

A Qualitative Study Investigating Gender Differences in Primary Work Stressors and Levels of Job Satisfaction in Greek Junior Hospital Doctors

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Primary work stressors and job satisfaction/dissatisfaction in Greek Junior Hospital Doctors (JHDs) are investigated to identify similarities and differences in the reports obtained from male and female hospital doctors. Participants in the study included 32 male and 28 female Greek hospital doctors who provided information through semi-structured, in-depth interviews. The findings revealed that a majority of Greek JHDs considered their profession very stressful, and that various differences were identified between male and female JHDs, with regard to perceived stress and satisfaction. The study has implications for the possible introduction of in-house stress management training programmes, both at a generic, and gender specific level. Future research aimed at increasing the individuals' coping mechanisms, and identifying environmental sources of stress are recommended. Key Words: Occupational Stressors, Job Satisfaction, Junior Hospital Doctors, Gender Differences, Qualitative Research, and Content Analysis

Introduction

It is widely acknowledged that work-related stress could have serious consequences as much for the individual as for the organization in which he/she works (Cooper, Dewe, & O'Driscoll, 2001; Sparks, Faragher, & Cooper, 2001). These consequences include absenteeism, depression, anxiety, and job dissatisfaction.

Individuals' responses to the disturbance of equilibrium might either result in a use of one's own backup resources or a cessation of functioning altogether (Deary & Trait, 1987; Maslach, Schaufeli, & Leiter, 2001; Schaufeli, 1999). In a study aiming to determine doctors' job satisfaction, stress, and their interconnectness, Makin, Rout, and Cooper (1988) found that general practitioners' professional satisfaction is negatively affected by factors such as poor pay and excessive workload.

Furthermore, the unpredictable and unplanned interruptions seem to be a great source of stress for doctors. Research by the British Medical Association, Health Policy,

and Economic Research Unit (1998) showed that, for a sample of 440 full-time Senior House Officers and General Practitioner trainees in the UK, the most common sources of stress were the long working hours, the work demands that interfere with their social and personal lives, and the extreme overload. A significant stress factor that is often overlooked is the fact that doctors, compared to other professions, are responsible for human beings rather than “objects” (Caplan, Cobb, French, Harrison, & Pinneau, 1975). Thus, omission of duties or misconduct has profound effects on human life (Antoniou, 2001; Sexton, Thomas, & Helmreich, 2000). There are many studies that suggest that the sources of stress among doctors differ not only according to type of the work, but also according to the grade and the specialty (Burbeck, Coomber, Robinson, & Todd, 2002; Coomber et al., 2002; Sutherland & Cooper, 2003).

Difficulties in patient contact and social pressure and interaction with other health professionals was not associated with the grade, but with the level of workload. Face-to-face contact with patients, their relatives, and other health professionals, together with the exposure to health risks and injuries, have previously been reported as significant sources of stress (Antoniou, 2006). Furthermore, in a review of prospective studies published over 20 years, Arnetz (2001), found that perceived overload, perceived medical-school stress, emotional pressure, and stress outside of work were predictors of mental health outcomes for young doctors during their first postgraduate years.

The fact that jobs involving caring for humans are particularly stressful, has given rise to a growing body of research on stress among the health care professions. As stated by Sutherland & Cooper (2003), “stress is inherent in the medical professions” (p. 12). In addition to identification of stress levels, researchers often report job dissatisfaction as a problematic theme among young doctors. As such, growing levels of work stress and job dissatisfaction in JHDs are well established in North American and British research. A study by Moss, Lambert, Goldacre, & Lee (2002), examined the reasons why JHDs might wish to leave UK medicine and found that 75% reported working conditions, although many of them wished to continue working in medicine in a different country. Job dissatisfaction and disillusionment was also cited as a possible reason for considering leaving UK medicine in a study by Davidson, Lambert, Goldacre, and Parkhouse (2001). A significant negative correlation was identified by Newbury-Birch and Kamali (2001), between stress and job satisfaction, whilst Ofili, Asuzu, Isah, and Ogbeide (2004) found that the rate of job dissatisfaction among Nigerian hospital doctors was much higher compared to their European and North American counterparts, although the reasons for this were unclear. In Greece, previous research into job dissatisfaction and stress in junior doctors revealed that predictors of physical and mental health, and job dissatisfaction could be predicted by Type A personality, and demands of the profession respectively (Antoniou, Davidson, & Cooper, 2003). Thus, stress in medical personnel appears to have negative implications in job satisfaction (Antoniou, 2006).

Few studies however, have focussed on the extent to which primary stressors and issues in relation to job satisfaction could be related to gender. It seems reasonable to assume that although men and women JHDs may encounter similar experiences regarding work stress and satisfaction, some fundamental differences might exist regarding how these are perceived.

Nowadays, there seems to be a growing increase in the number of women entering the medical profession (Levinson & Lurie, 2004), and an earlier report by the

Royal College of Physicians in the UK claims that working conditions for hospital doctors need to change, if women doctors are to be retained within the profession (Royal College of Physicians, London, 2001).

Previous findings using quantitative data have varied regarding the extent to which causes and effects of stress are similar or dissimilar in male and female medical professionals (Antoniou et al., 2003; Richardsen & Burke, 1991; Rout, 1999; Swanson, Power, & Simpson, 1996).

