Saturday 5 May 2001

BMJ

Why are doctors so unhappy?

There are probably many causes, some of them deep

See editorial p 1078
News pp 1082, 1083

BMJ 2001;322:1073–4

Doctors are unhappy. They are not all unhappy all the time, but when doctors gather, their conversation turns to misery and talk of early retirement. The unhappiness has been illustrated in a plethora of surveys and manifests itself in talk of a mass resignation by general practitioners from the NHS.[1] The British government is rattled by the unhappiness of doctors, recognising that a health service staffed by demoralised doctors cannot flourish. It has responded by trying to hand more control of the service to frontline staff.[2 3] But is this the right treatment? Treatment must, of course, follow diagnosis, and the causes of doctors' unhappiness may be many and deep.

The most obvious cause of doctors' unhappiness is that they feel overworked and undersupported. They hear politicians make extravagant promises but then must explain to patients why the health service cannot deliver what is promised. Endless initiatives are announced, but on the ground doctors find that operating lists are cancelled, they cannot admit or discharge patients, and community services are disappearing. They struggle to respond, but they feel as though they are battling the system rather than being supported by it.

Those in the NHS are the last survivors of a socialist inspired system. In a society that pays a businessman £500 000 a year and many public servants £10 000, they try to patch up the social and health damage that accompanies such divisions. It's difficult, if not impossible, work. And, worse, it is undertaken against a backcloth of negative media coverage. Dr Kildare has been replaced by Dr Shipman, and stories of errors outnumber tales of triumph.

Government ministers look down on the health service and don't quite understand. Resources are being increased in real terms. General practitioners have more time with patients than they had 20 years ago. Doctors are more and more involved in running the service—as czars, medical or clinical directors, or members of primary care groups. Dozens of initiatives—national service frameworks and health action zones—are being developed to counter problems that doctors have been highlighting for years. And the ministers work harder than anybody—criss crossing the country, chairing task forces, doing their ministerial work in the morning, answering parliamentary questions in the afternoon, and conducting surgeries on Saturday mornings.

Ministers are thus likely to diagnose doctors' unhappiness in terms of diminished control, more change, and increased accountability. It's impossible to reverse the increasing accountability. This is a worldwide phenomenon that affects not only doctors. Similarly, ministers cannot imagine slowing the pace of change. They live in a world where escalation of promises is routine. Ministers thus fall back on "sweeping away bureaucracy and giving more control to frontline staff," not least because nobody wants more bureaucracy. Health workers might, however, want better management of the service, and they themselves might not be the best people to do this.

And here we come to something deeper—the mismatch between what doctors were trained for and what they are required to do. Julian Tudor Hart, a general practitioner who retired recently, observed that what he learnt at medical school didn't serve him well for hospital medicine, which in turn didn't serve him well for general practice. In other words, he started three times as a doctor. But maybe now it's more extreme.

Doctors and patients: redrafting a bogus contract

The bogus contract: the patient's view

- Modern medicine can do remarkable things: it can solve many of my problems
- You, the doctor, can see inside me and know what's wrong
- You know everything it's necessary to know
- You can solve my problems, even my social problems
- So we give you high status and a good salary

The bogus contract: the doctor's view

- Modern medicine has limited powers
- Worse, it's dangerous
- We can't begin to solve all problems, especially social ones
- I don't know everything, but I do know how difficult many things are
- The balance between doing good and harm is very fine
- I'd better keep quiet about all this so as not to disappoint my patients and lose my status

The new contract

Both patients and doctors know:

- Death, sickness, and pain are part of life
- Medicine has limited powers, particularly to solve social problems, and is risky
- Doctors don't know everything: they need decision making and psychological support
- We're in this together
- Patients can't leave problems to doctors
- Doctors should be open about their limitations
- Politicians should refrain from extravagant promises and concentrate on reality

Trained in pathophysiology, diagnosis, and treatment, doctors find themselves spending more time thinking about issues like management, improvement, finance, law, ethics, and communication. Luke Filde's 19th century painting of a contemplative doctor alone with a sick child might now be replaced by a harassed doctor trying to park his car to get to a meeting on time. The gratification that comes from curing a sick child is different from that which comes from being part of the meeting that agrees to take an abused child into care. Christian Koeck—a doctor, professor of health policy, and member of the *BMJ* editorial board—thinks the problem goes deeper. He thinks the intellectual model of medicine is wrong and that instead of being trained simply to apply the natural sciences to peoples' health problems doctors should also be trained as change managers. That way they can help people adjust to the sickness, pain, and death that are central to being human.

