sickness absence and more often 'worked through' illness compared with a comparison group of 'fee earners' employed by a multi-national accountancy and management consultancy company. This was attributed both to the culture and expectations of doctors and the lack of flexibility of medical work.

The present report follows on from these earlier studies and investigates the extent to which current structures and services protect and promote doctors' health. It focuses specifically on the standards of their work environment in terms of accommodation, catering, recreational and other facilities, and the availability and acceptability of counselling services.

There has long been recognition of an association between the working environment and health, and the Health and Safety at Work Act 1974, established employers' statutory duty to provide a safe and healthy working environment for their employees.[5] The NHS Executive has produced a number of guidelines related to the reduction of specific risks in NHS places of work and in HSG(94)51 (Occupational Health Services for NHS Staff) recognised that '[poor] health in individuals may result from the way in which the employing organisation works: for example, anxiety and depression can be caused by poor job design as well as factors outside of work'.[6] This document also recognised the need to identify and prevent stress in the workplace, recommending that workplace stressors should be assessed and appropriate counselling and support should be offered to staff. In 1992 the 'Health at Work in the NHS' initiative was established to promote health

in NHS places of work and to contribute to the health and well-being of NHS staff through a range of health promotion activities.[7]

Junior doctors campaigned for many years to improve their working conditions and terms of service, arguing that these were adversely affecting their health, job satisfaction and service delivery. A new contract was agreed – the 'New Deal' – and signed in 1991.[8] This not only set a timetable for the reduction of working hours and set limits on the average number of contracted hours per week, but also set standards for other aspects of working conditions. Minimum standards for accommodation were defined and recommendations were made concerning catering, the provision of facilities for recreation, parking and study, and the establishment of complaints procedures. Other needs were also identified: comprehensive recruitment packages (describing provision for accommodation, support and educational and service features), accurate and informative job descriptions, and induction courses for new recruits. Guidance was also provided about reviewing the content of junior doctors' workload and the role of nurses, technical, administrative and other support staff. (Appendix 3.)

Details of the 'New Deal' are reproduced in documents intended for doctors in training, such as the 'Junior Doctors' Handbook' and 'Junior Doctors: The New Deal' by the British Medical Association (BMA) Junior Doctors' Committee.[9, 10] But these documents also attempt to raise the minimum standards. For example, the BMA proposes a 'star rating' system, listing facilities by which accommodation can be classified as one, two or three star. (Appendix 4.) The Junior Doctors' Committee offers advice about how doctors in training should ensure that agreed standards are met, for example by identifying a spokesperson to liaise with trust management.

Regional task forces were set up in 1990 with the aim of overseeing the implementation of the 'New Deal' at local level.[8] The task forces were accountable to regional health authorities and required to collect data on the reduction of hours for reports to ministerial and technical groups. Their responsibility for advising on the creation of new posts that were required to ensure the reduction of hours was envisaged to extend to 1994. The work of the task forces has been reported only confidentially, and so there is little information of the extent to which facilities now conform with minimum standards, and the gaps in provision.

At the same time, counselling services for doctors have now been set up in a number of areas, and, after some years of debate, the BMA has established and widely promoted a national telephone stress counselling service.[11] However, little evaluation of such services is yet available and there are no real data about levels of utilisation. Nor is it clear whether this is evidence of a growing need or a growing acceptance of counselling services.

The present study employed a case study approach to examine local provision and perceptions of the working conditions for junior hospital doctors, mechanisms for review, consultation and complaints, and the provision of counselling services for both hospital doctors and general practitioners. The study was conducted in three districts, selected as being inner city, urban and rural.

2 Aims of the project

1. To identify the extent to which good practices are being adopted locally in terms of the work environment for junior hospital staff:

   - Do current standards of accommodation, catering, recreational and other facilities attained in three districts (inner city, urban and rural) meet existing guidelines?
   - Are there mechanisms by which the provision of facilities can be reviewed, complaints made and consultation take place; and how do such mechanisms operate?
   - What is the role of the occupational health service in the promotion of doctors' health and provision of services?

2. To identify current availability and acceptability of counselling services for hospital doctors and general practitioners, methods of dissemination and level of use.

3 Methods and study participants

The short-term nature of the project, which was conducted over six months, influenced both the methods and selection of study participants. The study uses a case study approach to describe local responses to the issues outlined above, and from these to draw out implications for policy.[12] Our aim was not, therefore, to evaluate services in particular sites or to survey provision nationally. Rather, by building up a 'snapshot' picture of different centres, we aimed to identify issues as suggested by current practices in the management of the work environment and the provision of counselling services.

The research was carried out in three contrasting geographical areas: a London health authority, a city in the north of England, and a city serving a surrounding rural area in the south-west of England. To accelerate the recruitment process, we approached two medical directors of hospital trusts which had participated in our earlier research; they agreed to take part in the present study. A third hospital trust was approached but eventually declined to participate since, it was reported, a number of audits were then being undertaken at the hospital. A fourth trust was approached and agreed to take part. At each site a number of employees were interviewed, including the medical director, junior doctors' representatives, occupational health staff, clinical tutors and personnel staff. (Appendix 2.)

To meet the second aim of the study, primary care staff in the health authority relative to the participating hospital trust were also approached. Among those interviewed were primary care personnel employed by the health authority, local medical committee officers, and one regional adviser in primary care.

Schedules were developed for interviews with hospital employees and for those working in primary care. (See Appendix 1.) In the case of hospital trust interview schedules, criteria were derived from BMA guidelines (as set out in the 'Junior Doctors' Handbook' and themselves based on the 'New Deal'). Primary care schedules were designed to focus on local provision of services and the participation of the health authority or local medical committee in such provision.

Visits were carried out to each site in order to conduct interviews with personnel. All interviews were audio tape recorded (except in the case of one refusal) and transcribed. Interviews lasted for 30–60 minutes.

Additionally, discussions were held with other individuals with an interest in issues related to doctors' health, including researchers and providers of services. An anonymous list of those interviewed for the study is presented in Appendix 2.

4 The local settings

The three areas where research was conducted varied geographically, in the local restructuring of primary care and in the perceptions of those interviewed regarding the extent of local problems related to doctors' health. Area A is an inner city area with high levels of deprivation. There is a high proportion of single-handed general practitioners and those interviewed referred to marked difficulties in retention and recruitment of principals. The problems of stress amongst general practitioners are considered to be of high priority and this is reflected in the number of local initiatives to address these problems. Hospital Trust A is a district general hospital.

Area B is also urban, but with a wide variation in the socio-demographic status of the population, was characterised as having relatively high proportions of general practitioners under the age of 40 and of female general practitioners. Here, while those interviewed were well aware of the general problem as evidenced in the literature, and through some personal knowledge of doctors who had experienced health problems, the provision of services addressing general practitioners' health needs was not seen as an immediate priority. Rather, the problem was identified as the need to prevent stress and to encourage the use of existing facilities. Hospital Trust B is a teaching hospital and is located on a very large site.

General practitioners in Area C serve both urban and rural populations. There are

> *'very few general practitioners over 60 years of age' and the area has 'the lowest proportion of patients to doctor in the country and the highest number of practice nurses.'*
>
> **[Interview 26]**

However, this interviewee was aware of three general practitioner suicides in the area since 1989 and also knew of a very small number of doctors with heavy drinking or depressive illnesses. The participating hospital trust in this area is a district general hospital also set on a large site.

5 Working conditions for hospital doctors

This section investigates the ways in which standards concerning junior doctors' work environment and working conditions are set and maintained. The research focused in particular on elements which were addressed by the 'New Deal'.

