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Impact of Work Stress on Mental Health of Casualty Medical Officers at Government Hospitals, SWAT, Pakistan

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ABSTRACT

The study was aimed to investigate the impact of work stress on mental health of casualty officers at District Swat. The study was significant in this way that present government at Tehsil, district, division or even at provincial level may schedule the working hours of the medical officers to work at casualty departments and also can provide the necessary facilities to get rid off from over burden and mental stress. The study was also beneficial in this regard that, the future researchers can also investigate the hurdles faced by the medical officers during their duties into the hospitals.

All medical officers working in government hospitals of Khyber Pakhtunkhwa were constituted the population of the study. The scope of the study was delimited to the district Swat. Four government hospitals of district Swat were used to take sample of the study. Thus twenty medical officers working in casualty department were taken randomly from these four hospitals

as sample of the study. A questionnaire was prepared for medical officers, which was used as research instrument to collect data for the study. After collecting data through questionnaire from medical officers, data was presented in tabular form and then data was analyzed and manipulated by using appropriate statistical tools. Different problems were highlighted after analyzing the data and then suitable suggestions were made to remove mental stress of the medical officers working in casualty departments.

Key Points: Stress, Mental, Medical, Hospitals, Hurdles, Casualty, Health

Introduction

Education assists harmonious development of the individual. It increases the economic, social and political adjustment of the individual in the society. Education is an essential prerequisite for an efficient and equitable development process. It is a recognized fact that without a minimum education level for the entire population, a human centered development process cannot be sustained (Shami, 2005).

The education is becoming one of the defining enterprises of the 21st century with the emergence of globalization and increasing global competition. In the fast changing and competitive world, education and technology are the master keys for respectable survival and progress of Pakistan. Pakistan is determined to respond positively to emerging needs, opportunities and challenges of globalization. Education is being considered a key to change and progress. Progress and prosperity of the country depends on the kind of education that is provided to the people (Shami, 2005).

"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 changing patterns of work and position in society are creating new, and damaging, stresses" (Theorell T., (1989).

"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". They have introduced new terminology 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” (Dumelow C, Littlejohns P, Griffiths S., 2000).

An Emergency Department is really a scaled down version of a complete hospital, in effect a mini-hospital offering the same full breadth of patient care and administrative processes, albeit in a time abbreviated manner. Just as would occur to a patient being admitted as an inpatient at a full-service hospital, every ED patient goes through a registration and administrative intake process, a series of diagnostic testing encounters, one or more therapeutic interventions, and finally a disposition/discharge process, all of which take place, for the most part, within the four walls of the Emergency Department.

Emergency Departments’ patients must be registered into the hospitals information system and have their demographic and insurance information properly obtained. The patients managed care organization may need to be notified. Typically, the patient is initially assessed by a nurse (typically the .triage. nurse), who makes an initial judgment of how rapidly emergency care needs to be rendered. Then the patient is evaluated by a physician, who often orders a series of patient and problem-specific diagnostic tests such as x-rays, electrocardiogram, and blood tests. That physician may need to make multiple contacts to obtain information about the patient from the patients’ personal physician, from prior medical records, from the family, from information available at other hospitals. Depending on the emergency physicians’ assessment, a series of therapeutic interventions are then initiated, some definitive, others merely the first of many. The patient may be moved into other areas of the hospital in order to have certain tests done, particularly radiologic and other imaging tests. While this is all happening, the patient is continuously being monitored and reevaluated by machines, nurses, and physicians. Depending on information obtained by this continuous monitoring, a previously chosen course of diagnostic testing or therapeutic intervention may need to be modified. Many patients have complicated social and psychological dimensions in addition to their medical problem, all of which must be sorted out if the ED encounter is to be fully successful. At some point, a decision is made as to whether the patient needs to be admitted to the hospital or can be safely discharged home. An administrative disposition process then occurs in which the patients’ ED encounter is administratively closed out. No two paths through this system are the same for any two patients. Decisions by emergency physicians and emergency nurses as to what specifically to do next for

the patient are continuously being made and modified based on information about the patient that reveals itself and unfolds in real time.

