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Trainees' forum

Strain and stress in palliative care

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The Royal College of Psychiatrists' Guidelines for Training in Liaison Psychiatry (1988) recommend that trainee psychiatrists have the opportunity of working closely with an individual ward or department. Such an attachment may involve the trainee psychiatrist in staff support. This paper describes the involvement of a psychiatric trainee in the development of support structures in a hospice during a liaison attachment. The project not only shed light on the causes of staff strain in palliative care settings, but also provided an opportunity to participate in management.

The project

St Oswald's Hospice was opened in 1987 and provides a palliative care service to the Newcastle district. The service consists of in-patient, day-patient and out-patient facilities. There are 70 salaried employees, which include medical, nursing, social work, physiotherapy, administrative and ancillary staff. A liaison psychiatry service has been available since the opening of the hospice and is provided by a senior trainee.

After discussion between the hospice managers and the liaison psychiatrist, it was decided to embark on a project to assess the nature of the stressors to which staff were exposed and to determine the effects they were having so that appropriate measures could be taken. The project consisted of two components: a questionnaire survey followed by staff discussion.

Part 1. The survey

The survey was based upon a model of psychological strain and stress derived from mechanical concepts described by Milne & Watkins (1986). In this model stress is conceived as the load placed on an individual; strain is the level of symptoms experienced by the individual and strength is the individual's coping skills.

In the survey, acute and continuing stressors were identified by an open format questionnaire in which respondents were asked to describe a recent stressful situation at work and the work factor they dislike the most. An item to identify sources of job satisfaction was also included. The 28 item version of the General Health Questionnaire (GHQ-28) (Goldberg & Williams, 1988) was used to measure strain. Coping skills were measured using a modified version of the Coping Resources Questionnaire (Billings & Moos, 1981). A further item was included which asked respondents to indicate the staff group to which they belong. The above questionnaires were sent to all staff members in April 1990 with an explanatory letter. A reminder was circulated a month later.

Findings

Forty-two fully completed sets of questionnaires were returned out of 70 (60%). There was no difference in response rate between clinical (i.e. medical, nursing, and physiotherapy) staff (59%) and non-clinical (i.e. administrative, clerical and ancillary) staff (62%).

Using a GHQ cutoff score of 4/5, 20 (48%) respondents were identified as 'cases'. There was no significant difference in prevalence of 'caseness' between clinical (12/27, 44%) and non-clinical (8/15, 53%) staff groups.

There was no difference between the CRQ scores of clinical and non-clinical staff and between 'cases' and 'non-cases'.

Poor communication with colleagues was the most frequently cited acute stressor, given by 30% of the sample.

The most frequently quoted chronic work stressor was a perception of not being valued (23%), followed by poor communication (19%) and time pressure (19%), the latter being given solely by clinical staff.

Involvement in the delivery of care was the most frequently given positive work factor (55% of respondents).

Part 2. Dissemination and discussion

The results of the survey were then disseminated among the staff and meetings were convened to discuss them.

Several points were discussed at the staff meetings. It was noted that the prevalence of 'caseness' was as high among non-clinical as clinical staff and that the CRQ scores indicated that the amount of strain in the hospice was attributable to the work environment rather than to individual factors. The major causes of strain were remarkably similar in the two groups of staff: poor communication and a feeling of being isolated from decision making processes. It was agreed that identification with the hospice's ethos of providing high quality care was the main source of job satisfaction.

The discussion led to the identification of a number of factors underlying the major stressors most of which were structural and were consequences of the expansion of the hospice.

After a month a further staff meeting was convened to generate solutions to the problems which had been identified. On this occasion ideas were brain-stormed and discussed by the meeting.

More than 50 ideas were generated, ranging from the profound, such as the introduction of individual performance review for all staff, to the prosaic, for example, purchasing a dishwasher for the ward kitchen.

A report was then collated and delivered to the management council of the hospice for consideration and implementation.

Comment

The Royal College of Psychiatrists' Guidelines for Training in Liaison Psychiatry (1988) suggest that trainee psychiatrists in liaison attachments to other departments may convene staff support groups. If this suggestion had been followed then it is possible that many of the issues and solutions would not have been identified. A further advantage of the strategy employed in the project was that the involvement of staff in the process of bringing about improvements demonstrated a model for overcoming the major stressors identified in the survey.

Being involved in this project had benefits beyond those usually gained during liaison attachments: firstly as a research project and secondly as a practical exercise in staff management. In the light of the desirability of trainee psychiatrists having 'hands on' management experience (CTC Working Party Report, 1990), participation by trainees in further projects of this type may become a more common feature of clinical attachments.

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