5.1 Hours

The 'New Deal' established a timetable for the reduction in the working hours of doctors in training. Trusts and other employers were to ensure that by '31 December 1994 the maximum average contracted hours of duty ... do not exceed:

- 72 hours per week for doctors working on-call rotas in hard-pressed posts
- 64 hours per week for doctors working on partial shifts
- 56 hours per week for doctors working on full shifts.'[8]

In all three hospital trusts' 'New Deal' hours have been implemented. Junior Doctors' Hours Committees with a representative of doctors in training were set up in all three. One trust also employed a supernumerary junior doctor for three months to co-ordinate the implementation of new hours, interviewing juniors and organising discussions. Another trust received funds to pilot a scheme in which nurse practitioners perform some tasks usually done by junior doctors to attempt to ease their workload. A similar plan had been put forward in another trust.

While contracted hours may have been reduced, interviewees commonly referred to the increased intensity of doctors' work, with fewer opportunities for rest periods. A medical director also attributed the increased intensity of work to changing practices in patient management. For example, an increase in day surgery also means that in-patients would generally be a sicker and more dependent group, requiring more intensive care from all nursing and medical staff. Some junior doctors felt that reduced hours might have a negative impact on training, a concern which has also been expressed in the literature.[13, 14] Interviewees therefore felt that focusing attention on junior doctors' contracted hours has led to a neglect of what the Junior Doctors' Committee has called 'the basic problem – working too hard while on duty'.[15]

In one hospital a junior doctor noted another problem:

> *'The juniors in first on-call group are covering more than they should do at the moment because they're covering for study leave as well as annual leave which they shouldn't be doing.'*
>
> **[Interview 13]**

This study was not able to investigate in any depth the impact of the new contracted hours, but a number of issues are clearly emerging as significant. These include the differences between 'on paper' contracted hours and actual hours worked, the problems of intensity of the workload, the impact on training, provision for cover for annual and study leave, and the real impact of changes on doctors' physical and psychological health.

5.2 The working environment

As outlined earlier, negotiations for the 'New Deal' were not limited to the contracted hours of doctors in training, but also addressed issues related to their working conditions. The 1990 Heads of Agreement identified the need to ensure 'a reasonable working environment'[16] with the contract itself spelling out in greater detail what this implied, and BMA documents indicating how minimum standards might be raised.[9,10]

This section now considers two issues related to the working environment for hospital doctors: the current standards of accommodation, catering and other aspects of the working environment found in the three trusts in the study; and existing opportunities for the review of facilities and consultation.

5.2.1 Accommodation

In one of the trusts, on-call accommodation does not currently meet 'New Deal' minimum standards. Refurbishment has recently been undertaken and the areas which fall short (shower/bathroom facilities) are being addressed. The junior doctors' representative reported that although accommodation does not quite meet standards, he believes that it is 'acceptable'.

> *'I don't get too many complaints about the standard.... I don't think it's perceived as a major problem.'*
>
> **[Interview 22]**

Resident accommodation was described by a junior doctors' representative as 'not too bad', although 'it doesn't quite meet the standards of the BMA'.

Again this was not a major source of complaints to the mess president. Local authority regulations had required the upgrading of much of this accommodation although the Medical Director commented,

> *'I still feel we could provide better accommodation if resources were available.'*
>
> **[Interview 21]**

However, he suggested that it was difficult to defend spending funds on resident accommodation when some patient areas were still in need of improvement. With changes in training of doctors and nurses, the reorganisation of trusts in the city and a trend away from 'living in', the accommodation needs of all categories of staff have been reviewed and future plans are currently being evaluated. Here a trend for doctors to live in their own accommodation, rather than in the hospital, was noted.

In the two other trusts, on-call accommodation had also recently been refurbished with funds allocated by the regional task force and both met minimum standards with one meeting the criteria for the BMA two-star rating, and the other meeting the criteria for the one-star rating. Junior doctors had been consulted about how regional task force allocations should be spent.

Limited resident accommodation is available in both these trusts, but again the trend away from 'living in' was noted:

> *'.. the population of junior staff has changed. It's now far more mobile. We've found that with ... more regional registrars and more regional training posts being set up from [the regional centre], a lot of guys come up here and don't want to be based [here].'*
>
> **[Interview 10]**

5.2.2 Catering

Catering was generally perceived as more problematic than accommodation by those interviewed. Various standards were described: 'perfectly OK', 'usually of quite a good standard', 'quality has suffered recently', 'It's not the worst hospital I've ever seen'. In all three sites efforts to offer a wide choice of food were noted. On one very large site the quality of food was described as varying according to the particular dining room.

All interviewees remarked that arrangements for out of hours catering had caused problems. These included hours that were too restricted, dissatisfaction with the limited choice available and problems with one canteen shutting before its advertised time or running out of food.

Attempts to resolve such problems were made by representations to catering managers from, variously, a clinical tutor, a medical director and a mess president. The clinical tutor, for example, explained:

> *'Every single junior has complained about [canteen hours].... Every time I heard a complaint I wrote letters to the catering manager and just continued to point out that it's not on. That's all I can do ... continue to hammer away at it and point out that nearly everybody has complained.'*
>
> **[Interview 11]**

Vending machines are generally available; microwaves are available in two of the doctors' messes. Interviewees in two trusts remarked that sending out for take-away food is a common practice.

5.2.3 Other facilities

Mess

All three trusts have a doctors' mess, the standard of which was generally regarded as satisfactory or good. Facilities such as comfortable chairs, tables, television, microwave ovens, tea and coffee are generally available. In one site junior doctors had been consulted by the hotel manager before the mess was refurbished. By contrast, another mess was:

> *'redecorated by the hospital three years ago. There wasn't much consultation but they did make a fairly good job of it.'*
>
> **[Interview 22]**

The mess is a meeting point for trainee doctors but some interviewees remarked on the changing role of mess life for trainees. For instance, one medical director observed:

> *'doctors are less likely to want to stay in the hospital after hours. So the style where everybody would go to the mess or the bar at 5 o'clock or 6 o'clock has now changed ... as the continuing drive to reduce hours is likely, then doctors aren't going to want to stick around here if they're only working 56 hours ... so hospitals in the main are not putting as much emphasis on a mess because they're not being driven towards it but if there was a good mess I think that would support juniors more at the SHO level.'*
>
> **[Interview 10]**

In this trust the mess had been refurbished without a bar, according to the wishes of the juniors consulted at the time. Its location means that it is not suitable as a social venue. The junior doctor representative commented that this meant that the hospital now lacked

> *'a social area where you can meet and talk about these problems over a beer. The hospital is quite spread out so you never see a lot of the juniors. I've hardly ever met a paediatrician in this hospital and I've been here 18 months.'*
>
> **[Interview 14]**

Recreation

Other on site recreational facilities were limited in all cases but special rates with local leisure centres have been arranged by two trusts for all employees. In two cases, sports facilities which once existed have been replaced by new buildings. Two medical directors suggested that medical staff could use gymnasium facilities primarily intended for patient rehabilitation. One interviewee had enquired about using such facilities but reported that he was not encouraged to do so.

Parking

Limited space for parking is available in all three trusts and in two cases security was highlighted as a particular problem. No trust had special arrangements for doctors in training. A staff permit system operates in two trusts, but this does not guarantee availability of space.