Review of Literature

According to the *Child and Adolescent Emergency Department Visit Data Book*,[1] there are 31 447 000 child and adolescent visits to emergency departments (EDs) every year, corresponding to an annual rate of 41.2 visits/100 persons. Of these, 13 562 000 child and adolescent visits per year (17.8 visits/100 persons) were injury related. Children younger than 3 years represent the largest proportion of medically and injury related visits in this sample (Weiss HB, Mathers LJ, Forjuoh SN, Kinnane JM.,1997).

The Consumer Product Safety Commission surveyed a sample of 101 hospitals with EDs that were enrolled in the National Electronic Injury Surveillance System to identify the state of preparation of hospital EDs for managing pediatric emergencies.[2] The survey results were extrapolated to the estimated 5312 hospitals in the United States that have EDs. Although less than 10% have pediatric EDs or intensive care services, 76% admit children to their own facilities, and 25% of hospitals without trauma services admit critically injured children to their own facilities (Athey J, Dean JM, Ball J, et al. (2001).

Guidelines for Administration and Coordination of the Ed for the Care of Children

Provincial-Local Governments

1. A Physician Coordinator for Pediatric Emergency Medicine is appointed by the ED Medical Director.

i. The Physician Coordinator has the following qualifications;

a. The Physician Coordinator meets the qualifications for credentialing by the Hospital as a specialist in emergency medicine, pediatric emergency medicine, or pediatrics.

b. The Physician Coordinator has special interest, knowledge, and skill in emergency medical care of children as demonstrated by training, clinical experience, or focused continuing medical education.

c. The Physician Coordinator may be a staff physician who is currently assigned other roles in the ED, such as the Medical Director of the ED, or may be shared through formal consultation agreements with professional resources from a hospital capable of providing definitive pediatric care.

ii. The Physician Coordinator is responsible for the following;

a. Ensure adequate skill and knowledge of staff physicians in emergency care and resuscitation of infants and children.

b. Oversee ED pediatric quality improvement (QI), performance improvement (PI), and clinical care protocols.

c. Assist with development and periodic review of ED medications, equipment, supplies, policies, and procedures.

d. Serve as liaison to appropriate in-hospital and out-of-hospital pediatric care committees in the community (if they exist).

e. Serve as liaison to a definitive care hospital, which includes a regional pediatric referral hospital and trauma center; EMS agencies; primary care providers; health insurers; and any other medical resources needed to integrate services for the continuum of care of the patient.

f. Facilitate pediatric emergency education for ED health care providers and out-of-hospital providers affiliated with the ED.

2. A Nursing Coordinator for Pediatric Emergency Care is appointed.

i. The Nursing Coordinator has the following qualifications;

The Nursing Coordinator demonstrates special interest, knowledge, and skill in emergency care and resuscitation of infants and children as demonstrated by training, clinical experience, or focused continuing nursing education.

ii. The Nursing Coordinator is responsible for the following;

a. Coordinate pediatric QI, PI, and clinical care protocols with the Physician Coordinator.

b. Serve as liaison to appropriate in-hospital and out-of-hospital pediatric care committees.

c. Serve as liaison to inpatient nursing as well as to a definitive care hospital, a regional pediatric referral hospital and trauma center, EMS agencies, primary care providers, health insurers, and any other medical resources needed to integrate services for the continuum of care of the patient.

d. Facilitate ED nursing continuing education in pediatrics and provide orientation for new staff members.

e. Provide assistance and support for pediatric education of out-of-hospital providers affiliated with the ED.

f. Assist in development and periodic review of policies and procedures for pediatric care.

g. Stock and monitor pediatric equipment and medication availability.

Guidelines for Physicians and Other Practitioners Staffing the Ed

1. Physicians staffing the ED have the necessary skill, knowledge, and training to provide emergency evaluation and treatment of children of all ages who may be brought to the ED, consistent with the services provided by the hospital.

2. Nurses and other practitioners have the necessary skill, knowledge, and training to provide nursing care to children of all ages who may be brought to the ED, consistent with the services offered by the hospital.

3. Competency evaluations completed by the staff are age specific and include neonates, infants, children, and adolescents.

The relations between the provincial governments and the local governments are in transition and there are a number of issues that need to be addressed. The main problem arises from an administrative, instead of functional, division of powers between the provincial and local governments. So these administrative arrangements reveal practical delegation of powers and not necessarily devolution of functions.

