Editorial

Stress among doctors and nurses in the emergency department of a general hospital

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O that this too too solid flesh would melt,
Thaw, and resolve itself into a dew!
Or that the Everlasting had not fix'd
His canon 'gainst self-slaughter! O God! O God!
How weary, stale, flat and unprofitable
Seem to me all the uses of this world!
— Hamlet, act I, scene 2

Since Freudenberger[1] defined "burn out" 13 years ago, interest in stress syndromes among professionals has increased,[2] and reports on the impact of stress and stress-related illnesses on the delivery of health care have begun to appear.[3,4] Although all health care providers are exposed to severe stress at one time or another, physicians and nurses who practise the critical care specialty emergency medicine may be exposed to severe stress most of the time.

"Burned-out" physicians or nurses may feel that their needs for a sense of personal competence, recognition by colleagues and professional stimulation are not being met.[5] Diminished job satisfaction inevitably results in negative attitudes toward one's work, family, patients, colleagues and, ultimately, self.[6]

Sources of stress

Time pressure

Emergency department personnel work in a charged atmosphere that is overloaded with sensory stimuli (ringing phones, rushing people, beeping monitors), all in a framework of urgency that may change dramatically from one minute to the next. The quietest day may suddenly become extremely hectic. Rapid disposition of patients may be necessary to make space for patients in more critical condition.

Critical decisions

Emergency department staff must continually distinguish between patients who are simply worried, those who have minor illnesses, those who are candidates for sudden deterioration and those who are critically ill.[7] Initial evaluation and stabilization take priority over detailed history-taking and physical examination. The series of checks, rechecks and consultations available for in-hospital care is not possible in the emergency department. Decisions are not easily reversible. The fear of making an irrevocable mistake is always present.[8,9]

Provider–patient dissonance

Many people who present at an emergency department are bypassing their own physicians in search of a secure hospital environment for immediate treatment.[10,11] Many others seem to regard the emergency department as the first line of delivery of health and social services. About half the cases seen in the emergency department are not considered true emergencies.[10] Yet emergency medicine is becoming a more technical specialty, emphasizing critical care in the management of shock and trauma.[12]

Patient stress

Patients often present to the emergency de-

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partment unprepared, upset and in a personal crisis. Suicidal and psychotic patients are often brought in against their will. The need to rapidly establish trust and rapport with people they have not seen before places emergency department staff under additional stress.

Professional relations

Many emergency department nurses have had years of experience and have assumed physicians' duties that nurses in other areas of the hospital have never had to perform. Territorial disputes and struggles for dominance between physicians and nurses may result. Inadequate leadership, bureaucratic practices and poor working conditions are other factors that impair professional functioning.[5]

Treatment and prevention

Burned-out physicians and nurses are often reluctant to seek help, seeing such a request as a threat to the public's, and their own, confidence in their ability and self-image. Emergency department staff will usually respond to burn out by working at their usual level or even harder when good sense and judgement indicate otherwise.[13]

Most researchers have focused on tertiary interventions for physicians who are alcoholic, addicted to drugs, or emotionally or mentally unstable.[14,15] Methods of primary prevention, such as those that follow, are rarely discussed.

Education

Personnel selection should be based on needs and realistic expectations as well as on credentials. Supervisors should clarify the objectives of their program and avoid bureaucratic intrusion in day-to-day professional activities. To minimize family and mental discord emergency department personnel should participate in relaxing and enjoyable activities that are unrelated to work.[14]

Mutual support

Peer groups provide role models with whom to identify, receive feedback and encourage creative solutions to difficult situations. These groups can serve as a forum for ventilating about difficult problems, unexpected deaths and grief, thus reducing the health care worker's need to block out such emotions. The feelings of guilt, shame or omnipotence are lessened, and morale is improved.[16]

Control of working hours

Within a 24-hour work period the level of performance peaks within 6 to 10 hours, then drops off to a low at about 22 hours. Thus, shifts of more than 12 hours, especially when associated with sleep and circadian cycle alterations, may lead to poor performance.[17]

Orientation of nurses

Nurses should initially receive a structured orientation with graded responsibilities, formal instruction and close supervision.[18,19] Repetitive tasks should be balanced with more challenging and professionally satisfying activities organized around standard protocols or delegated functions. To prevent burn out and attract and retain the best emergency department nurses career ladders, incentives for upward mobility and sharing of patient care with physicians will play a very important role.

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