In the current study, we use a qualitative approach in order to identify specific perceptions and causes of stress in male and female junior hospital doctors. Our purpose is to investigate gender differences in primary work stressors, and job satisfaction, through a series of interviews. This issue has been rarely studied in small countries, such as Greece, and the study reported here aims at covering such a gap. It is felt that issues with regard to gender differences in Greece, might also be reflected in JHDs in other countries of a similar size and cultural structure, and that the findings could significantly contribute to the literature at a global level. Thus, the authors' efforts were geared toward contributing to the field by looking at an understudied group and their experiences with work related stress and job satisfaction, at both a generic and gender specific level. Furthermore, it is anticipated that the findings from this study could have implications for training and in-house stress management interventions in Greece. This paper was the first part of a two-part investigation that looked at JHDs and their feelings, ideas, and perspectives.

A Background Note

It may help the reader to better understand the findings of this paper if he/she knows a little bit about the culture of the JHD profession in Greece. JHDs in Greece graduate from medical schools having at least 6 years of medical school attendance and a minimum of a yearlong experience in rural medical centres. After completing their rural practice, JHDs apply for a post in an urban academic hospital, and during their training, which lasts at least 6 years, they are expected to move to various posts in different hospitals. There are no formal examinations during the 6 years in these posts and they do not change status until their final examination; successful results enable JHDs to work as qualified and specialized doctors, either in private practice or in the public sector. For the majority of JHDs, the public sector constitutes the first choice for their future career since the public sector is where they specialize, nevertheless, competition is strong and the available posts limited.

Method

Data were collected by means of semi-structured, in-depth interviews. Narrative analysis, a qualitative research technique, was used to analyze and categorize the data. According to Shaw and Gould (2001) the nature of narrative studies is both methodological and epistemological. Furthermore, it has been shown that the philosophy of narrative research is based on the notion that it is not simply a "conveyance" of individuals' subjective experiences, but also a procedure of re-integration for those who had lived difficult situations and traumatic events (Riessman, 1993). Although the

positivist authors criticise narrative research, mainly due to problems of generalizability, narrative inquiry with its idiographic rationale, has offered, in many cases, a more global and a more authentic view of the situation.

Qualitative research, according to the authors, was better suited to delineate the personal meanings (Flick, 1998; Strauss & Corbin, 1998) of the narrated experiences of the participants, without losing the richness and genuineness of their responses. Along those lines, the authors were interested in obtaining the views and opinions of Greek JHDs, which highlighted the everyday lives of male and female participants, and their collective and individual perspectives on their profession with regard to stress and satisfaction. An interactive process between the researcher and the participants was intended, with the participants' words and observable behaviour to be used as the primary data (Marshall & Rossman, 1999). Through a process of elicitation and thorough interpretation of expressions and behaviours, the interviewers investigated the perceptions of male and female Greek junior hospital doctors about the sources of stress and satisfaction entailed in the medical profession. In employing these assumptions, the authors aimed at exploring, explaining, and describing similarities and differences in male and female JHDs ideas and feelings related to stress and satisfaction.

Participants

The interviews were carried out during a 5-month period and involved 60 JHDs (32 male and 28 female) from a wide variety of medical specialties. The participants of the study worked in different hospitals in the area of greater Athens (including Piraeus) and agreed to participate in this study voluntarily. All interviews were confidential, protecting the participants' identity.

The biographical data and specialties in relation to gender follow. Participants ranged in age from 28 to 39 years-old, with a mean age of 33.5 years. The majority of JHDs were single (51.67%), while 29 participants (48.33%) were married. Gender differences with regards to specialty were made evident; cardiology, neurology, surgery, and gynecology were specialties attracting more male population, while rheumatology, endocrinology, and microbiology attracted more women in the study sample. The average male JHD profile in the interview sample was that of a 33-year-old married man, specializing in pathology, who had spent one year in rural practice and had one year of hospital experience. Conversely, the average female JHD profile in the interview sample was a 31.5-year-old single woman, specializing in pathology, with 2.5 years of hospital experience.

Before contacting Junior Doctors for participation in this study, it was necessary for the researchers to obtain the consent of the consultants responsible in each of the participating hospitals. The head of each department was also aware of the research, and permission was granted to carry out the interviews. Hospitals were selected via an investigation of press releases, which had indicated that certain hospitals were "in trouble," either due to lack of staff, or because they were receiving more patients than they could deal with, or for any other reason. Some of the participants were acquaintances of the authors, given that the latter have been involved in research with medical personnel for a long time. The process by which the authors ensured credibility

and controlled potential biases of the results, given that some physicians were acquaintances of theirs, will be explored later in the paper.

Procedure

All consultants agreed to the research being carried out in their departments. Ways of contacting JHDs were suggested, even though the majority expressed their reservations about JHDs' participation, mainly due to their time shortage and full work schedule. The first meeting with JHDs was devoted to describing the study to them and making arrangements for convenient interview times. Roughly 85% of those JHDs approached agreed to be interviewed; the main problem with the remaining 15% was failure to agree on a time that would suit their schedules.

All interviews were carried out within hospital settings in private rooms to ensure confidentiality and eliminate disruptions. At the beginning of each interview, participants were asked to read a formal letter from the University of Manchester, which contained details on the interviewers' background, the aims of the study, the use that will be made of the results, as well as some ethical considerations. Moreover, the letter assured the participants that confidentiality would be kept at all times and that their co-operation was strictly voluntary, stressing their right to withdraw from the study at any time and without any previous notice.

