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The experience of health and suffering in the medical profession

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Abstract

Objective: To evaluate the existential distress through simple measurements of the emotional state, health and well-being of doctors involved in outpatient and ward activities.

Method: an observation group of 77 physicians with male prevalence (58.4%), between the ages of 26 to 67 years old (mean 46.30 years; SD = 11.1). The mean of the length of service is 18.71 years (SD = 10.50); data collection took place through an initial questionnaire, an instrument referring to the emotional and affective state (POMS, McNair et al, 1992), the motivation at work scale MAWS (Gagnè, 2010, the Italian version Galletta et al, 2011), scales related to well-being (GHQ-12, 2000) and health (WHO, 1998)

Results: half of the participants in the study work during the night shift (50.6%), another percentage suffer from medical pathologies (41.6%) and follow drug therapies regularly (33.8%); significant positive correlations emerged among some MAWS scales (autonomous motivation, ego ideal - item 7,8, motivation for medical work - item 3,4) and psychological well-being; significant positive correlation between the POMS force scale and psychological well-being, among some POMS scales (Tension or Anxiety, Depression or Dejection, Fatigue or Inertia, Confusion or Bewilderment, Anger or Hostility, Vigor or Activity, Total score) and psychological distress and suffering; significant negative correlations among the POMS scales (Tension or Anxiety, Depression or Dejection, Anger or Hostility, Fatigue or Inertia, Confusion or Bewilderment, Total score) and psychological well-being, among the POMS , Vigor or Activity, psychological distress and suffering.

Conclusions: in the field of work and the medical profession, the experience of this study refers to the importance of conscious and deep autonomy, as a possibility to adhere to the humanistic experience of the profession; the states of slight maladjustment can turn out to be particularly counterproductive, such as maladaptive psychopathological phenomena.

Key words: Health, Suffering at work, Emotions, Psychological well-being.

Introduction

Work experience is intended as the possibility to realize desire and its frustration, to the extent that we consider the possibility of satisfaction. Although it may seem fundamental that the awareness of a concrete or latent realization may insist on its existence, the experience of clinical psychology in the field of occupational health, leads us to clarify which dynamics can be subtended to satisfaction. The distress that results from dissatisfaction is in fact associated with physiological hyperactivation, negative cognitions and negative mood, and has been associated with a wide variety of physical and mental health problems (Manocha et al., 2011). Including different conditions, such as overwork, unemployment or job insecurity and lack of family-work balance (Nakao, 2010), the appearance of specific phenomena (Collins & Long, 2003) such as Compassion fatigue (Figley , 2002), Secondary traumatic stress (Figley, 1995), Burnout (Maslash, 1982; Huggard & Unit, 2013; Ray et al, 2013). The result can lead to a reduction in the

quality of care (Bültmann, 2002) to the abandonment of work (Medland et al., 2004). This condition has been described as a combination of emotional friction, depersonalization and reduced personal fulfilment (Elwood et al. , 2011); then maladjustment can occur as a final result due to exposure to high levels of stress at work (Maslash, 1982) or to the sudden appearance of relevant symptomatology (Rossi et al, 2012). In their literature review Michie & Williams (2003) suggest that the studies considered show higher levels of psychological maladjustment, this occurs in health care rather than in non-health care workers; that levels and distributions are similar across continents and in reference to specific working conditions (2011). The particular conditions of healthcare work refer to long hours or abnormal conditions in the case of one out of five workers; the main physiological consequence of such shift programs is the disruption of the circadian rhythm that may have a detrimental effect on performance, sleep patterns, accident rates, mental health and cardiovascular mortality (Harrington, 2001). The presence of fatigue, physical and psychological distress are common in the active population (Bültmann et al, 2002). Specifically the emotional and representational phenomena influence strongly the psychic assets of workers. The working autonomy and motivation (Dolea & Adams, 2005) can be considered as exogenous components positively correlated to the emotional commitment (Galletta et al., 2011). Their direct consequence is identified in the dissatisfaction, in the use of non-evolved defense mechanisms, in the maladjustment and in the suffering at work. In psychodynamic terms our commitment to work could be considered from the point of view of the relationship between the Ego ideal (Freud, 1914) and the failure to combine between desire and existential project. An existential project must be understood as a set of aspects related both to consciousness and to that kinds of perceived dimensions not adequately expressible. In analytical terms the lack of convergence between consciousness and unawareness could be considered as a non-achievement of a transcendent process useful for the individuation process. Although this last dimension would seem disproportionate to the proposed method, modestly we would like to highlight some shades.