The provinces, therefore, should confine themselves to the functions not decentralized to the district governments and must avoid undue interference in routine discretionary dispensations by the district government. Monitoring should be carried out by the provinces in accordance with a well-defined monitoring mechanism that clearly sets out the indicators of such evaluation. Doctors' training should not be split and, for reasons of uniformity of standards, it may be the responsibility of the provincial governments itself (Javed, 2007).

Local Governments: District, Tehsil and Union

The local government has three tiers: district, tehsil and union. Medical education is primarily the responsibility of the district government and the current causes of lack of coordination between the three tiers need to be addressed by the district governments. Despite the principle of subsidiary embedded in the local government system, decentralization in education has failed to percolate to schools.

Governance and Management of education at the local level needs to recognize the role the community can play. Presently, community participation in management is not concretely institutionalized to ensure accountability. Parent-Doctors' Associations and civil society organizations within a formal though limited, structure can contribute to a more accountable delivery system (Javed, 2007).

Other Linkages

Education is pile into various sectors and distributed to various organizations at the federal as well as the provincial levels. Such splintering may have its merits but it has implications for policy making. Various sectors of education are inter-linked and policy cannot be made disconnected amongst these. At the federal level, several Ministries separately deal with parts of education. At the provincial level, the set up varies from province to province. In Khyber

Pakhtunkhwa, education is separate from the Department of Literacy & Non-Formal Education, the technical and vocational rests with Technical Education & Vocational Training Authority. In Baluchistan, the Social Welfare Department looks after literacy and so on. While there may be merits and demerits for such functional classification, an important consideration for policy and planning in education is the need to consider the linkages to allow for a holistic approach. Presently, policy making and planning by each is not in tandem, except where individual initiatives have made it possible. The institutional arrangements are disturbed to say the least. There is no argument with the autonomy that certain institutions require for an efficient implementation of their plans. Without sacrificing this autonomy, policy formulation must be developed and ensured through one coordinating mechanism (Javed, 2007).

Causes of Stress among Doctors

i. Time stress

Emergency department personnel work in a charged atmosphere that is overloaded with sensory stimuli (ringing phones, rushing people, beep- ing 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.

ii. Important decisions

(Brenner BE, Simon RR, 1984), described that, "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".

Rosen P, Markovchick V, Dracon D (1983) explained that, "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 (Quick JD, Moorehead G, Quick JC et al., 1983).

iii. Provider-patient conflict

"Many people who present at an emergency department are bypassing their own physicians in search of a secure hospital environment for immediate treatment" (Bartolucci G, Drayer CS, 1973).

"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" (Wagner DK, 1982).

iv. Patient anxiety

Patients often present to the emergency department 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.

v. Expert 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" (Wilder JF, (1981).

vi. Handling and avoidance

"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" (Ivanevich JM, Matterson MT, (1981).

Abbott C, (1987) described that, "Most researchers have focused on tertiary interventions for physicians who are alcoholic, addicted to drugs, or emotionally or mentally unstable. Methods of primary prevention, such as those that follow, are rarely discussed".

vii. Edification

"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 (Abbott C, 1987).

viii. Joint 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 (Eisendrath SJ, (1981).

ix. Management 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 (Schwartz GR, (1975).

x. Orientation of nurses

"Nurses should initially receive a structured orientation with graded responsibilities, formal instruction and close supervision. 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" (Jeglin-Mendez AM, (1982).

According to World Health Organization, (2007), Low-income countries Deaths in millions % of deaths were;

Low Income Countries	Death in Millions	% of Death
Coronary heart disease	3.29	11.4
Lower respiratory infections	2.72	9.5
HIV/AIDS	2.06	7.2
Stroke and other cerebrovascular diseases	1.83	6.4
Perinatal conditions	1.78	6.2
Diarrhoeal diseases	1.48	5.2
Tuberculosis	1.01	3.5
Chronic obstructive pulmonary disease	0.97	3.4
Malaria	0.87	3.0
Road traffic accidents	0.60	2.1

Research Methodology

Population

All medical officers working in government hospitals of Khyber Pakhtunkhwa were constituted the population of the study.

Delimitation

The scope of the study was delimited to the district Swat. Four hospitals of district Swaat were used to take sample of the study.