Table 1 The working environment for hospital doctors: summary points

- Hours: all trusts comply with the new contract hours. Concern was expressed that as a result of reduced hours and new practices in patient management, work has intensified with fewer opportunities for breaks.
- Accommodation was generally reported as satisfactory; refurbishment has recently taken place in all three trusts. One trust currently does not meet minimum standards.
- Catering: generally regarded as satisfactory but out of hours catering is a problem in all three trusts.
- Other facilities:
  - mess standards are generally satisfactory but the mess seems to be less of a focus for junior doctors.
  - some on site recreational facilities have been lost.
  - parking space is limited in all three sites; no special arrangements for junior doctors were reported.

6 Mechanisms for consultation and complaints

The study was also intended to investigate mechanisms by which the provision of facilities could be reviewed, complaints made and consultation take place. Local arrangements vary considerably, and those interviewed referred to a variety of mechanisms by which working conditions may be assessed and problems addressed. We describe here three types of mechanisms: national, local and informal.

6.1 NATIONAL MECHANISMS

The regional task forces are an important formal mechanism by which working conditions and terms of service for junior doctors have recently been assessed. Since the focus of the task force's work was to ensure the implementation of the 'New Deal', it was concerned not only with the reduction of doctors' hours and any changes in work practice which this might require, but also in the improvement of accommodation and other facilities for juniors and the administration of funds allocated for this purpose.

A doctor in training was nominated as a core member of the task force. In all three trusts there are Junior Doctors' Hours Committees. One junior doctor described the remit of the committee as follows:

> *'We're supposed to look at the 'New Deal' – junior doctors' working hours, terms of service and make sure that [the trust] is coming up to scratch, look at ways of redistributing doctors' workload.'*
>
> **[Interview 13]**

The Royal Colleges were also referred to by some trainees as providing a mechanism for ensuring that standards were met. For example, one junior doctor described some of the shortcomings in working conditions:

> *'[The trust] are trying. They've not got there yet. There are financial constraints with the problem of locum cover for study leave. Adequate recreational facilities hasn't been addressed but pressure is being brought to bear by the College and they*

can threaten to withdraw recognition if you don't have adequate on call facilities I'm sure it's a very powerful weapon. Colleges are very useful in those terms.'

[Interview 2]

A number of guidelines exist which set standards for accommodation, catering and other aspects of the working environment. As well as generally applicable guidelines dealing with health and safety at work, these include details of working conditions agreed for the 'New Deal' and the BMA star-rating system for hospital accommodation. Most of those interviewed were acquainted with at least some of the details of the minimum standards set out in the 'New Deal'. Many were also aware of the BMA star-rating system. One junior doctor representative admitted that her precise knowledge of the details was sketchy but added 'If I had to complain, I'd consult them'.

More importantly, perhaps, in one trust the accommodation manager had used the checklist from a borrowed copy of the BMA Junior Doctors' Handbook to assess the standard of accommodation for which she is responsible.

6.2 LOCAL MECHANISMS

In each of the trusts there are local arrangements for junior doctors to express their views and make complaints. For example, in Trust A there is a weekly meeting of pre-registration house officers; some sessions are for teaching while others are left open. In Trust C, a Junior Doctors' Liaison Group is a more formal attempt to give juniors a forum where problems can be raised. These might include problems with catering, accommodation as well as

'things like bleeps, portering services, x-ray, phlebotomy, practical things like car parking security.'

[Interview 22]

Here, the mess president acts a conduit between other junior staff and management and when interviewed gave examples of meetings which he had held with relevant staff to resolve problems which had been identified. Trust B has a Junior Doctors' Working Group which meets with the medical director at three-month intervals to discuss aspects of working conditions.

6.3 INFORMAL MECHANISMS

The mess and social groups of doctors were cited as networks where problems were being raised and possible solutions investigated. Educational supervisors, consultants and clinical tutors were cited as individuals to whom specific complaints could be made. It was also suggested that, informally, complaints and suggestions could be made directly to domestic staff, accommodation staff and medical staffing. One accommodation manager said that domestic staff whom she managed were in fact a good source of information about doctors' complaints and needs.'

In Trust A the medical staffing and postgraduate education centres have been amalgamated into one service, and staff interviewed described strategies used to ensure that this is 'user-friendly'. These include offering breakfast and refreshments in the centre, providing juniors with a C.V. writing service, and helping with the production of slides and overheads for presentations.

> *'There isn't a formal mechanism: they have the opportunity to do it through their own educational supervisor or through [the clinical tutor] or the counselling system. At the start of their job they get told that if there's any problem that they can't resolve through their own educational supervisor they should come to me. I put myself over to them as on their side against the trust and that I'm their friend. I will fight their corner.'*
>
> **[Interview 3]**

The role of the postgraduate education centre manager as a link between juniors and management was confirmed by a junior doctors' representative:

> *'[The manager of] the postgraduate centre is probably a vehicle, a link between us and management and she's very sympathetic.'*
>
> **[Interview 2]**

6.4 LIMITATIONS OF PRESENT ARRANGEMENTS

Although there is a wide range of possible mechanisms for reviewing arrangements and procedures for consultation and complaint, there are some limitations to their effectiveness. Significantly, the work of the regional task forces is due to end, since these were created to oversee the implementation of the

'New Deal' hours. No other such trust-wide mechanism for formal review exists.

Even where there are specific procedures, not all those interviewed were aware of these. This perhaps reflects a need for more information in trusts, either at induction or throughout the year.

> *Is there a complaints and review procedure?*
> *'For terms and service hours, not that I know of. There isn't an obvious complaints procedure to go through; you could go through the mess president or your consultant.'*
>
> **[Interview 2]**

A medical director explained why there might be a lack of clarity about procedures:

> *'Well, there is [a procedure]; whether the junior doctors have any idea that it's there I don't know. We have one now that is in line with the recent committee on complaints, procedures and reviews. I think one of the problems is with a rapidly shifting population, the chances of them knowing exactly how they should formally complain is probably low. The informal mechanisms of feedback to senior clinicians which is now a regular part of the induction and training of clinical staff would afford an opportunity to complain about things but it would be interesting for me to know whether the junior staff have any idea that there's a formal complaints procedure. I suspect they don't.'*
>
> **[Interview 1]**

Another problem referred to was that contact between juniors was also hindered by geography: the trusts participating in the study are all large with hospital buildings spread over extensive sites. This means that some staff might not have much contact with others and might not know, for example, who the mess president was. There was sometimes difficulty in recruiting junior doctors to committees which was attributed partly to their rapid turnover.

Informal mechanisms rely on interpersonal relationships. Thus the effectiveness of these is dependent on the quality of such relationships. The willingness of individuals approached informally to take action might also be dependent on their level of interest in the issues raised.

Table 2 summarises the mechanisms by which consultation may take place and complaints voiced.

Table 2 Mechanisms for consultation and complaint

- Three types of mechanisms were identified:
  - national
  - local
  - informal
- A number of guidelines by which standards are set exist. Some of these were cited by interviewees.
- There are limitations to present arrangements. For example, the high turnover of junior staff; informal mechanisms are dependent on the nature of interpersonal relations and individual interest.

7 Occupational health services

The role of occupational health services in the National Health Service has recently been outlined by the NHS Executive:

OHS in the NHS exist to:

- 'promote and maintain the physical, mental and social well-being of all staff' (World Health Organization OHS definition)
- assess applicants for employment, to ensure they are fit for and placed in appropriate work
- help management to protect staff from physical and environmental health hazards arising from their work or conditions of work, and to provide advice on the working environment
- help management to protect patients, visitors and others from staff who may represent a hazard
- contribute to increasing the effectiveness of the organisation, by enhancing staff performance and morale through reducing risks at work which lead to ill-health, staff absence and accidents.[6]

In its submission to the Nuffield Provincial Hospitals Trust Working Party on Doctors' Health, the Faculty of Occupational Health described in more detail 'the functions of an OHS in the context of the sick doctor'.[17] These include interventions in the case of a doctor with an illness or disorder such as advice on return to work, providing confidential support and advice, and providing access to a consultant specialist. Also listed are preventative activities such as identification of hazards in the workplace (including psychological risks), immunisation programmes and health promotion initiatives.