With reference to what we suggested above, we hypothesize that:

Hp 1: Evaluating the relationship between the scale of motivation at work (see Gagnè 2010) and the scale of well-being (WHO questionnaire);

Hp 2: Evaluating the relationship between the motivation scale at work (Gagnè 2010) and the general well-being questionnaire (GHQ-12);

Hp 3: Evaluate the items that are most significant at POMS (T points <40 and> 60) and the general well-being scales (GHQ and WHO);

Materials and method

Participants

A sample of 77 physicians (58.4% males) working at an University Hospital of Messina participated in this study. The age of participants ranged from 26 to 67 years old, with a mean age of 46.30 years (SD = 11.1). The mean length of service was 18.71 years (SD = 10.50), and the mean length of service in the ward where the respondents worked at the time of investigation was 13.43 years (SD = 9.89). Half of participants reported having night shift work (50.6%). A high percentage suffered from any medical condition (41.6%) and followed a drug therapy regularly (33.8%).

Missing data

Missing data was infrequent (<5%). Missing items were replaced with the individual's mean item score of the completed items.

Statistical Analysis

We computed descriptive statistics for the key observed study variables including means and standard deviations, skewness and kurtosis indices, and minimum and maximum values of standardized scores. The latter descriptive analysis results allowed verification of the univariate normality of the distributions. When it was the case, non-normally distributed variables were transformed to improve normality and extreme outliers. Scores beyond |3.29| standard deviations from the mean (Tabachnick & Fidell, 2013), were excluded from the analyses (not exceeding 5% of total participants). Furthermore, we used the Mahalanobis distance to identify other potential multivariate outliers. Then, the final descriptive statistics for the study variables were computed.

We evaluated the associations of the demographic, work-related and health-related variables with the main study variables. Particularly, we conducted a multivariate analysis of variance (MANOVA) to examine whether participants' scores for autonomous motivation, introjected regulation, external regulation, ego ideal , motivation for medical work, tension/anxiety, depression/dejection, anger/hostility, vigor/activity, fatigue/inertia, confusion/bewilderment, total mood, psychological well-being, psychological distress, and work suffering , differed based on gender (0 = male; 1 = female), shift night work (0 = no; 1 = yes), presence of disease (0 = no; 1 = yes), drug therapy (0 = no; 1 = yes). We computed Pearson's correlation coefficients to describe potential significant relations between age, length of service in years, length of service in the ward where the respondents worked at the time of investigation and the above-mentioned key study variables.

After reporting bivariate correlations for the key and control study variables we used partial correlations to test associations between the key study variables controlling for the effect of the significant control variables (age and length of service in the ward).

Results

Tables 1 summarize the descriptive statistics. Autonomous motivation, motivation for medical work, tension/anxiety, depression/dejection, anger/hostility, and fatigue/inertia were not normally distributed (Table 1) with skewness and kurtosis values > |1.00| (Curran et al., 1996; Kline, 2010) as well as maximum values of standardized scores > 3.29. A transformation was applied for non-normal variables by computing the square root for each distribution as the best solution. After re-calculating descriptive statistics for the transformed variables, two cases presenting extreme outlier standardized scores (>|3.62|, calculated as 3.29 plus a tolerance of 10%) were excluded from the sample. The new distributions showed adequate skewness and kurtosis values (see Table 1). Using Mahalanobis distance with $p < .001$, no cases were identified as multivariate outliers.

Table 1. Means, standard deviations, skewness, kurtosis, minimum and maximum values of standardized scores or the key study variables both in their original version and in their transformed version.