Another way to think about doctors' unhappiness is to think of the change in the contract between doctors and patients. We hear much about doctors changing from being authorities to being partners with patients, and some find this transition unsettling. But perhaps the change is deeper still. Maybe we are changing from what has become a bogus contract between doctors and patients to something more real (see box). Doctors are often acutely aware of the limitations of what they can do, whereas patients—partly through the exaggeration of doctors—have inflated ideas of the power of medicine. Negative media coverage might represent the world's waking up to the limitations of doctors and medicine, and—though it's uncomfortable now—it may lead to a much more honest, adult, and comfortable, relationship.

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1 Kmietowicz Z. GPs shut surgeries in protest at government targets. *BMJ* 2001;322:1082.
2 Klein R. Milburn's vision of a new NHS. *BMJ* 2001;322:1078-9.
3 Wise J. Milburn to shift power to health staff. *BMJ* 2001;322;1083.

Is transmitted drug resistance in HIV on the rise?

It seems so

Papers p 1087

The transmission of drug resistant variants of HIV-1 has the potential seriously to limit the therapeutic options of newly infected patients. The selection of HIV drug resistant variants among individuals who are already receiving treatment also clearly limits both the size and duration of the viral supression induced by drug treatment.[1 2] Reports from North America and Europe indicate that up to 14% of recently infected patients have been infected with a strain of virus bearing well characterised drug resistance mutations (in 1-10% of cases) or reduced susceptibility to a particular drug (2-14% of cases).[3–5] Temporal trends in the transmission of drug resistance for these populations are not yet available, but a paper from the United Kingdom in this week's *BMJ* suggests an increase in the risk of being infected with drug resistant HIV virus between 1994 and 2000 (p 1087).[6]

Estimates of the likelihood of transmission vary depending on the type of exposure and the magnitude of viral load in the HIV infected partner.[7] An incomplete understanding of the biological factors that influence viral transmission further limits the accuracy of projected estimates of transmitted drug resistance. In order to interpret the relative prevalence rates of drug resistance among recently infected subjects we must consider the route of exposure (mucosal or blood borne), possible geographical variations, detection assay type (genotype *v* phenotype), susceptibility threshold (for phenotypic assays) or type of mutations considered (for genotypic assays), and perhaps HIV subtype (non-B *v* B *v* recombinant subtypes). Available assays generally identify only the resistance profile of the predominant viral variant in the infected subject. In the absence of drug selection pressure, reversion to a more replication competent, perhaps drug susceptible, variant may occur, which may in turn preclude the detection of drug resistant variants. Prevalence estimates of transmitted drug resistance in newly infected patients should not therefore be generalised to patients with established infection who have not yet started treatment with antiretroviral drugs, who may harbour drug resistant variants within archived latent reservoirs of virus that may re-emerge in the presence of drug selection pressure.

In the study this week from the UK Collaborative Group on Monitoring the Transmission of HIV Drug Resistance, 69 subjects who developed HIV infection during 1994–2000 were evaluated for resistance within 18 months of their infection; none had received treatment with antiretroviral drugs at the time of resistance testing.[6] Genotypic resistance was detected in 14% of the subjects, 3% with mutations conferring drug resistance to all three of the available classes of antiretroviral drugs. These estimates are consistent with previous reports of transmitted drug resistance in recently infected subjects.[3–5] These investigators also identified an increase in the prevalence of transmitted drug resistance during the period of study, with drug resistant variants detected in 27% of subjects identified in 2000. Significant increases in the prevalence of transmitted drug resistance have been reported from North America during this same period.[8]

The clinical importance of transmitted drug resistance, particularly using different thresholds of susceptibility, has not been established. However, among patients already established on treatment there is generally good correlation between genotypic and phenotypic markers of resistance and virological responses to treatment.[9]

Methods to improve drug adherence and targeted HIV prevention messages may ultimately reduce the risk of transmitted drug resistance. However, the study this week from the UK group clearly identifies the urgency that needs to be associated with these steps.

BMJ 2001;322:1074–5