This study investigated the causes of stress among both nurses and doctors working in a busy renal setting, and methods used to reduce stress.

**Stress and coping strategies in renal staff**

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There is much research into stress among nursing staff, but no comparisons of stress levels between doctors and nurses in nephrology. This study aimed to address this gap by looking at stress triggers in this specialty and comparing those of renal nurses with those of nephrologists to identify coping mechanisms.

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In the modern healthcare setting, stress is stressful. It is a complex environment in which health professionals continually have to learn new skills, work long hours, constantly care for ill people and face death, and have high levels of responsibility and reliance.

The prevalence of stress having a negative impact among the general working population is around 18%; among doctors it is 28% (Oikinoua et al, 2004). Stress levels are highest among doctors caring for patients with terminal or long-term conditions (Ross and Deverell, 2003).

Stress is a natural human response that enables people to respond quickly to events they need to react to. Responses may depend on personal characteristics, experiences, coping mechanisms and the specific circumstance (McCvicar, 2003).

**Literature review**

Two national surveys examined the mental health of hospital consultants; a major finding of these studies was that the prevalence of psychiatric morbidity was higher among hospital consultants (27%) than in the general working population (18%) (Ramirez, 1996). The prevalence of stress increased significantly to 32% among consultants in 2001 (Taylor et al, 2005).

In both these surveys, poor mental health was related to high job stress, while high levels of job satisfaction had the opposite effect, protecting people from the harmful effects of stress. The increase in mental ill health between 1994 and 2002 appears to be due to an increase in stress at work without a comparable increase in job satisfaction (Ramirez et al, 2008).

Lambert and Lambert (2001) found many factors influence nurses’ levels of stress:
- High job demands;
- Low supportive relationships;
- Dealing with death and dying;
- Work overload;
- Uncooperative family members and patients;
- Inability to reach physicians;
- Unfamiliarity with situations;
- Inability to deliver high-quality nursing care;
- Time demands;
- Poor relationships with supervisors;
- Low organisational commitment.

Huber (1995) found workplace stress had a negative effect not just on nurses’ health but also on their job satisfaction and the overall quality of care. It also increased the amount of sick leave taken, job turnover and number of accidents.

Tabak and Koprak (2007) found being a more junior and less experienced nurse might be intrinsically more stressful, but pointed out that more research was needed to confirm this. They also found increased stress levels were associated with lower job satisfaction, a finding that is supported by other studies (Spector, 1997).

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**In this article...**

- Literature review on causes of stress in health professionals
- How stress triggers in nurses and doctors differ
- Methods used to deal with stress

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**5 key points**

1. High job stress is a cause of mental ill health
2. Job satisfaction is a protective factor against workplace stress
3. Renal settings can be particularly stressful environments
4. A lack of staff, or inadequate skill mix with a high proportion of inexperienced staff, is a cause of stress in health professionals
5. Good interpersonal relationships are important for reducing stress
TABLE 1. REPORTED STRESSORS

<table>
<thead>
<tr>
<th>Nurses</th>
<th>Doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too much paperwork, therefore it is very difficult to do actual patient care</td>
<td>Increased workload, reduced time</td>
</tr>
<tr>
<td>The unbelievable amount of paperwork that has to be filled in each day and takes time away from essential nursing care</td>
<td>Conflicting requirements in limited time available</td>
</tr>
<tr>
<td>Not being able to give patients the time, for example a late shift has one staff nurse, 12/13 patients; 7.5 hour shift=patients get less than 20 minutes of my time if divided equally between them</td>
<td>Tight deadline</td>
</tr>
<tr>
<td>Not enough time to complete all management tasks</td>
<td>Time pressures and long hours, ever-increasing performance management that in reality only serves to cut into the time available to do the job</td>
</tr>
<tr>
<td>Not being able to give quality time and care to patients</td>
<td>Unpredictable surges in workload</td>
</tr>
<tr>
<td>Not being able to appropriately organise timetable of tasks to run the ward smoothly, for example trying to complete a busy medication round, serve out meals and feed immobile patients within one hour</td>
<td>Clinical uncertainty</td>
</tr>
<tr>
<td>The expectations of the care you want to provide, but you physically cannot provide</td>
<td>Job planning to be more meaningful from the timing/scheduling perspective</td>
</tr>
<tr>
<td>Less expectation, more and more work is being piled on nurses</td>
<td></td>
</tr>
<tr>
<td>Less paperwork</td>
<td></td>
</tr>
</tbody>
</table>

Poor inter-staff relationships has also been shown to increase stress (Hayes and Bonner, 2010); Hillhouse and Adler (1997) showed that, apart from being one of the main source of stress for nurses, conflict with doctors is more harmful and taxing than other types of interpersonal conflict.