Sample

Twenty medical officers working in casualty department were taken randomly from these four hospitals as sample of the study.

Research Instrument

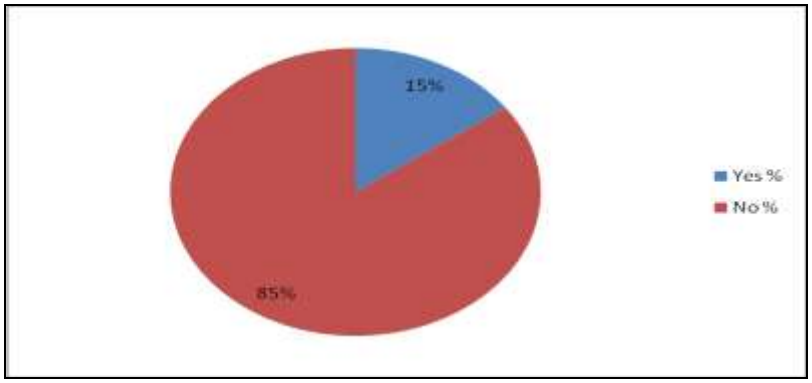
A questionnaire was prepared for medical officers, which was used as research instrument to collect data for the study.

Results And Discussion

Data was collected through questionnaire from the doctors who were working in casualty departments of the hospitals of district Swat. It was observed that there was lot of problems which were going to decrease the efficiency of the doctors over there and also minimizing the hope of life. Data which was obtained from the doctors is discussed below;

1. Did government provide all necessary equipment related to the emergency department of the hospitals?

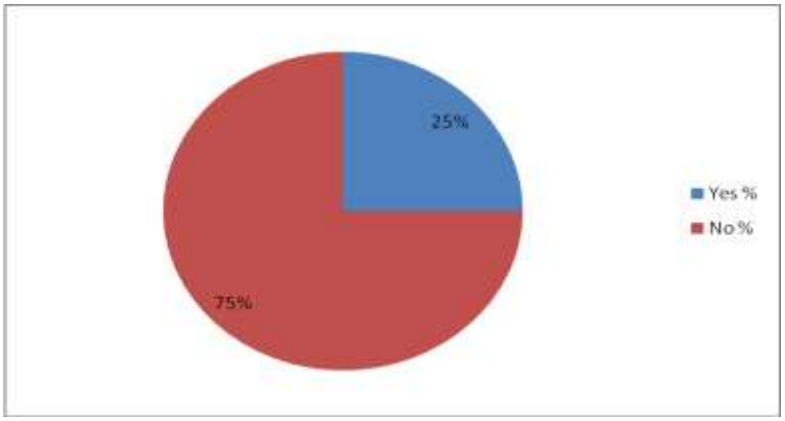
No of Doctors	Yes	No	Yes %	No %
20	3	17	15 %	85 %



The above table illustrates that 15% of the doctors were satisfied with the equipment provided to deal emergency patients but 85 % doctors said that there were no enough facilities to deal with the emergency patients.

2. Did government provide all necessary facilities related to the emergency department of the hospitals?

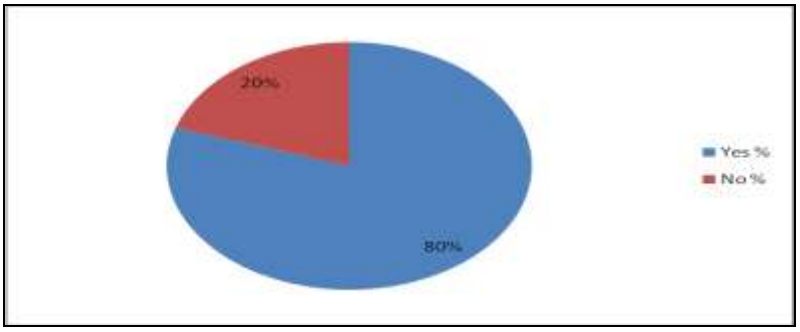
No of Doctors	Yes	No	Yes %	No %
20	5	15	25 %	75 %



Value of the table shows that 25% doctors observed that there were sufficient facilities but 75% doctors said they have not been provided with sufficient facilities into the emergency department.