Clearly then, OHS have a role in the provision of services to medical employees and the promotion of doctors' health in the workplace. However, as has been reported elsewhere, this role may be hampered by, for example, doctors' perceptions of OHS.[1] The present study also enquired about the activities of occupational health in the three sites visited.

All three of the sites participating in the study have an occupational health department offering a range of services to trust employees but there are some important differences in the organisation of these departments. Such differences have an impact on the work of individual services.

Only one site has a consultant-led occupational health service; another was due to appoint a consultant to post at the time of the research while the third's service is led by a manager with a background in nursing. Here general practitioners with experience in occupational health are employed on a sessional basis. Having a consultant-led service was perceived by one interviewee as important in the process of convincing doctors employed by a trust of the relevance of the service.

The consultant-led service provides occupational health services for other trusts in the city and some outside concerns but had

> *'a very clear brief from the trust that the primary function is to provide an NHS occupational health service, and that any income generation must not be at the expense of the service provided to NHS ... we do work in a trust where occupational health is understood and valued as part of the trust. The chairman and chief executive understand what we're about and are supportive in developing that role and they don't see it, as some trusts do, as a money making machine for the trust.'*
>
> **[Interview 12]**

By contrast, the manager-led service is required to generate income to cover its core funding from the trust. This requirement was felt to limit the amount of health promotion activities that might be undertaken.

> *'Since the trust was set up ... it's been quite an effort to survive so a lot of our efforts have gone into bringing in money to offset the cost of the services to the trust and the trimmings have taken a back seat ... so some of the nice things we' d like to do, the health promotion work for example, were slightly pushed into a corner ... we've got to generate income and what generates income is the bread and butter stuff such as pre-employment screening, sickness absence medicals, etc.'*
>
> **[Interview 4]**

While implementation of health and safety regulations and guidelines are within the remit of occupational health, the departments participating in this study were not otherwise involved in the environmental aspects of work (accommodation, catering, etc.) which have been discussed so far. As far as medical staff are concerned, the main task in OHS in all three sites was described as pre-employment screening and implementation of Department of Health requirements for immunisation.

It was reported in all three trusts that take up of occupational health services by medical staff was generally low, and it was agreed that this group tends to regard occupational health as appropriate to nurses or other hospital employees but not to doctors, and as part of management and therefore viewed with some suspicion. Difficulties were reported with achieving full pre-employment screening and required vaccination among doctors.

> *'Time and workload obviously come into that but there is a general resistance [among doctors].... It makes our work slightly harder, just getting the DOH Hep. B requirements sorted out was bloody hard work, they were the most difficult group to complete, the senior staff were most difficult to complete.'*
>
> **[Interview 4]**

'We have terrible trouble getting them to come for simple routine things like immunisations, pre-employment screening.'

[Interview 23]

Some strategies had been used to encourage this greater uptake of services such as introducing greater flexibility in appointments for doctors for vaccination and results. With the co-operation of the medical director and personnel department, one trust has made a clearing from occupational health a prerequisite for the first payment of new employees' salaries.

Occupational health staff were concerned that doctors should be treated like other trust employees but they were also well aware of the particular ways in which doctors manage their own health and recognised their needs.

'I look at some of the junior doctors and the issues that they are dealing with in day to day work and wonder how they are coping with it... I worry about the level of support that can overlap on the supervision/counselling type of support that certainly junior staff might need.'

[Interview 4]

In another trust, recognition of the time pressures on doctors and trainees' lower rates of registration with a general practitioner has led to an exceptional service for medical employees:

'For doctors I will, in very limited situations, provide short-term medication if necessary – we do for doctors but we don't for the rest and that's in recognition of the fact that certainly the resident staff often find it difficult to get to their GP. Just for acute things like antibiotics... it is a bit of a double-edged sword because some of the juniors interpret that as me being prepared to keep them at work when I'll not do it for anyone else; but it isn't – it's to take the pressure off them about getting to their GPs. At induction to housemen I make the point that although they are now doctors, they have to have a GP, that they must not prescribe for themselves or each other and if they are in a situation where they need antibiotics and they genuinely can't get to their GP then we will help them.'

[Interview 23]

Two of the occupational health staff interviewed had had experience of dealing with medical employees who had required psychiatric intervention. In both cases, advice had been given on referrals using local knowledge built over time. In the third case, a locum consultant in post for three months, with no such local knowledge, had not been made aware of where he might refer doctors.

'There were some guidelines on handling sensitisers, etc. drawn up by the previous doctor but I felt that if there were systems in place they weren't very obvious.

There are quite good systems in place for health and safety practices in general for the trust but not guidelines of where doctors can get help.'

[Interview 15]

In Trust C the occupational health consultant provides 'acute' counselling:

'For the doctors, by and large – I see only a very small group – often all they need is a chat and a box of tissues and a cup of coffee, maybe come back a couple of times. Sometimes they just need someone to talk to, who's a little bit out of the hierarchy.'

[Interview 23]

Those in need of further treatment can be referred to local clinical psychologists, and, if necessary, psychiatrists outside the area.

Table 3 Occupational health services: summary points

- OHS vary according to factors such as
  - consultant led or manager led
  - importance of income generation for the service
- OHS physicians with local knowledge of specialists to whom doctor-patients can be referred are an important resource.
- Uptake of service by doctors is nevertheless low because of factors related to doctors' perceptions of OHS, its role and its relevance to them.

8 Special initiatives

Since issues related to doctors' health are currently topical and widely debated, we wished to investigate whether any initiatives had been undertaken in the three hospital trusts to meet doctors' perceived health needs locally. Some interviewees described health-promotion activities that had taken place or were planned including campaigns to encourage healthier eating or more exercise; but these were aimed at all trust employees and not specifically at doctors. In Trust A the occupational health service plans to seek funding for stress management training. In one trust discussions had taken place between consultants and general practitioners when a local support group for doctors was set up. (See page 24.) However, another interviewee described some consultants' disdainful response when the initiative was explained to them.

Clinical tutors in Trust C had organised two sessions on coping with stress for doctors in training. Efforts were made to encourage participation: food was provided and time-off was given to attend the sessions. The response was disappointing with the house officers judging the session 'a waste of time' and poor attendance from SHOs and registrars.

This reluctance was attributed by the clinical tutor to an inability or unwillingness to recognise stress and a high degree of motivation among the trainees, rather than an absence of stress.

Others interviewed were not aware of any particular initiatives. A medical director explained:

> *'We recognise that as clinical directors we have responsibility for identifying hassles as they arise but you're not talking about Hepatitis B and all that – that's done by occupational health and that's all routinised. You're talking about the drug addicted or alcoholic doctor or the doctor with unrecognised depression, I presume. We don't have any formal methods.'*
>
> **[Interview 1]**

We note that no interviewee referred to the 'Health at Work in the NHS' initiative.

Table 4 Special initiatives: summary points

- Very few local initiatives for hospital doctors were reported. Those cited by interviewees were mostly limited to health promotion campaigns directed at all trust employees.