Observed variable	Transformation	*M*	*SD*	Skewness	Kurtosis	Min. stand.	Max. stand.
Initial sample, N = 77							
1. Autonomous motivan	No	28.44	5.74	-1.20	1.84	-3.73	1.14
2. Introjected regulation	No	9.09	3.23	0.01	-0.79	-1.88	1.83
3. External regulation	No	8.12	2.91	-0.01	-0.49	-1.76	2.36
4. Ego ideal	No	7.25	1.91	-0.69	0.22	-2.75	1.44
5. Motivation for medical work	No	8.16	1.88	-1.14	1.68	-3.28	0.98
6. Tension/Anxiety	No	7.77	5.17	1.14	0.56	-1.50	2.75
7. Depression/Dejection	No	5.64	6.31	1.39	1.73	-0.89	3.70
8. Anger/Hostility	No	8.87	8.15	1.08	0.91	-1.09	3.45
9. Vigor/Activity	No	18.21	4.95	-0.05	0.24	-2.67	2.38
10. Fatigue/Inertia	No	6.43	4.80	1.39	3.26	-1.34	4.29
11. Confusion/Bewilderment	No	7.19	4.22	0.81	0.35	-1.70	3-27
12. Total Mood	No	17.69	26.50	-0.32	0.29	-1.50	2.54
13. Psychological well-being	No	15.44	4.35	-0.31	0.24	-2.40	2.20
14. Psychological distress	No	15.52	3.69	0.08	0.26	-2.31	2.57
15. Work suffering	No	13.04	3.03	-0.32	0.29	-2.32	2.63
Final sample excluding extreme outliers, N = 75							
1. Autonomous motivan	Yes (square root)	5.34	0.51	-1.15	1.18	-2.62	1.03
2. Introjected regulation	No	9.17	3.22	-0.02	-0.78	-1.88	1.83
3. External regulation	No	8.08	2.93	0.02	-0.50	-1.76	2.36
4. Ego ideal	No	7.31	1.83	-0.58	0.00	-2.75	1.44
5. Motivation for medical work	No	2.87	0.29	-0.89	0.60	-2.25	0.89
6. Tension/Anxiety	Yes (square root)	2.67	0.86	0.66	-0.37	-1.81	2.27
7. Depression/Dejection	Yes (square root)	1.86	1.49	0.23	-0.93	-1.27	2.39
8. Anger/Hostility	Yes (square root)	2.58	1.50	-0.00	-0.65	-1.73	2.34
9. Vigor/Activity	No	18.13	4.99	-0.00	0.21	-2.67	2.38
10. Fatigue/Inertia	Yes (square root)	2.37	0.95	0.12	0.35	-2.40	2.92
11. Confusion/Bewilderment	No	7.27	4.26	0.77	0.28	-1.70	3.27
12. Total Mood	No	18.04	26.66	0.81	0.05	-1.50	2.54
13. Psychological well-being	No	15.32	4.26	-0.41	0.19	-2.40	1.97
14. Psychological distress	No	15.48	3.74	0.11	0.21	-2.31	2.57
15. Work suffering	No	12.99	3.05	-0.27	0.25	-2.32	2.63

We then examined the influence of demographic, work-related and health-related variables on the key study variables. No significant multivariate effects were observed for gender, Wilks' Lambda = .69, $F(15, 59) = 1.77$, $p = .06$, shift night work, Wilks' Lambda = .69, $F(15, 59) = 1.75$, $p = .07$, presence of disease, Wilks' Lambda = .88, $F(15, 59) = 0.56$, $p = .89$, and drug therapy, Wilks' Lambda = .87, $F(15, 59) = 0.60$, $p = .86$. Age was significantly and negatively related to anger/hostility, $r = -.25$, $p = .030$, fatigue/inertia, $r = -.27$, $p = .020$ and confusion/bewilderment, $r = -.24$, $p = .042$, but not to the other variables (see Table 2). Furthermore, length of service in the ward was significantly and positively related to motivation for medical work, $r = -.24$, $p = .041$, but not to all other variables. No significant correlations were found between length of service and all key study variables.

Based on the preliminary analyses, age and length of service in the ward were used as control variables. Correlations between the key and control study variables are displayed in Table 2.

Table 2. Correlations for key and control study variables.

		1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.
1.	Autonomous motivation	-																
2.	Introjected regulation	.43**	-															
3.	External regulation	.08	.35**	-														
4.	Ego ideal	.68**	76**	.15	-													
5.	Motivation for medical work	.87**	.28*	.06	.42**	-												
6.	Tension/Anxiety	-.23*	-.05	.07	-.09	-.29*	-											
7.	Depression/Dejection	-.22	.01	.00	-.09	-.25*	.66**	-										
8.	Anger/Hostility	-.06	.06	-.01	.06	-.03	.70**	.70**	-									
9.	Vigor/Activity	.21	.00	.06	.15	.23*	-.27*	-.49**	-.19	-								
10.	Fatigue/Inertia	-.21	-.13	-.04	-.16	-.17	.76**	.74**	.68**	-.22	-							
11.	Confusion/Bewilderment	-.23*	-.27*	-.04	-.30**	-.17	.68**	.67**	.61**	-.22	.76**	-						
12.	Total Mood	-.22	-.06	.03	-.14	-.20	.86**	.89**	.82**	-.46**	.85**	.80**	-					
13.	Psychological well-being	.47**	.18	.15	.33**	.37**	-.35**	-.54**	-.28*	.47**	-.34**	-.33**	-.49**	-				
14.	Psychological distress	-.22	.12	-.00	-.12	-.19	.29*	.43**	.19	-.50**	.34**	.25*	.41**	-.32**	-			
15.	Work suffering	-.22	.16	.04	-.10	-.22	.29*	.40**	.17	-.48**	.28*	.24*	.38**	-.23*	.96**	-		
16.	Age	-.05	.06	.05	-.03	-.01	-.21	-.16	-.25*	-.13	-.27*	-.24*	-.22	-.14	.07	.08	-	
17.	Length of service in the ward	.12	-.01	.10	-.04	.24*	-.08	-.00	-.07	-.09	-.05	.02	-.05	-.05	.02	-.01	.67**	

Table 3 showed intercorrelations between the key study variables controlling for the effect of age and length of service in the ward.