3. Are the working hours for the doctors to work in casualty department too long?

No of Doctors	Yes	No	Yes %	No %
20	16	4	80 %	20 %



Above table shows that 20% doctors were satisfied from their duty hours in emergency department but 80% doctors were not satisfied from their duty hours in casualty departments. It means that this is injustice to get too much output from the doctors being a human being.

4. Is there any deployment of security personnel into the hospital for doctors and paramedical staff?

No of Doctors	Yes	No	Yes %	No %
20	2	18	10 %	90 %

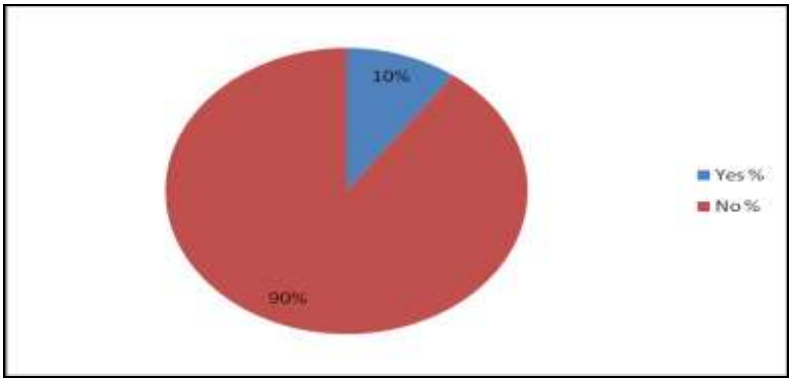
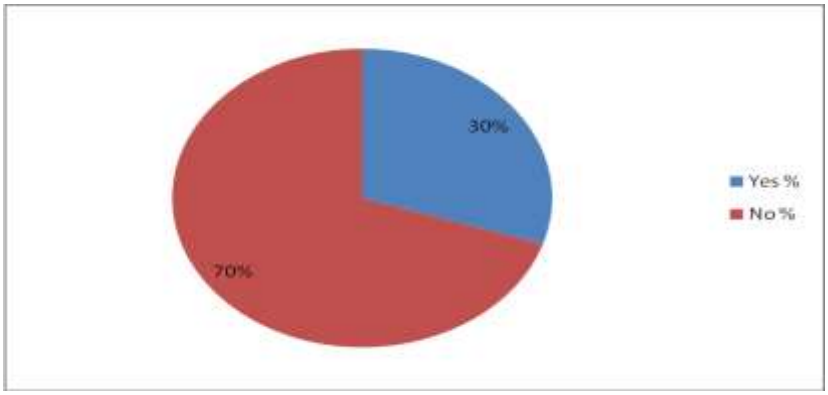


Table shows that only 10% security was there but 90% doctors and paramedical staff were working under security threats.

5. Do the people have civic sense to behave into the hospitals?

No of Doctors	Yes	No	Yes %	No %
20	6	14	30 %	70 %



Percentage of the table indicates that only 30% have civic sense but 70% people did not know that how to cooperate with paramedical staff and especially with the doctors.

6. Do the doctors perform their duties well in manner?

No of Doctors	Yes	No	Yes %	No %
20	8	12	40 %	60 %

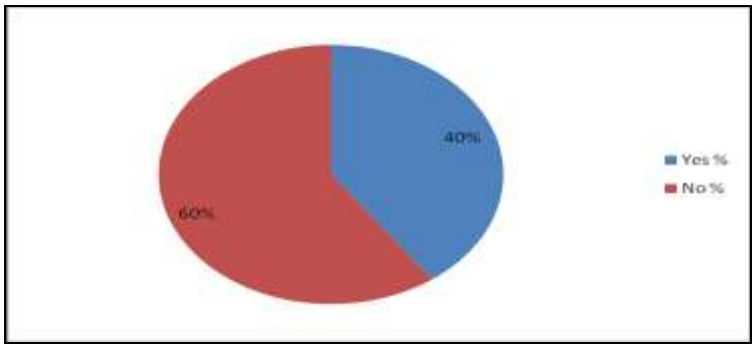
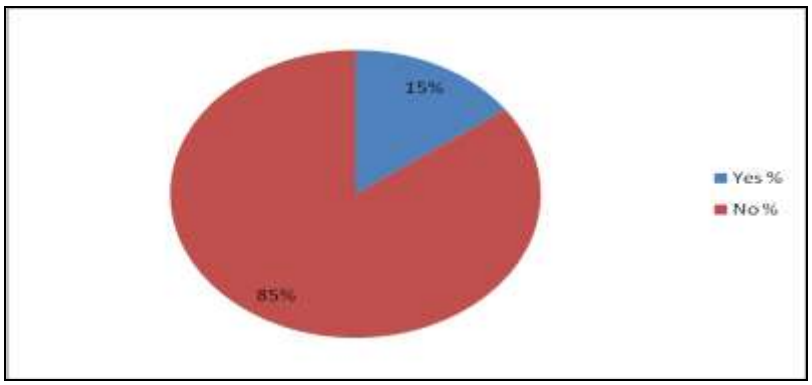