Renal care
Renal settings can be particularly stressful environments (Lewis et al, 1994). They involve complex technology and care provided by highly skilled nurses and doctors to chronically ill patients (Bevan, 1998).

Dialysis nurses report unrealistic demands from patients (Dermody and Bennett, 2008), leading to high levels of verbal and physical abuse, and insufficient training to deal with such incidents (Murphy, 2004). There is little evidence to suggest that the number of people needing dialysis is likely to stop increasing, so the workload and potential stress on practitioners caring for these patients are likely to increase.

To provide optimum support for renal nursing staff, there is a need to better understand the stressors they experience and the coping strategies that promote successful coping and minimise burnout.

There are many studies measuring stress among nursing staff in general, but no comparisons of stress levels between doctors and nurses in nephrology. We therefore undertook a study to look at stress triggers in this specialty and compare those of renal nurses with those of nephrologists to identify coping mechanisms.

Method
A modified version of the Hospital Consultants’ Job Stress and Satisfaction Questionnaire (HCJSSQ) (Ramirez et al, 2008) was used to quantify stress levels and triggers, following ethical approval. The HCJSSQ is a 42-item self-report questionnaire that assesses the levels and sources of job stress and satisfaction among consultants.

We added six open questions and gave the questionnaires to the 44 nurses and 11 doctors in a renal directorate; 20 questionnaires were returned from nurses and eight from doctors. As the number of questionnaires returned was too small to analyse reliably, the results discussed are all related to the open questions and the qualitative data from the questionnaires.

Results
From the six qualitative questions, nine main themes emerged.

Staffing
This was mentioned in three questions, and included skill mix and staffing levels. In terms of skill mix, nurses described stress associated with being newly qualified and working with newly qualified nurses: “Being newly qualified and being left with even more newly qualified to deal with the patients and relatives.”

Concerns were voiced about the high levels of bank nurses who were unfamiliar with the specialty and continuity of staff with experience. One nurse wanted: “Safe patient-to-staff ratio from government/NMC/RCN, anyone!”

Nurses had other concerns about staffing, including: “Not having enough staff to cope with the workload, which compromises care given to patients.”

“Not enough staff to meet the demands of the job.”

“[We need] two trained or one trained and two HCAs on late shift, present numbers: one trained for 13 patients [is] unsafe.”

“Better staffing levels so staff can provide more ‘hands-on’ care.”

Nurses also highlighted stress associated with medical staffing and suggested that more doctors needed to be available on the ward, especially at F2 grade and above.

The doctors echoed the views of nurses, highlighting a need for “more middle grade support and clinical nurse specialists”, as well as a larger workforce generally.

Dependence and workload
Nurses also identified stress from caring for dependent patients without adequate staffing: “The patients often need high levels of care for them.”

Doctors also found caring for extremely unwell patients stressful. Comments about workload included paperwork, time and uncertainty (Table 1).
**TABLE 2. ACTIVITIES UNDERTAKEN TO REDUCE STRESS**

<table>
<thead>
<tr>
<th>Nurses</th>
<th>Doctors</th>
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</thead>
<tbody>
<tr>
<td>Go to the gym most nights to forget</td>
<td>Exercise</td>
</tr>
<tr>
<td>Try not to dwell on what you couldn’t do</td>
<td>Basketball</td>
</tr>
<tr>
<td>Don’t answer the phone, isolate myself</td>
<td>Running, squash, football</td>
</tr>
<tr>
<td>Reading, long walks</td>
<td>Delegate responsibilities</td>
</tr>
<tr>
<td>Don’t think about it at home/outside work</td>
<td>Prioritise work</td>
</tr>
<tr>
<td>Drinking alcohol at home</td>
<td>Prayer and reflection</td>
</tr>
<tr>
<td>Eat</td>
<td>Seek support from colleagues</td>
</tr>
<tr>
<td>Shop</td>
<td>Rant at the missus</td>
</tr>
<tr>
<td>Being able to discuss things with colleagues</td>
<td>Seek support from family</td>
</tr>
<tr>
<td>I do like my job; I enjoy caring for people and being able to provide a clinical and personal professional service, which ultimately aims to improve people’s quality of life. Focusing on this helps me to cope with dealing with stress factors that are out of my control</td>
<td>Ensure adequate time given to family, friends, activities outside work</td>
</tr>
<tr>
<td>Take a deep breath and carry on! Always smile and, if you need help, the nicer you are to people it usually helps you get through thus reduces stress levels. Working together as a team</td>
<td></td>
</tr>
<tr>
<td>Express concerns to managers</td>
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<tr>
<td>Chat to colleagues</td>
<td></td>
</tr>
<tr>
<td>Speak to senior staff and inform them what is causing concern</td>
<td></td>
</tr>
<tr>
<td>Exercise</td>
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</tbody>
</table>