Twenty-five percent of the overall JHD population, who had initially agreed to take part in the research, declined to do so when they were informed that the interviews would be tape-recorded. For the interviewees, any comments made after the tape recorder was turned off were noted at the end of the interview, with their consent. According to Patton (1989) and Seidman (1991) tape recording is considered to be the most effective method of interviewing because at any moment there is immediate access to the authentic interviewees' words, free from any paraphrases or arbitrary interpretations by the interviewers. Moreover, Vygotsky (1987) has argued that the words someone speaks reflects his/her consciousness. In addition, tape recording is a means to ensure accuracy in cases where transcripts include vagueness.

At the end of each interview, the researchers thanked the participants and gave them the time to ask questions. All participants were then given a thank you letter, including a debriefing of the study.

Interviews

The aim of the in-depth semi-structured interviews was to investigate the major sources of occupational stress and levels of job satisfaction, and the extent to which these may be related to gender. Items included in the interview format were formulated from an extensive literature review. Six unstructured open-ended interviews were conducted in the beginning of the research in order to pilot the questions of the interview and understand the participants' views on the major issues involved in the study. According to Hitchcock and Hughes (1989), content analysis of more structured interviews is easy to analyze and fairly objective. Based on this suggestion, the initial interviews helped to make the rest of the study questions more structured. The average duration of each interview was 60 minutes. After the first few interviews, the researchers used some of the

comments made by the participants to guide the structure of the interviews that followed, and some questions were added as the interviews progressed. The entirety of the interviewing questions and the transcribed material are available to the reader upon request. However, examples of how the questions were enriched by the interviewees' comments will be provided so that the reader can have a better understanding of how the authors' and the participants' ideas informed each other throughout the process. One such example refers to both male and female JHDs' disillusionment of their profession; when asked to explore "the sources of job dissatisfaction regarding their profession," JHDs expressed positive ideas regarding the status, the amount of hard work, and the monetary gains of their profession. However, they also talked about the personal, familial, and relational sacrifices they make due to the long hours they put in as professionals. Those two contradictory realities (work versus personal/social life) created, as the interviewees suggested, a sense of disillusionment regarding their job as well as a powerful source of occupational stress.

The key interview questions fell into two main categories:

1. *Potential stress factors at work.* JHDs were asked to describe ideas regarding their profession, their specialties, and their perceived sources of stress.
2. *Job dissatisfaction.* JHDs were asked to describe job stresses that impacted their personal lives, how satisfied they were with their job, how they evaluated their own job performance and habits, how they demystified their profession due to their experience, and how they would advise medical school candidates who wished to pursue a career in medicine.

Results/Data Analysis

Content Analysis/Narrative Analysis

Due to the large number of participants, the authors used content analysis in addition to narrative analysis in order to be able to quantify the data responses in a systematic and replicable manner (Krippendorf, 2004; Miles & Huberman, 1994; Neuendorf, 2002; Riffe & Frederick, 2005; Weber, 1990). Content analysis is "a research technique for the objective, systematic and quantitative description of the manifest content of communication" (Berelson as cited in Bryman, 2001, p. 45). Content analysis proved a particularly appropriate method in this study since it was a useful tool for the interviewers to identify and group the various sources of stress of junior doctors practicing medicine in Greek hospitals. Through content analysis the potential correlation between work-related stressors and levels of young doctors' job satisfaction became evident.

Since the authors were also interested in learning from the experiences of the doctors, they applied the qualitative technique of narrative analysis in order to explore the interviewees' narrations with depth and rigor (Fish, 1996; Franzosi, 2004; McQuaide, 1998; Mishler, 1995; Riessman, 1993). For instance:

Interviewer: What do you believe is the most serious stress factor in your profession?

Junior Hospital Doctor (Female): Bureaucracy seems to be for me the most stressful factor for Junior Hospital Doctors in Greek hospitals today.

Interviewer: For what reasons do you think bureaucracy is the most stressful factor for you?

Junior Hospital Doctor (Female): Because we have not only to treat patients, but after a long day in the hospital we also have to supplement and archive files, gather examinations and make things that don't have any medical or scientific interest.

Interviewer: In your opinion, are there ways to overcome this?

Junior Hospital Doctor (Female): If hospitals were more organised, if we had the appropriate technical support, if we had electronic files for each patient, we would also have easier access to them and we would certainly be more effective and more flexible.

Thus, the quantitative content analysis helped quantify the large amounts of data and the qualitative analysis helped explore the meanings and personal interpretations of the participants' experiences.

Process of Analysis

The process of analysis was conducted as follows:

1. After the interviewing process was finished and the interviews were transcribed, the data was categorised, and the authors searched for meaningful relationships among the data within the categories (Roberts, 1997).
2. With "emergent coding," categories were established following some preliminary examination of the data (Haney, Russell, Gulek, & Fierros, 1998). Any repeated experience was noted and was put together with similar narrations in order to get a feel of what was emerging with regard to the content of each category.
3. Through repeated listenings of the transcribed texts as well as numerous viewings of the data, the formation of categories became evident, based on meaning and coordination among the data in order to form "new relationships" (Goetz & LeCompte, 1981, p. 58) among the recorded data.
4. As far as reliability is concerned, Weber (1990) notes, "To make valid inferences from the text, it is important that the classification procedure be reliable in the sense of being consistent: Different people should code the same text in the same way" (p. 12). After the qualitative process was completed and the authors had created numerous categories and subcategories, content analysis was used to help quantify the data and put it into larger and easier to conceptualise categories. This second step, content analysis, was also used to draw percentages, and thus help compare and contrast the content of the categories in a quantifying sense as well.