Table 3. Intercorrelation for key study variables controlling for age and length of service in the ward.

		1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.
1.	Autonomous motivation	-														
2.	Introjected regulation	.45**	-													
3.	External regulation	.06	.36**	-												
4.	Ego ideal	.70**	76**	.15	-											
5.	Motivation for medical work	.87**	.32**	.03	.44**	-										
6.	Tension/Anxiety	-.27*	-.04	.08	-.10	-.34*	-									
7.	Depression/Dejection	-.27*	.03	-.01	-.09	-.32*	.65**	-								
8.	Anger/Hostility	-.11	.08	-.02	.06	-.08	.69**	.69**	-							
9.	Vigor/Activity	-.21	.01	.07	.15	.25*	-.31**	-.52**	-.24*	-						
10.	Fatigue/Inertia	-.28*	-.11	-.05	-.17	-.26*	.75**	.72**	.65**	-.27*	-					
11.	Confusion/Bewilderment	-.32**	-.26*	-.06	-.32**	-.28*	.66**	.65**	.57**	-.26*	.74**	-				
12.	Total Mood	-.28*	-.04	.03	-.15	-.27*	.86**	.88**	.80**	-.51**	.84**	.79**	-			
13.	Psychological well-being	.47**	.19	.15	.34**	.37**	-.40**	-.59**	-.33**	.46**	-.41**	-.40**	-.55**	-		
14.	Psychological distress	-.22	.12	-.00	-.12	-.19	.32**	.46**	.23	.-.50**	.38**	.29*	.45**	-.32**	-	
15.	Work suffering	-.20	.15	.04	-.10	-.20	.33**	.44**	.21	-.48**	.33**	.29*	.43**	-.22	.96**	-

Discussions

The results show interesting data related to the medical profession and to the phenomena that exist in relation with external facts that can be immediately reported and internal facts, whose elaboration, evolution and symbolization require different processes. In these terms, what emerges refers to the inside in the measure in which the characteristics of autonomy are at the base of the experience of mental health and personal well-being (Hp1), transversal to cultures (Church et al., 2013). In this sense, the possibility that work experience becomes a possibility of self-determination, coincides with the maintenance and establishment of one's own well-being (Gagnè et al., 2015; Howard, Gagnè, Bureau, 2017).

What emerges in fact refers to a motivational structure, whose direction is homologous to the possibility of experiencing positive work experiences. In more specific terms, from the introjection of primary, secondary and tertiary figures there is an ideal state whose best case scenario is to be closer to its climax, the more it starts to be close to state of health. In this sense we mean that in the polarity between the real and the ideal, the more the distance is shortened, the more the benefit of a profession is possible. As far as medical science is concerned, whose purpose is referred to human and health representations, the desire for the maintenance of the Other's health is expected to be transformed into practice.

This conception stands in antithetical terms with respect to the dynamics of narcissism, from which springs the antì- pàthos (motion of the opposite soul) which cannot be foreseen when there is the need to understand and take care of the Other (Figlio, 2018). It therefore follows that medical practices provide for a certain amount of energy to be allocated to activities through motivational instances, which also emerged in the study in line with the experience of psychological and physical well-being (Hp 2). Consequently, what is available in diametrically opposed terms, concerns the possibility of experiencing a maladjustment. In a set of possibilities arranged in polar terms, beyond the possibility that the phenomena are clustered around a specific diagnostic category given, the result of bad adaptation involves approaching the negative polarity, especially with regard to emotions. Clinical practice consists of exposure to the suffering of others, can produce pathological outcomes, highly emotional efforts that affect their functions (LeBlanc, McConnell, Monteiro, 2015) and aspects such as desensitization to patients' conditions (Gleichgerrcht, Decety, 2014).

The emergences of this study and the related analyzes, have on the same axis and with respect to a similar directionality, abnormal emotional experiences and the presence of psychological distress of suffering and therefore of maladjustment (Hp 3). This cannot refer only to the working environment, but to all the experiences, whose positivity gives meaning to the experience (Seligman, Csikszentmihalyi, 2014).

With this it is meant that the need to identify the use of pharmacological therapies and the related pathologies that require their use, suggests that the corporeity should not be excluded from the outcomes of the experiences and, the other way around, the experiences should not be considered as untied by the corporeality.

Conclusions

The more realistic the possibility of doing work close to an ideal that is not completely conscious is real, the more the maintenance of a physical and psychological state of health is realistic. The dynamics and the phenomena involved in these considerations can be considered transversal to the emotional, cognitive, and representational sphere. In the field of work and the medical profession, the experience of this study refers to the importance of conscious and profound autonomy, as a possibility of adhering to the humanistic experience of the profession; the states of slight maladjustment can turn out to be particularly counterproductive, to the point where it can lead to actually maladaptive psychopathological realities.

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