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Changing society: changing role of doctors

The stresses must not be allowed to get too great

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The role of the doctor has changed drastically since the 1930s and 1940s, when practitioners struggled with unbelievably large numbers of patients in their districts. Today the numbers of patients are much smaller, but their qualitative demands are much higher. At the same time the high status of the doctor has been diminished. These chang›ing patterns of work and position in society are creating new, and damaging, stresses.

Our own studies in the 1980s at the Swedish National Institute for Psychosocial Factors and Health showed that doctors had longer working hours and more exposure to shiftwork schedules (being on call) but also more stimulating work than men and women in most other occupations.[1] Doctors also claimed that in relation to most aspects of their work they had rea›sonable control over their working situation —more than in most other occupations. Since then the situation has changed.

Recent studies of the working population in Sweden show that both female and male doctors report both high demands and little ability to control their work, in comparison with other occupations.[2] In the terminology of "demand›control"[3] this indicates job strain. Furthermore, the differences between doctors and other healthcare workers have dimin›ished, with most healthcare workers having low scores for ability to control their work. Everyone in health care thus seems to be in the same boat in relation to these demands.[4]

It's hard to combine work with family life

One of the most important changes in role has to do with gender roles and family pressure. How do doctors combine a very demanding working life with a normal family life? In this issue of BMJ Dumelow et al describe an interview study of hospital consultants in Britain (p 0000).[5] They have introduced new terminol›ogy to describe three different strategies that men and women adopt to try to manage both a family and a demanding career: "career dominant," "segregated," and "accommodated."

The career dominant strategy (15% of the women and 3% of the men) implies a continuous, full time career and a reduced family life—living single or divorced and childless as a consequence of the career. The segregated strategy (55% of the women and 85% of the men) implies a continuous, full time career with family roles organised so as to enable more time to be devoted to the career. The accommodating strategy (30% of the women and 12% of the men) implies that work involvement has been reduced in some way to allow more time for family roles.

Women consultants stated that the segregated strategy was the most successful in terms of both fam›ily and career whereas male consultants found this strategy less satisfying for family life. The career domi›nant and accommodating strategies were assessed in the same way by both men and women—the first good for the career and bad for the family and the second good for the family and bad for the career. The differ›ence in attitude to the segregated strategy reflects gen›der roles, which are changing very slowly. Female doctors react psychophysiologically, with more arousal than male physicians when they get home after work.[6] Analyses of emotional states recorded in diaries during the round of daily life in several occupations show that doctors have more emotional reactions, positive as well as negative, during their working day than those in other occupations,[7] and this has been particularly evident in female physicians.

Women may be more sensitive than men

The gender difference may also teach us something about the doctor's role in general because women may be more sensitive than men to emotional demands made on doctors. In the old era, when the numbers of patients were very large, the system allowed very little scope for emotional demands from patients. This is different today: patients demand empathy, and doctors (women more than men, perhaps) feel that demand on them to show empathy. This may be one reason why women doctors have tended to have a higher suicide rate than male doctors.[8] In a period of restricted spending on health care, which is occurring in most Western countries, these demands may create insur›mountable pressures.[9]

A study of life events has shown that doctors report more negative life events dealing with deaths and illnesses among friends and relatives than do other working men and women.[10] The explanation of this is probably that friends and relatives (who may be relatively distant from the physician socially and would accordingly not be recorded as friends or relatives in life event explorations by other men and women) con›tact the doctors in their social network when they become ill. This may develop from informal consulta›tions to very close ties, and as a consequence deaths and serious illnesses among these friends and relatives are more often recorded as critical life events.

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So far, faced with these pressures, women have tended to select a less career oriented life. Even in the late 1980s the labour market in Sweden was very gender segregated.[11] But as the proportion of women doctors increases, other solutions will have to be found: a more humane situation must be created.

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Fluctuations in lower urinary tract symptoms in women

Reassurance and watchful waiting can prevent overtreatment

Urinary symptoms are common in both men and women. Traditionally "prostatism" has been used to describe the symptoms in men, while urinary incontinence and dysuria were used for women.[1] For some years the term lower urinary tract symptoms (LUTS) has been used to describe any constellation of symptoms occurring in patients of either sex at any age. The symptoms are not disease specific and the term does not suggest any cause for the symptoms. It has been shown that instruments developed to score symptoms in men (for example, the international prostate symptom score scale) are not sex specific, as the symptoms are as prevalent in women as in men.[2 3]

Lower urinary tract symptoms may come and go

In this issue Møller et al (p 1429) present data on the incidence and rates of remission at one year of lower urinary tract symptoms in 2284 Danish women aged 40-60.[4] The prevalence was 29%, the incidence 10%, and the rate of remission was 28%. The authors state that lower urinary tract symptoms are common and they may come and go. These findings may have important clinical implications. But the magnitude of the results may be biased by the design of the study and the definitions used.

Several validated questionnaires have been used in similar studies but they emphasise different aspects of the disorder. For example, in this study women were not asked about dysuria and the popular concept of overactive bladder, but incontinence is extensively covered. Incidence was defined rather unusually as the proportion of women who either developed symptoms or whose symptoms increased from sometimes to weekly or more than weekly. Similarly, remission was defined not only as the disappearance of symptoms but also as a fall in the frequency of symptoms to less than weekly.

Research into incontinence has shown that estimates of prevalence and incidence can change dramatically when different thresholds and definitions are used and that remission rates are high.[5 6] Caution should therefore be used in applying epidemiological data to a clinical context: there is a large transitional zone between healthy and diseased, hence there is a risk of medicalisation and overtreatment.[6]

Most people with urinary incontinence and LUTS do not seek help from health professionals.[6] Many suffer with their illness, despite the availability of good symptomatic treatment. However, for many people with mild or occasional symptoms it is probably reasonable not to seek help. Møller et al's study introduces another factor into this debate: symptoms fluctuate, and there is a good chance that people will have fewer symptoms or even stop having them within a reasonable time.

When a patient consults it is the responsibility of the doctor to make a proper working diagnosis and suggest treatment options. But it is also the practitioner's responsibility to protect patients from unnecessary investigations and treatments. The general practitioner usually knows if the patient has other illnesses and is already taking medication. LUTS is particularly suitable for management in primary care: patients with urinary incontinence and overactive bladders have been shown to be well cared for in general practice.[7 8] Patients should, however, be referred when there is suspicion of organic disease. Patients whose symptoms have changed significantly should be seen urgently by a specialist.

The patient's view of the problem is important

The decision not to treat patients should be based largely on how much their symptoms interfere with daily activities and how willing they are to wait and see if they need medication. Individuals' opinions of what symptoms are bothersome vary considerably; the patient's overall view of the problem is therefore as important as clinical scores.

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