Trustworthiness

The interviews were randomly assigned to all authors. In that sense whatever interviews were used as piloting material to help guide the process were part of the data chunks and remained unknown to the three authors. As was noted earlier, the primary author was an acquaintance with a couple of the doctors who participated in the process. However, by securing the identity of the interviewees, by treating all data as one big chunk, and by randomly assigning it to the authors, it was very hard to trace the data bits to particular respondents/interviews. In case the primary author had any sense of familiarity with the transcribed bits, it was agreed among the authors, that the other two would analyse the data. That however never happened because the body of the data was so big it was humanly impossible for the primary author to recall the particularities of the responses from a couple of acquaintances. In that sense, the credibility of the data was protected. The data was also protected by the curious position of all three researchers who treated the data chunks with no preconceived notions or preassigned categories of how the data would be formalized. The categories that emerged for the data spoke to the understandings of the participants. The authors used those narratives to categorize and analyze the text. After the data was formed into categories, the authors looked at the commonalities of those categories and agreed on the final format, which consisted of two large categories that entailed all relevant subcategories and helped the authors quantify them.

Results

Male and Female JHDs' Similarities Regarding Potential Stress Factors in the Workplace

The following described the sources of stress as they were narrated by both male and female interviewees. One source was specialization, that is, choosing what kind of professional a doctor wanted to become. Within the medical profession, not surprisingly, surgery was considered as the most stressful of all specialties (26.67%), followed by cardiology (21.67%), oncology (16.67%), and finally psychiatry (15%). A second source of stress was the prospect of being unemployed for long periods of time (95%). Being unemployed relates to the fact that, by the time JHDs complete their basic education, rural practice, and specialization training, they have reached the age of about 31 without having yet been fully qualified as doctors. This could result in social as well as financial difficulties. The most popular specialties, such as surgery and pathology, have fewer positions available for junior doctors and, consequently, have long waiting lists (average waiting period of one year).

The long waiting lists and time periods are related to the third most stressful work situation (nearly 90%) for both male and female JHDs, namely, the lack of freedom to choose a specialty and style of practice. A large proportion of JHDs reported that they were "not allowed to take initiatives even for minor issues."

Furthermore, JHDs' working conditions, such as sleep deprivation and the insufficient collaboration between doctors of different specialties and departments, contributed to junior doctors' stress. Both of these situations were placed within the top

five in the sources of stress scale, characterizing the latter as unacceptable, resulting in major conflicts between doctors of different ranks and departments.

The sixth factor of occupational stress was the adverse publicity of doctors in the press. In our sample, 43.33% of male and female JHDs correlated the publicity with the bad attitude they sometimes get from patients. As a female junior doctor said,

patients are often very aggressive and that's because they don't seem to trust us. Mass media and adverse publicity have damaged our profession. I often feel that my job is being rated by patients, who believe that we are indifferent to their suffering. And the worst thing is that we are constantly accused of taking bribes in order to do our job.

This intimidation strategy coupled with the role of the media were viewed as being so invasive to doctors' work that it deteriorated their relationships with their patients and their patients' relatives.

Additional sources of stress were the lack of "appreciation of their [male and female JHDs] work by patients" (28.33%) and the time-consuming "bureaucratic procedures" (26.67%), such as hospital referrals and paperwork that JHDs are required to carry out themselves. As a JHD explained,

Bureaucracy seems to be the most stressful factor. Not only do we have to treat patients, but after a long day in the hospital we also have to supplement files, gather examinations and make certain things that don't have any medical interest. If hospitals were more organised, if we had the right instruments, if we had electronic files for each patient, we would also have an easier access to them and we would certainly do a more effective work.

Moreover, the ninth source of stress for JHDs was claimed to be the "constant need for information about medical developments (i.e., reading journals and attending training)" (28.33%), along with "being on duty and suffering from sleep deprivation" (36.67%).

Patients' excessive demands (30%) and doctors' daily contact with chronically and terminally ill patients, and their relatives (31.67%), were reported to be "fairly stressful." Male and female JHDs also rated as fairly stressful situations of conflict in their interpersonal relationships with colleagues and the rest of the staff (28.33%; 13th source of stress), patients' complaints (35%; 14th source of stress), lack of social life (30%; 15th source of stress), and problems in their work environment such as lack of facilities, equipment, and support staff (31.67%; 16th source of stress).

Some JHDs suggested that their problems are carried over during their sleep: "I often have nightmares concerning hospital matters" or "My wife has told me that I talk in my sleep about medications and operations."

Relationships in their workplace appeared to be another major source of stress for the interviewees. In particular, 26.67 % of JHDs explained that their colleagues were competitive. Competition was defined as "stealing of another doctor's case." "It is a common practice," participants suggested, "for the JHDs to *steal* cases and operations

from their colleagues in order to gain valuable experience since there is not a structured educational programme for the JHDs in the hospitals.”