9 Counselling

In this section we describe counselling services for both hospital doctors and general practitioners, and report on mechanisms for support and the prevention of excessive stress, as these were referred to by participants in the study.

9.1 SERVICES FOR HOSPITAL DOCTORS

In all three hospital trusts two forms of counselling were identified by study participants. These were staff counselling services and provision for career and/or personal development for doctors in training.

A staff counselling service operates in two of the three hospital trusts. In Trust A, this had been established some years ago and is now managed by the occupational health service. It is advertised as being available for all trust employees through staff notices and bulletins. In Trust B, staff sessions are made available by the clinical health psychologist and similarly advertised. In the third trust there is no formal counselling service as such. As indicated above, here the consultant in OH provides acute counselling and refers to outside specialists where necessary.

In all three cases, use of such services by medical staff was reported to be low, with interviewees citing doctors' own reluctance to seek help. It was reiterated by medical and non-medical interviewees alike that seeking help is regarded as tantamount to an admission of inability to cope.

> *'I think that the feeling around is that [doctors] are of professional status – they may be using counselling services outside but to use workplace counselling services would seem to be not coping. That culture that one has a stiff upper lip.'*
>
> **[Interview 4]**

> *'There have been a few examples where a patient committed suicide and a letter was sent round offering a counselling service. Unfortunately the way we're built and the way we see problems day in day out, we tend to laugh a little bit; but there comes a time where you need to talk to someone. Most of us will go home and chat with friends and tensions are released that way because often counselling is a vehicle for you to get things out in the open and if you've got a couple of friends you can do that.... There's still a bit of phobia about counselling. I think people feel it's a sign of a lily livered approach or that they're weak willed.'*
>
> **[Interview 2]**

9.2 PROVISION FOR CAREER AND/OR PERSONAL DEVELOPMENT

There is provision for some form of personal and career development for doctors in training in all three trusts but local arrangements vary. In Trust C a programme of personal development plans had been set up but, according to the mess president, this system was not functioning well despite a great deal of work by the consultant responsible for the programme.

> *Professor A has tried to get people to fill in what they call PDP (personal development plans) for some time. There has been some resistance from the juniors and a lot of resistance from the consultants – some were willing to do it, most avoided the issue.... 'Prof. A has got fed up. He blames the junior doctors because they don't fill them in because they don't see the point of them, though the consultants are at fault as well. If both were compelled to do them, then it would work. There's apathy on both sides despite a lot of effort on his part.'*
>
> **[Interview 22]**

In another trust, all juniors are invited to three meetings throughout their post: an initial meeting with their consultant, another midway through the rotation, and a final assessment at the end of the rotation. Trainees are also offered optional 'cross counselling', with the clinical tutor from outside the trainee's speciality. This is not compulsory but refusals are followed-up. The meeting, organised by the Postgraduate Medical Centre, is described as:

> *'... very friendly: the tutor comes in and ensures that he knows that junior's Christian name, and coffee and biscuits are supplied. Very informal; obviously confidential ... any issues at all.'*
>
> **[Interview 3]**

The clinical tutors offering 'cross counselling' have received training in career counselling.

Trust C also offers counselling for junior staff. This is organised and supported through the postgraduate centre and provided by a counselling group, comprising three consultants and two general practitioners. Trainees are offered an appointment with a counsellor from a different speciality; women can elect to see the female consultant who acts as women's mentor. A second appointment is offered to those who do not take up the first. Those who are seen are told that they can make further appointments if they wish. Again, the session is informal and confidential, and is intended to be an opportunity for trainees to receive support and to voice any concerns they

have. To date these have largely been related to aspects of working conditions, including the working relationship between juniors and one consultant. Where appropriate, members of the counselling group have sought solutions to the problems identified.

The service is monitored by the counselling group and anonymised details are collated and reviewed at six-monthly meetings. Uptake was estimated at 60–75%.

9.3 SERVICES FOR GENERAL PRACTITIONERS

Only one area participating in the study had a local counselling service specifically for general practitioners. This service was recently established as a pilot project and currently operates in four other health authority areas. Funding comes for the work and its evaluation from a number of sources: health authorities, General Medical Services Defence Fund, Department of Health, and the Nuffield Provincial Hospitals Trust. The service is provided by a commercial counselling agency whose trained counsellors can be contacted on a 24-hour telephone line. Face to face sessions can be arranged and up to six sessions are available free of charge to the service user. Project evaluation will monitor uptake of the service and assess its impact.

This health authority also operates a stress fund to which general practitioners can apply. Applications are assessed during a personal meeting between the applicant and a general practitioner consultant employed by the health commission. The meeting serves to identify the causes of the applicant's experience of stress and assess the best way to manage this. Funds may be granted to allow the applicant to employ a locum, for example.

Local general practitioner support groups have been established in all the participating areas, although these provide peer support rather than professional counselling. One such group had been established following suicides by two local general practitioners. A small group of doctors met together and agreed to make it known to colleagues that they could offer informal support. With the support of the health authority and Local Medical Committee, details were circulated to all local general practitioners. At the time of interview, the group was due to meet to consider its future in the light of the recent establishment of two services: the BMA telephone helpline and a 'listening ear scheme' sponsored by the local faculty of the Royal College of General Practitioners. In the same area, the LMC secretary also keeps a list of local and out of area general practitioners willing to provide support to colleagues. The LMC newsletter regularly advertises such services.

9.4 OPPORTUNITIES FOR PREVENTION

A number of interviewees identified as relevant other initiatives and structures designed to enhance general practitioners' skills, personal development and working practice. While it was acknowledged that these were not substitutes for therapeutic services, it was felt that they provided opportunities for the *prevention* of excessive stress and burnout in general practice.

General practitioner networks, for example, were commonly identified as reducing the isolation felt by general practitioners and providing opportunities for peer support. Some such networks were relatively well established, for example young principals' groups and trainers' groups. Others were newer such as the amalgamation of local practices into localities, now in place in all the areas in the study. The appointment of officers with a specific remit to encourage primary care development and of locality managers to liaise between practices and the health authority was also regarded as a potential way of identifying causes of stress, helping to prevent stress, and improving communication between the health authority and general practitioners. Regular meetings of locality fora were also identified as another network.

In Area A, recruitment and retention of general practitioner principals and recruitment of locum doctors is regarded as especially problematic and likely to add to general practitioners' experience of stress. Projects to address these problems have been initiated. In the two remaining areas, while these problems exist, they were not felt by interviewees to be so serious as to be priorities for intervention.

A performance-monitoring project was being developed in Area A with input from local general practitioners and the regional adviser in general practice. This was also identified as, potentially, a way of identifying doctors with health problems since these could lead to under performance.

Similarly, educational programmes were identified as opportunities for improving general practitioner morale and preventing stress. Thus mentoring schemes, personal learning programmes and specific courses in time management, for example, were cited as preventative measures. The regional adviser in general practice commented:

> *'A lot of things we run, such as management courses, are to help people cope better with change, pressures put upon them ... time management – it's not so you can get through patients in four minutes. It's how you learn to prioritise, teaching people strategies to deal with the pressures that time puts on, a way to prevent stress.'*
>
> **[Interview 7]**

In Area A, therefore, GP stress and burnout were acknowledged as a priority and having an impact on service delivery. Initiatives are being developed to tackle

some of the factors leading to stress and to counteract the adverse impact on service delivery. In other areas, problems of GP stress were acknowledged but not prioritised in terms of specific interventions.