**Relationships**
The categories included within this theme were communication, support, colleagues, relatives and managers. Nurses identified multidisciplinary miscommunication as a cause of delays to patient care and one nurse felt hospital managers did not support nurses when there was a complaint: “Hospital managers [are] on the side of complaining relatives; nurses [are] not listened to [when they] try to defend themselves.”

Nurses identified that they needed more ward meetings to discuss concerns, and debriefing sessions for staff following difficult experiences. One nurse suggested: “Designate staff for one-to-one confidential time to discuss any concerns and help formulate action plans to de-stress situations.”

The doctors identified stress when dealing with difficult colleagues. They also felt unsupported by their managers and felt they were not given adequate resources to do what they were asked: “Increasing demands from management without the provision of adequate resources, thereby increasing risks to patients and whittling away the areas of excellence that took a lot of hard work to set up.”

**Equipment**
Nurses highlighted missing and faulty equipment as a source of stress, and doctors suggested a lack of equipment undermined their ability to provide the best care. “More staff, more equipment needed and equipment faulty/missing. Low stock/no stock.”

“Better resourcing to reduce workload pressures.”

“Not having the right estate to work in—development required. Unable to develop service that is required for patient care due to financial constraints in the NHS.”

**Managers, targets, trust issues**
Nurses identified pressure from bed managers to discharge and admit new patients as a cause of stress: “No support from non-ward based management in regards to bed management ie 9am + 11am discharges/new admissions.”

“Getting rid of some of the government targets, which have an impact on funding and bed management.”

They also felt their work was not always acknowledged by managers: “How about acknowledgment and praise from directorates and upper management that nursing staff and HCAs do their best—in a difficult high-pressured job. Rather than chastising us for not being able to always reach ridiculously set targets.”

Doctors identified a need for a supportive management culture and reduced demands on acute medicine.

Many staff had their own ways of dealing with stress (Table 2). We also asked what employers do to help them relieve stress (Table 3).

**Increasing stress**
All but two participants said stress had increased, citing staffing, workload, responsibilities and time as reasons for this (Table 4).

**Discussion**
Managerial responsibilities, difficulties in relationships with staff and dealing with change were broadly reported by both groups as causes of stress.

Nurses also marked being poorly paid and dealing with increasing bureaucratic procedures as a higher stress trigger than doctors. Although we were not surprised that the pay nurses receive was a stress trigger, we were surprised that the doctors
did not report bureaucratic procedures as a higher stress trigger than they did.

Both groups described staffing levels and skill mix as inadequate. Doctors said they felt more junior staff were needed, while nursing staff wanted more senior staff. Both groups agreed that patient dependencies were high and they needed more time. Nurses said paperwork was one of the biggest stress triggers because of the time it took up.

The nurse group said they needed more support, debriefing and acknowledgment or gratitude from management; both groups mentioned several times that pressure from management and government targets were a huge source of stress.

All but two participants said stress had increased, with nurses citing paperwork, management pressures, responsibilities, increased workload, no support, cost-cutting, bad media coverage and time pressures as the reasons. Doctors cited staffing, number of patients, increased responsibility, staffing cuts, doing more for less and proving efficiencies.

It was generally agreed that staff were given no help to deal with stress. However, most participants had found their own ways of coping, such as exercise, reflection and talking to friends and colleagues.

Although Hayes and Bonner (2010) and Hillhouse and Adler (1997) suggested that nurses find conflict with doctors more harmful than other sorts of interpersonal conflict, none of the nurses or doctors in this study reported this, suggesting good interpersonal relationships between the two groups.

**Conclusion**

The main stress triggers reported by both groups were:

- Staffing;
- Workload;
- Patient dependencies;
- Paperwork;
- Demand from management and patient;
- Resources;
- Government targets.

Paperwork, lack of staff and management pressure were cited by the nurses as contributing to recently increased stress. This was echoed by the doctors. Both had had to identify their own ways of coping with this stress, as most were not aware of what was available to help them cope.

Media coverage played a part in rising stress levels and this needs to be explored. However, both groups reported a high level of job satisfaction, which is a protective factor, along with good interpersonal relationships between the groups.

**References**