With regards to junior doctors’ interaction with patients, 25% declared that patients were demanding and had many complaints, while a lack of appreciation for their work (18%) and a lack of communication (18%) were rated as the 19th and 20th source of occupational stressors respectively. Moreover, work stress was related to two more factors that were described as lack of support from superior doctors (28.33%) of JHDs and excessive demands and pressures upon the JHDs from the higher-ups (20%).

Male and Female JHDs’ Similarities Regarding Stress and Job Dissatisfaction

Stress was related to degrees of job dissatisfaction according to the interviewees. Male and female participants suggested that stress and lack of occupational gratification were interrelated and attributed to their high levels of stress. In particular, a female doctor specified that, “Hospital training is extremely poor. We don’t have a library. We are constantly charged with many responsibilities we can’t handle. Senior doctors seem to be too exhausted to give lectures and teach us about things we don’t know.” The majority of Greek JHDs were dissatisfied with their work, with a total of 28 junior doctors (46.67%) rating their satisfaction below moderate. Twenty-three junior doctors (38.33%) reported to be moderately satisfied with their job, while only 9 JHDs (15%) reported satisfaction scores above the moderate scale.

The majority of junior doctors (51.67%) maintained that job dissatisfaction was connected with their low levels of payment. One doctor commented that “society does not recognize the significance of your profession when it pays you such humiliating wages.” And another maintained, “the levels of financial satisfaction are very low, but I think I have no choice.” Junior doctors’ job dissatisfaction is, however, best described by a male doctor’s quote, “We are so much underpaid in comparison with other employees who didn’t have such a hard training as we did, or had so many responsibilities and they can go home in the afternoon and forget their job.” An additional reason for JHDs’ job dissatisfaction was the lack of formality and vagueness of their job description. They complained that they were compelled to do menial jobs such as secretarial, nurse, or even stretcher-bearer work (20%). They also considered that their job description did not have a fixed agenda (18.33%), and that very often, when something went wrong, they were the easy targets for their superiors to blame (8.33%). As one interviewee put it,

The insufficiency of our responsibilities is a serious source of stress. You don’t know where or when your responsibilities begin. Sometimes you do things that you are not supposed to and sometimes you don’t do things you are supposed to. Constantly.

JHDs’ job dissatisfaction was also made evident through their reported feelings of disillusionment about their profession as well as the advice they would give to future medical school candidates.

Of the male and female JHDs, 86.66% explained that their disillusionment stemmed mainly from the poor financial rewards of their profession (23.33%), the low prestige and social role of doctors (which are quite different from what they had imagined

they would be) (23.33%), as well as their limited capacities together with the finite limits of medicine (15%). As was characteristically mentioned by a male doctor,

I have been so much disillusioned about medicine that I wonder why I keep doing this job. One should know that medicine has a lot of limitations, should know what people are expecting from us and what we can offer to them. There is an erroneous belief that because man has stepped on the moon, he can do everything. But that's wrong.

Furthermore, most JHDs hold doctors themselves responsible for this general feeling of disappointment (48.33%), stating that they were "frustrated" by "the morality of doctors in hospitals and especially some in the high ranks."

Consequently, most male and female junior doctors related their job dissatisfaction with vague career prospects and job insecurity (15%), low financial gains compared to the work accomplished (13.33%), poor working conditions (13.33%), and lack of leisure time (11.67%).

Male and Female JHDs' Differences with Regard to Stress and Job Satisfaction

Gender seemed to play an important role in the lives of JHDs and was interconnected with stress and job dissatisfaction. A total of 11 JHDs (18.33%) stated that female junior doctors were discriminated against by patients, especially in specific specialties (i.e., surgery). Moreover, JHDs in general found that male junior doctors were treated with more respect by patients, who considered them as more efficient (13.33%), stating "sometimes patients and their relatives pay more respect to male JHDs in the first year of training than a female consultant," while six junior doctors (10%) stated that they believed patients have less trust in female JHDs. However, 3 male doctors (9%) stated that their female counterparts have more opportunities in their career development due to their gender. Gender differences were also noted in the choice of specialties. According to the majority of Greek junior doctors, "general surgery, urology, gynaecology, angioplasty, and orthopaedics were considered as male specialties" due to the prevailing notion that women are less effective in these, mainly because of their high physical demands.

Female JHDs felt that the lack of appreciation for their work by patients and their relatives was a very stressful factor, while male JHDs described bureaucratic procedures in the hospital as extremely stressful. Out of 17 JHDs (28.33%), who claimed that they do not worry about problems at their work, only five (29.41%) were female, suggesting that women are more stressed about problematic work situations in comparison to their male counterparts. Accordingly, male JHDs (28.33%) appeared to be more satisfied with their jobs than females (18.33%) and believed that their payments were unsatisfactory (35%) compared to the female population (16.67%).

Balancing the work and home interfaces (13.33%) and the lack of appropriate hospital facilities (18.33%) were the main sources of stress for the female interviewees, while their male counterparts declared that being constantly in need of information about new medical developments (16.67%) and excessive job demands (11.67%) constituted great sources of stress. Interestingly, when asked about their interest in attending a stress

management programme, out of the 19 JHDs who answered positively (31.67%), 12 were female and only 7 were male. Moreover, 13 male and 8 female JHDs answered that they had no time to attend such a programme, stating that they were not willing to “spend additional time.”