Table 5 Counselling: summary points

- Two trusts had a formal staff counselling service. These appeared to be little used by medical staff.
- All three trusts organise, in different ways, provision for personal/career development for junior staff. Uptake relates to mechanisms for encouraging participation.
- Only one area has a (recently established) counselling service for GPs.
- GP (peer) support groups exist in all areas.
- A number of opportunities to prevent GP stress and burnout were cited. These include
  - established local GP networks.
  - newer networks such as GP localities.
  - continuing education programmes.
- Primary care personnel in one health commission have started a number of initiatives to address GP stress and problems in recruitment and retention.

10 Discussion

This study investigated two related aspects of the management of doctors' health: the extent to which current structures and services ensure that working environments protect and promote the health of doctors employed in hospital trusts; and the availability of counselling services for both hospital doctors and general practitioners. The importance of ensuring a healthy working environment for the prevention of stress, distress and dissatisfaction was acknowledged by all those who participated in the study and expressed by an occupational health consultant thus:

> *'If the infrastructure in the hospital is right then the major health issues for doctors will go away and they'll have ordinary health issues that anybody can expect. The big issues are about stress – things like lack of support, can't get a hot meal at night, having to change the bed in the on-call room, there aren't enough phones, batteries gone in your dictating machine and you can't find any more. Trivial, but it all builds up to make life a misery.'*
>
> **[Interview 23]**

However, case studies in three contrasting geographical areas of England illustrate that there is wide variation in local needs and responses. We recognise that the generally satisfactory picture presented by our three case-study hospital trusts will probably not hold for all sites. The trusts' willingness to participate is itself likely to be a positive bias. Interviewees in Trust C, for example, compared their working conditions favourably with those of another hospital in the city. Moore *et al.* describe action taken to increase recruitment of junior doctors to the Wirral Hospital NHS Trust after a number of problems were identified: 'inadequate personal support and career guidance, haphazard education, poor living and working environments and inappropriate working practices.[18]' Nevertheless, the empirical findings of the case studies raise a number of issues which are now addressed.

10.1 A MULTIPLICITY OF MECHANISMS

Through preparation for this study and interviews conducted during the study we have identified a large number of individuals, agencies and guidelines which have a role (actual or potential) in ensuring a health-promoting working environment for doctors. These are presented in Table 6.

Table 6. Protecting and promoting health at work: relevant guidelines, agencies, individuals

Guidelines

- The Health and Safety at Work Act 1974
- HSG(94)51 (Occupational Health Services for NHS Staff)
- The New Deal : minimum standards
- BMA Junior Doctors' Handbook

Agencies, services

- Regional Task Force
- Junior Doctors' Hours Committee
- Royal Colleges (accreditation)
- BMA
- Junior Doctors' Liaison Groups (mess, committees)
- Occupational Health Service
- Health at Work in the NHS

Individuals

- Trust Chief Executive (statutory responsibility)
- Medical Director
- Consultant as 'line manager'
- Clinical Tutor
- Women Doctors' Mentor
- Medical Staffing/Postgraduate Education Centre
- Accommodation Manager/Domestic staff
- Catering Manager
- Mess President
- BMA Junior Doctors' Representative

This list, which is unlikely to be exhaustive, suggests that there are in fact many mechanisms for setting and maintaining standards in the workplace. These include both policy documents which set out standards, and mechanisms by which these can be reviewed and problems addressed. Still other mechanisms

for controlling for aspects of a healthy working environment were proposed by interviewees. For example, one suggested a social audit of the hospital working environment as it affects the health of all employees; another suggested that each training post should be audited by the junior doctor who had just completed it, evaluating aspects such as the working environment, effectiveness of management and provision for support. Such an audit would be used to review training posts.

There are, however, limitations to existing mechanisms. The 'New Deal' makes comprehensive reference to aspects of the working environment and conditions which should be reviewed, but the guidelines state that 'Responsibility for achieving and maintaining high quality living and working conditions for doctors in training, as for other staff, rests with unit general managers'.[8] Thus review and action, although recommended, may be dependent on the priorities and interest of individuals within different settings. Some interviewees suggested that patient needs were prioritised over, for example, the need to improve doctors' accommodation. Such review and action might also depend on the existence of good working relations between different interested parties, such as doctors and managers. Similarly, although consultants as 'line managers' and trust managers also have a role to play in the maintenance of standards, their willingness and ability to do so may be dependent on levels of personal commitment and interest.

Implementation of 'New Deal' guidelines has been overseen by the regional task forces, which appear to have been instrumental in bringing about some changes described in the three trusts visited for this study. But some interviewees suggested that the ability of the task forces to insist on improvements to accommodation, for example, was linked to the financial resources which they had at their disposal. Furthermore, the work of the regional task forces is due to end, perhaps leaving a gap. The problem seems not to be a lack of mechanisms but a means of ensuring that mechanisms are used effectively at the local level and this appears to depend on the willingness and ability of individuals within trusts to ensure this.

10.2 THE CHANGING WORK ENVIRONMENT

As a result of changes in patient management, training of health care workers and the organisation of work itself, the hospital as a place of work is changing. Older interviewees in particular commented that the hospital appears to be less and less a focus of social life for junior doctors outside working hours. A number of factors are at work here, such as a decreasing requirement for doctors to be resident and less provision for recreational facilities on site. This – plus increased isolation which partial shifts may cause[19] – means that traditional forms of peer support may be in decline. Peer support is clearly important for job satisfaction and management of stress at work. Some juniors suggested peers are best placed to resolve individual problems of distress or stress, at least at an early stage.

> *'Most of us will go home and chat with friends and tensions are released that way ... if you've got a couple of friends you can do that.... The first thing to do is to get to the root of the problem and it's probably better to do it informally.'*
>
> **[Interview 2]**

But such an approach depends on the existence of structures which promote informal networks and encourage social relationships. If the changing working environment is indeed leading to a decline in opportunities for the development of such networks and relationships, it may be necessary to find new ways of creating these. One example is provided by Trust A where the postgraduate medical centre and medical staffing were amalgamated and attempts are made to make this a focus for junior doctors. (See page 13.)

In contrast, those we interviewed in primary care suggested that there is a move towards fostering networks among general practitioners who traditionally have been more isolated than their hospital colleagues. For example, the creation of GP localities in a health commission area was seen as a way of encouraging greater communication between general practitioners and the health commission, and among GPs themselves. Such local networks were envisaged as opportunities for peer support. Educational opportunities were also described as ways of preventing stress and burnout. The expectation of the preventative powers of participation in local networks and educational programmes has a commonsense appeal, but this is as yet untested and could usefully be investigated.

10.3 OCCUPATIONAL HEALTH: AN ON-GOING DEBATE

There are opportunities for occupational health services to contribute to the management of doctors' health, as the remit of OH outlined above makes clear. Within the specialism itself there is on-going debate about the future of OH, with calls for 'able consultants [to provide] services for their local areas as well as for their fellow employees.[20]' It has also been proposed that OH physicians could provide a service to general practitioners[6] and this possibility has been explored in all three of the study areas. However, as far as hospital doctors are concerned, there are a number of factors influencing the level of contribution that is actually made. These include the nature of the local service (whether consultant or nurse-manager led) and the pressure to generate income. Perhaps a greater barrier lies in the problem of doctors' perceptions of OH and reluctance to use this service and other formal medical services. This problem would need to be addressed before OH can take a more active role in the management of doctors' health and the provision of services.