Table shows that 40% doctors were performing their duties well but 60% doctors were not performing their duties in their good manners due to many problems regarding their lives.

7. Is there good discipline into the hospitals?

No of Doctors	Yes	No	Yes %	No %
20	3	17	15 %	85 %



Result of the table indicates that there was only 15% discipline into the hospitals so hospitals require more discipline for the smooth functioning of the hospitals.

8. Is there any interference of the people into the hospital?

No of Doctors	Yes	No	Yes %	No %
20	9	11	45 %	55 %

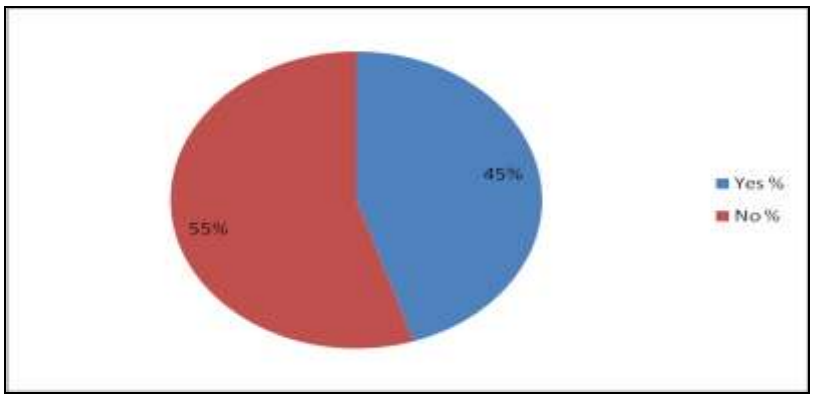


Table value indicates that there was 45% interference of unnecessary people into the hospitals which is quite sufficient to decrease the efficient working of hospitals.

Conclusions

In the light of the analysis of data and findings of the study following conclusions were drawn;

The common causes of increasing mental health issues among casuality medical officers includes

1. Facilities found insufficient into the casualty department of the hospitals.
2. Working hours for doctors to work in casualty departments are too long.
3. There is no particular training of the staff about disaster risk management into the hospitals.
4. There is no proper arrangement for the security of doctors and paramedical staff.
5. There is lack of civic education.
6. There is no discipline into the hospitals.
7. There is lot of interference of Army and Taliban into the affairs of hospitals.

   All above leading Doctors to face different mental diseases like irritation, depression, sleeplessness, headache, and less concentration upon patients.

Recommendations

Following recommendations are made from the study;

1. There should be sufficient facilities to deal with the patients into the casualty department of the hospitals.
2. Strength of the doctors should be increased in casualty departments for performing efficiently.
3. Doctors should work in casualty departments for not more than four to six hours.
4. There should be some refresher courses about disaster risk management for the paramedical staff biannually or at least once in a year.
5. There should be availability of security staff for efficient and smooth working of hospitals.
6. Doctors should be provided full security for providing their best services to the people of Swaat and its contiguous areas.
7. People should be given civic education to get full cooperation from the doctors and paramedical staff.
8. There should be good discipline into the hospitals to get rid of from unnecessary interference of the people other than patients into the hospitals.

9. Doctors should be given full cooperation from the government to keep themselves away from the different diseases like irritation, depression, sleeplessness, headache, and less interest into their profession.
10. Government should provide assistance of Army because they are already deployed into Swat region so that interference of unnecessary people should be eradicated.

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