This is how some JHDs expressed themselves regarding occupational stress and job dissatisfaction. “Sometimes, the patients and their relatives pay more respect to a male JHD in the first year of his training than a female consultant” (male).

At the end of a long and tiring hospital duty, I normally go back home and perform the usual daily routine that all women do. For a woman to be able to combine both tasks, however much she tries, finally she will fail in both (female).

“During an operation, there is no chance of a woman being trusted when there is a man surgeon present” (female). “At present, an increasing number of women confide in a woman gynaecologist” (male). “I believe that a woman surgeon is not considered the ideal wife because of the irregular hours of work” (female).

Discussion

Through the data analysis, it was made evident that the majority of both male and female JHDs participating in the interview sessions considered their profession to be the most stressful, with many reporting high levels of job dissatisfaction. There were a number of similarities between male and female JHDs’, with professional prospects constituting a major issue and concern about the present and the future. For a significant proportion of the study sample, being unemployed for long periods of time constituted a major source of occupational stress. Spending several years in medical school and in specializing, junior doctors in Greece face many social and financial difficulties, very often reaching their 30s without unemployment and still in a stage of training.

Additionally, the long waiting lists and periods of time between changing clinics and hospitals in order to cover the high demands of their specialty, constituted a devastating period for Greek JHDs since almost half of the study’s sample were married and had children.

In Greece, both male and female JHDs are the population among hospital doctors who suffer the most from diverse working conditions, since they spend more working hours in hospitals than doctors in other ranks (Antoniou et al., 2003; Pipili, 1996). In particular, working conditions during night shifts are considered unacceptable; noisy staff rest rooms and lack of air conditioning, especially during the summer season, are the conditions under which JHDs are expected to work. Research indicates (British Medical Association, 1992; Dudley, 1990) that the unacceptable general facilities and in particular, those associated with sleeping and eating conditions, limit JHDs’ opportunities for social interaction and increase their levels of stress.

JHDs’ poor relationships in the workplace, especially with their patients and supervisors, appeared significant in relation to their levels of stress. Both male and female JHDs equally expressed their frustration regarding patients’ constant complaints about their treatment and the quality of their hospital stay, while male doctors expressed

more frequently their dissatisfaction about the adverse publicity their profession holds in the press. Lack of appreciation of doctors' work and patients' distrust of women doctors, in conjunction with some cases of aggressive behaviour lead some junior doctors to reduced levels of personal and professional motivation.

The fear of making mistakes and the adverse publicity turn doctors to "defensive medicine" (Antoniou, 1999; Chatzioannidou, 1996): Doctors spend more time and money on radiological and laboratory tests in order to ensure reliable results and diagnosis. Even though doctors try their best to avoid malpractice, some interviewees mentioned that patients at times exhibit inappropriate behaviour, which doctors considered humiliating both personally and professionally, thus affecting their self-respect.

Little less than half of the study sample, and especially male junior doctors, reported significant problems concerning their relationships with their superiors. According to the interviewees, their superiors were excellent scientists, but not supportive and sympathetic enough regarding JHDs' job related problems. A possible explanation of this phenomenon is that consultants have been through similar or worse difficulties during their own training, and perhaps do not consider JHDs' complaints as valid and important. Lack of feedback about JHDs' performance also constituted a major problem and was also demonstrated in previous research findings (Wise, 1995).

The majority of male and female JHDs reported being dissatisfied with their job, mainly due to its financial and moral aspects. In addition to identifying similarities in work stress between male and female HCPs, this study also focused on differences between the two. In particular, male junior doctors were generally found to experience higher levels of stress than their female counterparts.

A high percentage of female junior doctors expressed their anxiety and frustration against patients' complaints, their lack of appreciation of their job, and their excessive demands, which could probably reflect patients' unequal attitudes and behaviours towards female and male junior doctors. Many JHDs believe that "there are stereotypical roles for the male and the female JHDs in the hospital." For example, when patients are in need of a specialized doctor, such as a surgeon, they frequently react negatively when assigned a female doctor. This corresponds to the relatively low number of female surgeons, compared to males. A female JHD argued, "...a woman surgeon is not yet accepted. That is why I changed my specialty during my training to do skin surgery instead of general surgery. By their nature, surgery specialties are extremely competitive."

In general, female JHDs expressed their concerns about their difficulties in and out of hospital settings. Although the majority of the female population in this study declared their devotion to the humanitarian character of medicine, they were forced to make great efforts in order to work with dignity. The stereotypical roles of male and female junior doctors are nurtured within Greek hospital settings extending to unjustified competition with other health care professionals (i.e., nurses). JHDs frequently reported hostile behaviours towards them by nurses, which were unjustifiable.

In particular, male junior doctors regarded the lack of communication in their interpersonal relationships with staff and colleagues as a significantly higher source of stress than females, while female junior doctors generally regarded dealing with problem patients as more stressful than their male counterparts.

This study was a qualitative study, which investigated particular variables in a particular period of time. Inferences for causes and effects are not possible since the findings are descriptive (Cohen & Manion, 1989). A number of researchers (Burke, 1986; Frese & Zapf, 1988) have appealed for more longitudinal designs in order to provide more detailed information and to investigate stress over long periods of time. The small sample size and the nature of the study sample had an inherent built-in bias since it was constituted by JHDs working in the greater Athens area only.