10.4 PSYCHOLOGICAL SUPPORT

The need to provide doctors at all levels of training with opportunities for pastoral and psychological support was acknowledged by interviewees. Such support takes many forms: informal peer support dependent on informal social relationships, opportunities for personal development review and formal services offering counselling or therapeutic intervention. Responsibility for the provision of such support is not always clear, but seems to be shared among different agencies and roles. For hospital trainees for example, trust management, clinical tutors and consultants all have a part to play, but there appear to be limited opportunities for co-ordinated strategies. Again, the interest and ability of individuals appears to be a decisive factor. The role of consultants as managers of junior staff, with pastoral responsibilities (as well as responsibilities for training and service delivery) could be enhanced, one interviewee suggested, through training in management skills.

General practitioners, the health commission, LMC and regional advisers in general practice are all concerned with strategies for improving general practice (for example, by improving communications between GPs and the health commission and among GP practices). A desired outcome of such strategies is most certainly an enhancing of GPs' health, though this is not proven. These agencies may also become involved in organising care for individual GPs with health problems. Provision of specific services is not within their remit, although in one of the case study areas some were in fact involved in setting up a counselling service.

Although this is not necessarily represented by the three case studies presented here, there is now a growing number of local counselling services for general practitioners in England. Some of these at least seem to have arisen out of a response to a crisis situation and they seem to have required the initiative of individuals inspired 'to do something'. Thus they appear to depend on local perception of need and the commitment of local individuals. It will be important to monitor uptake of such services, encourage evaluation of these and disseminate examples of best practice.

10.5 A CO-ORDINATED RESPONSE?

There is some variation in local responses to the problems of doctors' health, both in terms of service provision and strategies to ensure that the working environment is health promoting. This variation depends on local needs but also on the quality of relationships between those with an interest in the area and the use which individuals in post make of available policy guidelines. For example, the London Health Commission participating in the study has prioritised the prevention and reduction of stress among GPs and has begun to develop strategies which aim to achieve this. In the other sites, fostering GPs' participation in locality system structures and supporting team development appeared to be a

more immediate priority for the health commissions. Among hospital trusts there is also variation in the level of priority which issues related to doctors' health seems to be given in terms of different responses to, for example, trainees' needs for pastoral care or procedures for consultation.

It might be argued that local responses reflect local needs, and certainly the clear priority to address stress among GPs in London reflects local difficulties in the recruitment and retention of GP principals. However, it was recognised by those interviewed that the approach to date has been fragmented with no clarity about who or which bodies have responsibility for ensuring that the identified health needs of the profession are met. The fact that there continue to be calls to address the problems of doctors' health suggests that it may not be enough to rely on purely local solutions being found and put into practice. In fact, given the tendency of doctors to seek help informally, real levels of need may be underestimated locally.

In its report 'Taking Care of Doctors' Health', the working party convened by the Nuffield Provincial Hospitals Trust proposed the establishment of independent regional bodies whose task would be to take an overview of doctors' health services and needs, to monitor these and to collect and disseminate information about services.[17] Such a mechanism might therefore provide a focus for the many parties which have some, but not complete, responsibility for meeting doctors' health needs.

The research provided an opportunity to elicit reactions to this proposal, although in fact only one interviewee had read the report at the time of interview. A wide variety of reactions was received. There was no particular pattern of association between profession or grade and the view reported. Some were enthusiastic and felt that the co-ordinated approach that such a body might take would be useful. Others felt there was merit in the proposal but that it should not apply exclusively to doctors but to all NHS employees. Some were not keen to see the establishment of a specific structure, fearing that it might be another level of bureaucracy or that it might be too prescriptive. Rather, it was suggested that existing structures (such as the GMC or LMCs) might be encouraged to include this role within their remit. Specific questions were raised about what the membership of such a body might be, and what powers to remedy gaps in provision it might have. Here a direct comparison was drawn with the regional task forces whose power was seen to reside in the funds it administered.

Therefore some mechanism to co-ordinate and oversee the implementation of strategies and interventions, and to ensure the exchange of local information and examples of best practice, might indeed be useful. But the form of such a mechanism needs to be such that it is acceptable to all the interest groups and is appropriate to a health system which is increasingly decentralised and yet has power above the ability to make recommendations.

Even in a small sample, such as those interviewed for this study, a very wide range of views was reported and so gaining the support of doctors for the proposed regional bodies is unlikely to be straightforward. If the proposal is to be carried forward, there is clearly a need to promote the idea more widely among the many interested parties to invite comment and obtain the support needed.

11 Recommendations

1. The Nuffield Provincial Hospitals Trust working party on doctors' health has proposed a strategy to oversee responses to the broad health needs of doctors. There appears to be a need to co-ordinate the activities of the many interest groups, but if the working party's proposal is to be advanced, wider consultation is needed to invite comment and create support from all interest groups. These include:

   - Royal Colleges and Faculties
   - NHS Management Executive trust executives
   - Junior doctors' representatives
   - Consultants' representatives
   - Current service providers

2. Mechanisms should be established to ensure that local counselling (and other) services for doctors are monitored and evaluated and the results of such research is systematically disseminated, especially to primary care staff in health commissions, local medical councils and hospital trusts.

3. Research (or a systematic review of available research) into the impact of the 'New Deal' on junior doctors' health is needed to improve efforts to reorganise workloads.

4. Where traditional structures for informal support among hospital doctors are diminishing, reflected in changing working patterns, decreasing importance of mess life and loss of recreational facilities, trust managers and others with a responsibility for doctors' pastoral welfare should ensure that new forms are created.

5. The study areas identified a number of new opportunities to provide peer support and to promote psychological health among GPs, arising out of local reorganisation of primary care. There is a need to investigate their existence and development nationally, and to evaluate their effectiveness.

References

1 Silvester S, Allen H, Withey C, Morgan M, Holland WW (1994). *The Provision of Medical Services to Sick Doctors.* London: Nuffield Provincial Hospitals Trust.

2 McKevitt C, Morgan M, Simpson J, Holland WW (1996). *Doctors' Health and Needs for Services.* London: Nuffield Provincial Hospitals Trust.

3 Caplan R. (1994). Stress, anxiety and depression in hospital consultants, general practitioners and senior health service managers. *British Medical Journal*, **309:** 1261–1263.

4 Ramirez AJ, Graham J, Richards MA, Gregory WM (1996). Mental health of consultants: the effects of stress and satisfaction at work. *Lancet*, **347:** 724–728.

5 HMSO (1974). *The Health and Safety at Work Act.* London: HMSO

6 NHS Executive (1994). HSG(94)51: *Occupational Health Services for NHS Staff.*

7 Health Education Authority (1994). *Health at Work in the NHS: Working Well: A Guide to Success.* London: HEA.

8 NHS Management Executive (1991). *The New Deal: Junior Doctors.* London: NHS ME.

9 British Medical Association (1994). *Junior Doctors' Handbook.* London: British Medical Association.

10 British Medical Association Junior Doctors' Committee (1991). *Junior Doctors: The New Deal.* British Medical Association.

11 Armstrong M (1996). BMA's helping hand for doctors. *British Medical Association News Review*, **22**(4): 6.

12 Keen J, Packwood T (1995). Case study evaluation. *British Medical Journal*, **311:** 444–446.

13 Dickson L, Heymann TD, Culling W (1994). What the SHO saw. *Royal College of Physicians of London*, **28**(6): 523–526.

14 Fisher EW, Moffat DA, Quinn SJ, Wareing MJ, Von Blumenthal H, Morris DP (1994). Reduction in junior doctors' hours in an otolaryngology unit: Effects on the 'out of hours' working patterns of all grades. *Annals of the Royal College of Surgeons of England*, **76**(Suppl): 232–5.