It is essential to replicate this research to larger samples utilising quantitative as well as qualitative methods, selecting participants from all regions of Greece in order to allow for the findings to be generalised to the general population. Therefore, a longitudinal study is suggested in order to learn more about JHDs' stressors and gender differences.

Antoniou (1999) suggests that the existence of systematic training programmes will benefit male and female JHDs and provide them with the necessary and complete educational targets and practical tasks, which they ought to carry out in every training year towards the completion of their specialty. He supports that the determination of these targets is of crucial importance, on the one hand because JHDs must recognise the boundaries of their specialty, which will help them avoid conflicts with other professionals, on the other hand, in order to avoid "shrinkage" of the existing programmes on the part of the consultants and the supervisors. The establishment of central coordinating bodies in each hospital is necessary to assess the various programs. These bodies should be independent of the government and the universities, so as to be objective and result in the upgrading of JHDs' training.

Recommendations can also refer to JHDs at an individual level, and at identifying particular primary stressors specific to male or female JHDs. Keeping a stress diary can be an effective strategy towards the reduction of stress, which will help going over stressors, rationalising them, and coping with them effectively. Moreover, types of training such as assertiveness, time management, and progressive relaxation training can also contribute to junior doctors' stress management (Sutherland & Cooper, 2003). Creating a strong social support system, justified by the findings of this study, constitutes one of the most effective strategies towards the reduction of stress levels (Antoniou, 1999; Hulse, Sim, & Khong, 2004). Bearing in mind that doctors have very busy schedules, asking them to do anything on top of their daily responsibilities in the hospital may prove cumbersome and may be neglected. This is why it is important to provide doctors in general, and junior doctors in particular, with a list of possible alternatives, so they can pick and choose the ones best suited to them (Jagsi & Surender, 2004).

In conclusion, the findings of this study may have implications for training and in-house stress management programmes in Greece, both at a generic and gender specific level. Future research should focus on the one hand, on improving the individual's capacity for coping and, on the other hand, to identify the environmental sources of stress in order to make the appropriate changes towards stress reduction for JHDs.

References

- Antoniou, A.-S. (1999). Personal traits and professional burnout in health professionals. *Archives of Hellenic Medicine*, 16(1), 20-28.

- Antoniou, A.-S. (2001, February 20). (Ed.). Occupational stress: Acute and chronic stress factors [Special issue on Occupational Stress]. *Eleftherotypia* [Free Press], 100.
- Antoniou, A.-S. (2006). *The occupational health of hospital doctors*. Athens, Greece: Parissianou Medical Editions.
- Antoniou, A.-S., Davidson, M. J., & Cooper, C. L. (2003). Occupational stress, job satisfaction, and health state in male and female junior hospital doctors in Greece. *Journal of Managerial Psychology, 18*, 592-621.
- Arnetz, B. B. (2001). Psychosocial challenges facing physicians of today. *Social Science and Medicine, 52*, 203-213.
- British Medical Association. (1992). *Stress and the medical profession*. London: Author.
- British Medical Association, Health Policy, and Economic Research Unit. (1998). *Work-related stress among junior doctors*. (A report from the BMA Cohort Study of 1995 medical graduates). London: Author.
- Bryman, A. (2001). *Social research method*. Oxford, UK: Oxford University Press.
- Burbeck, R., Coomber, S., Robinson, S. M., & Todd, C. (2002). Occupational stress in consultants in accident and emergency medicine: A national survey of levels of stress at work. *Emergency Medical Journal, 19*, 234-238.
- Burke, R. J. (1986). The present and future status of stress research. *Journal of Organisational Behavior Management, 8*(2), 249-267.
- Caplan, R. D., Cobb, S., French, J. R. P., Jr., Harrison, R. V., & Pinneau, S. R., Jr. (1975). *Job demands and worker health: Main effects and occupational difference*. Report to the National Institute for Occupational Safety and Health, HEW Publication (NIOSH Publication No. 75 160). Washington, DC: U.S. Department of Health, Education, and Welfare.
- Chatzioannidou, E. (1996, March 17). The “medical mistakes” and how we cope. *E Kathimerini* [The Daily], 28.
- Cohen, L., & Manion, L. (1989). *Research methods in education* (3rd ed.). London: Routledge.
- Coomber, S., Todd, C., Park, G., Baxter, P., Firth-Cozens, J., & Shore, S. (2002). Stress in UK intensive care unit doctors. *British Journal of Anaesthesia, 89*(6), 873-881.
- Cooper, C. L., Dewe, P., & O'Driscoll, M. (2001). *Organisational stress: A review and critique of theory, research, and application*. London: Sage.
- Deary, I. J., & Trait, R. (1987). Effects of sleep disruption on cognitive performance and mood in medical house officers. *British Medical Journal, 295*, 1513-1516.
- Dudley, H. A. (1990). Stress in junior doctors. 1-Stress and support. *British Medical Journal, 301*, 75-76.
- Fish, B. (1996). Clinical implications of attachment narratives. *Clinical Social Work Journal, 24*(3), 239-253.
- Flick, U. (1998). *An introduction to qualitative research*. London: Sage.
- Franzosi, R. P. (2004). *From words to numbers: Narrative, data, and social science*. New York: Cambridge University Press.
- Frese, M., & Zapf, D. (1988). Methodological issues in the study of stress: Objective vs. subjective measurement of work stress and the question of longitudinal studies. In C. L. Cooper & R. L. Payne (Eds.), *Causes, coping, and consequences of stress at work* (pp. 62-77). London: John Wiley & Sons.