15 Porter M (1993). Failure of the new deal on juniors' hours. *British Medical Journal*, **307:** 1147 (letter).

16 Ministerial Group on Junior Doctors' Hours (1990). *Junior Doctors' Hours: Heads of Agreement*, Department of Health.

17 Nuffield Provincial Hospitals Trust (1996). *Taking Care of Doctors' Health: Reducing Avoidable Stress and Improving Services for Doctors' Health.* London: Nuffield Provincial Hospitals Trust.

18 Moore JK, Neithercut WD, Mellors AS, Manning D, Makin CA, Jones H, Alman RJ, Al-Bachari M (1994). Making the new deal for junior doctors

happen. *British Medical Journal*, **308**: 1553–1555.
19 Grainger C, Harries E, Ingrams G (1995). New deal shifts may increase house officers' stress. *British Medical Journal*, **311:** 952 (letter).
20 Seaton A, Agius R (1995). Occupational medicine: the way ahead. *Occupational and Environmental Medicine*, **52:** 497–499.

Appendix 1 Interview schedules

PROMOTING DOCTORS' HEALTH

Assessing the Organisational and Service Needs

HOSPITAL INTERVIEW SCHEDULE

Interviewee: .....

Interview date: .....

A. HOSPITAL DATA

1. Status
2. Number of beds
3. Number of medical staff:
   - consultants
   - junior grades

B. ACCOMMODATION

4. What accommodation is provided for staff who are required to be resident?
5. Is there both single and married staff accommodation?
6. Is there accommodation for between-duty periods?
7. Does the accommodation meet the 'New Deal' minimum standards?
   - *located within the hospital grounds (or, if not, conveniently located for the H)*
   - *rooms sound- and light-proofed*
   - *heating thermostatically controlled by occupant*
   - *serviced at least three times/week*
8. Does the accommodation meet the BMA two- or three-star rating?
   - *two star as above,* plus:
     - *direct dial telephone*
     - *radio and clock*
     - *tea- and coffee-making facilities*

- *three-star as above,* plus
  - en suite *bathroom and toilet*
  - *daily servicing*
  - *24-hour room service for light snacks*
  - *security patrols*
  - *door bell and intercom with main door*
  - *colour TV*
  - *adjacent car parking*

C. CATERING

9. Are catering facilities separate from those provided for patients and visitors?
10. Are meals for doctors in training '*adequate, varied, well presented, freshly prepared*' (BMA)?
11. What arrangements are there for out of hours catering (for example, after set meal times, middle of night) (*vending machines, microwave ovens?*)

D. OTHER FACILITIES

Recreation

12. Is there a doctors' mess? (*size, equipment, location*)
13. Are there on-site recreational/sports facilities? If not, is there any arrangement with local sports centre?

Parking

14. Are there special arrangements for doctors in training? (*reserved spaces, charges?*)

E. ROTAS/SHIFTS

15. What rota/shift systems are in operation?
16. Are there any particular problems associated with these?
17. What arrangements are there to cover a doctor who has taken sick leave?

F. COMPLAINTS AND REVIEW PROCEDURES

18. Is there a complaints and review procedure? (*system, uptake*)
19. Do junior doctors have a formal structure to meet and discuss problems, and voice these to management?

20. Who has overall responsibility for pastoral care of junior doctors? (*how appointed, duties, publicity, accessibility*)

G. COUNSELLING SERVICES

21. Are counselling services currently available for medical staff?
22. If so, how, when, why did these come to be set up?
23. How are these funded?
24. How are these advertised?
25. What uptake is there?

H. NEEDS FOR SERVICES

26. Have any particular initiatives been undertaken to address the health needs of doctors here?
27. What are your views on how doctors' needs for services might best be met in this area? *(special services, encouraged to use existing services, body with responsibility to oversee)*

PROMOTING DOCTORS' HEALTH

Assessing the Organisational and Service Needs

LMC, FHSA INTERVIEW SCHEDULE

Interviewee: .....

Interview date: .....

1. What, if any, is the role of the (FHSA) (LMC) in issues related to GPs' health?
   - monitoring
   - providing information
   - providing support *(i.e.?)*
2. How would particular problems be made known to the (FHSA) (LMC) and what possible courses of action would you be able to take?
3. In general terms, what are the health problems of GPs in this area?
4. Do GPs in this area have particular needs for health services?
5. What mechanisms of support are available to GPs?
6. Have any particular initiatives been undertaken to address the health needs of GPs here?
   - counselling services
   - support groups
7. In your view, are the health problems and service needs of GPs different from those of hospital doctors?
8. What are your views on how doctors' needs for services might best be met in this area?
   - special services
   - encouraged to use existing services *(how?)*
   - body with responsibility to oversee

Appendix 2 Individuals interviewed for the study

AREA A

Hospital Trust

1. Medical Director
2. Junior Doctors' Representative
3. Postgraduate Education Centre Manager
4. Occupational Health Services Manager

Primary Care

5. Chairman, Local Medical Committee
6. Associate Director, Provider Development
7. Regional Adviser in General Practice
8. Consultant in Public Health Medicine9. Health Commission GP Consultant

AREA B

Hospital Trust

10. Medical Director
11. Postgraduate Clinical Tutor
12. Women Doctors' Mentor/Counsellor
13. Junior Doctors' Hours Representative
14. Mess President
15. Occupational Health Consultant (locum)
16. Personnel Manager, Medical Staffing
17. Residence Manager

Primary Care

18. Secretary, Local Medical Committee
19. Director of Localities and Service Delivery
20. General Practitioner, support group co-founder

AREA C

Hospital Trust

21. Medical Director
22. Junior Doctors' Mess President
23. Occupational Health Consultant
24. Personnel Assistant, Medical Staffing

Primary Care

25. Chairman, Local Medical Committee
26. Consultant in Primary Medical Care

OTHERS

27. Director of Public Health NHS Executive
28. Director of Counselling in Primary Care
29. RCGP & DH Stress Fellow
30. Lecturer in Psychology, Evaluator of counselling scheme

Appendix 3 The 'New Deal': outline of aspects covered

The NHS Management Executive documents detailing the 'New Deal' cover a wide range of aspects of working conditions for junior doctors in training agreed as part of the new contract.[8]

These include:

- hours and patterns of work
- provision of resident and on-call accommodation
- minimum standards for such accommodation
- catering arrangements for doctors in training
- mechanisms for complaints
- the need to provide induction courses
- the need to provide a job description covering living and working conditions, duties, training available
- access to library
- personnel: the need for links between medical staffing and doctors in training
- recreational and other facilities including, mess, parking and sports facilities
- guidance on regional task forces' role
- the development of support from nursing, technical, administrative and clerical staff and support systems.

Appendix 4 The BMA Accommodation Charter

The BMA Accommodation Charter proposes a three-star rating system for accommodation for doctors in training.[9] These are as follows.

One-star standard

'New Deal' minimum standards with the following additions:

- rooms should be sound- and light-proofed
- rooms should be serviced at least three times a week
- heating should be thermostatically controlled and adjustable by occupant

Two-star standard

One-star standards with the following additions:

- rooms should contain a direct-dial telephone
- rooms should contain a radio and clock
- rooms should have tea- and coffee-making facilities

Three-star standard

Two-star standards with the following additions:

- rooms should have *en suite* bathroom and toilet
- rooms should be serviced daily, including weekends and bank holidays
- 24-hour room service for light snacks
- 24-hour security patrols
- rooms should have designated door bell and intercom with main door
- rooms should have a colour TV
- car parking adjacent to the building