- Goetz, J. P., & LeCompte, M. D. (1981). Ethnographic research and the problem of data reduction. *Anthropology and Education Quarterly*, 12, 51-70.
- Haney, W., Russell, M., Gulek, C., & Fierros, E. (1998). Drawing on education: Using student drawings to promote middle school improvement. *Schools in the Middle*, 7(3), 38-43.
- Hitchcock, G., & Hughes, D. (1989). *Research and the teacher: A qualitative introduction to school based research*. London: Routledge.
- Hulse, G., Sim, M. G., & Khong, E. (2004). Management of the impaired doctor. *Australian Family Physician*, 33, 703-707.
- Jagsi, R., & Surender, R. (2004). Regulation of junior doctor's work hours: An analysis of British and American doctors' experiences and attitudes. *Social Science and Medicine*, 59, 2181-2191.
- Krippendorff, K. (2004). *Content analysis: An introduction to its methodology*. Thousand Oaks, CA: Sage.
- Levinson, W., & Lurie, N. (2004). When most doctors are women: What lies ahead? *Annals of Internal Medicine*, 141, 471-474.
- Makin, P. J., Rout, U., & Cooper, C. L. (1988). Job satisfaction and occupational stress among general practitioners—A pilot study. *Journal of the Royal College of General Practitioners*, 38, 303-306.
- Marshall, C., & Rossman, G. B. (1999). *Designing qualitative research*. London: Sage.
- Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. In S. T. Fiske, D. L. Schacter, & C. Zahn-Waxler (Eds.), *Annual review of psychology* (Vol. 52, pp. 397-422). Palo Alto, CA: Annual Reviews.
- McQuaide, S. (1998). Opening space for alternative images and narratives of midlife women. *Journal of Clinical Social Work*, 26(1), 39-53.
- Miles, M. B., & Huberman, M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed). Thousand Oaks, CA: Sage.
- Mishler, E. G. (1995). Models of narrative analysis: A typology. *Journal of Narrative and Life History*, 5(2), 87-123.
- Moss, P. J., Lambert, T. W., Goldacre, M. J., & Lee, P. (2002). Reasons for considering leaving UK medicine: Questionnaire study of junior doctors' comments. *British Medical Journal*, 325, 685-686.
- Neuendorf, K. A. (2002). *The content analysis guidebook*. Thousand Oaks, CA: Sage.
- Newbury-Birch, D., & Kamali, F. (2001). Psychological stress, anxiety, depression, job satisfaction, and personality characteristics in preregistration house officers. *Postgraduate Medical Journal*, 77, 109-111.
- Ofili, A. N., Asuzu, M. C., Isah, E. C., & Ogbeide, O. (2004). Job satisfaction and psychological health of doctors at the University of Benin Teaching Hospital. *Occupational Medicine*, 54, 400-403.
- Patton, M. Q. (1989). *Qualitative evaluation methods*. Beverly Hills, CA: Sage.
- Pipili, L. (1996, March 17). "The lost honour" of the Greek doctor. *To Vima* [The Pace], 84-85.
- Riessman, C. K. (1993). *Narrative analysis*. Newbury Park, CA: Sage.
- Riffe, D. S. L., & Frederick, G. F. (2005). *Analyzing media messages: Using quantitative content analysis in research* (2nd ed.). Mahwah, NJ: Lawrence Erlbaum.

- Roberts, C. W. (Ed.). (1997). *Text analysis for the social sciences: Methods for drawing inferences from texts and transcripts*. Mahwah, NJ: Lawrence Erlbaum.
- Rout, U. (1999). Gender differences in stress, satisfaction and mental wellbeing among general practitioners in England. *Psychology, Health, and Medicine*, 4, 345-354.
- Royal College of Physicians, London (2001). *Women doctors need major change in NHS working patterns*. Retrieved September 3, 2008, from www.rcplondon.ac.uk
- Schaufeli, W. B. (1999). Burnout. In J. Firth-Cozens & R. Payne (Eds.), *Stress in health professionals: Psychological and organizational causes and interventions* (pp.17-32). London: Wiley.
- Seidman, I. E. (1991). *Interviewing as qualitative research*. London: Columbia University.
- Sexton, J. B., Thomas, E. J., & Helmreich, R. L. (2000). Error, stress, and teamwork in medicine and aviation: Cross sectional surveys. *British Medical Journal*, 18, 745-749.
- Shaw, I. F., & Gould, N. (Eds.). (2001). *Qualitative research in social work*. Thousand Oaks, CA: Sage.
- Sparks, K., Faragher, B., & Cooper, C. L. (2001). Well-being and occupational health in the 21st century workplace. *Journal of Occupational and Organizational Psychology*, 72, 261-264.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.
- Sutherland, V. J., & Cooper, C. L. (2003). *De-stressing doctors: A self-management guide*. London: Elsevier Science.
- Vygotsky, L. S. (1987). *The collected works of L. S. Vygotsky* (Vol. 1). New York: Plenum.
- Weber, R. P. (1990). *Basic content analysis*. Newbury Park, CA: Sage.
- Wise, A. Rutledge, A., & Craig, M. (1995). *Preparing proper doctors: An evaluation of the intern training in Queensland hospitals 1990*. Australia: University of Queensland.

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