Personal Paper

A stressful life

DEREK MEYERS

Words, introduced for a given purpose, can escape from control, and take on a significance never originally intended. "Stress" already had several interpretations before Hans Selye used the term in 1946 to refer to various influences on the body which could produce several measurable consequences. The first spectacular results of using cortisone in rheumatoid arthritis, so avidly described in the press, and the popular misinterpretation of Selye's ideas helped to spread to a receptive lay public, at a most opportune time, the notion of stress as a noxious agent.

Life used to be real and earnest. Now the welfare State and its many well-intentioned functionaries, not content with bringing succour to those in evident need, do their best to wrap the citizen in cotton-wool, insulating him from the many injustices of a harsh world. Though the citizen is encouraged to expect a stress-free life, he does not always get it. His introduction is appropriate. The journey down the birth canal, "ex utero in frigidum mundum," should prepare the infant for anything that could come. But the baby is put down when he wishes to be picked up, given a nurse and a bottle when he wants his mother's breast, and left alone without a kindly word for hours on end. The toddler has the traumas of kindergarten, where, instead of loving relatives to whom he is accustomed, he finds aggressive and hostile older children. The comforts of the nursery give way to the stark austerity of the classroom, the competitiveness of examinations, the uncertainties of job applications, the demands of supervisors, the spectre of illness, the approach of dissolution. How unjust, how cruel!

Medicine's greatest successes lie in prevention. With the conquest of the infectious diseases that used to reap off so many in their prime, health maintenance has come to the fore. The more privileged groups look to their regular medical check as a near approach to the elixir of life. What can the personal doctor do? Many advocate a search for cancer, especially of the lung, cervix, breast, and large bowel, as well as the much simpler measurement of blood pressure and lipid profile. The patient readily submits to the necessary procedures, yet will usually decline the advice, much more important for the community at large, to drink less alcohol, eat less, stop smoking, drive carefully, and take regular exercise. But what of stress?

Promoted beyond his ceiling

In the not yet egalitarian society there is still no shortage of ambitious people. With promotion comes an increase in pay and status, together with an increase in responsibility and a need to delegate. Every doctor who has examined senior members of the public service or private firms is familiar with the person promoted, as General Montgomery put it, beyond his ceiling. The good company commander may be hopeless with a battalion.

The good office manager, impressive to his superiors (not that they realise his impressive record is the result of an obsessional personality) becomes a nervous wreck when promoted to a position where he must delegate and can no longer attend to every detail himself. Such a person presents a problem in the public service, where, it appears, nobody can be returned to a level from which he has risen; "promotion sideways" is commonplace in the private sector, and a fair method of dealing with a person injudiciously selected for higher office.

The doctor is occasionally asked to give an opinion about a person's eligibility for an invalid pension, disability benefits, or early retirement on health grounds, the terminology depending on the type of fund to which the claimant belongs. Complicating the issue is the fact that an employee may retire on a considerably bigger income or greater lump sum benefit if he leaves his work for health reasons than if he elects to retire early. In workers' compensation cases an illness is, or is not, related to employment, according to the opinion of the person, board, or court entitled to make the decision. What part does stress play in all this?

The normal retiring age is 65. In many occupations it is 60, while in some the employee has the option of retiring at 55. With unemployment falling most heavily on young people there have been suggestions that early retirement of the elderly is desirable to provide more opportunities for youth. The entitlement to take more money on the basis of retirement because of invalidity tends to make applicants see themselves as sicker than they are, and to bring pressure on the doctor, especially the family doctor, to provide a certificate favourable to their case. Add to this the boredom that many people feel with a job held for many years and which no longer presents challenges to them, resentment of the middle aged for their juniors (often much better trained), and the frustrations of those whose attainments fall short of their ambitions; the pressure on the doctor to provide the certificate can become formidable.

Life's only two certainties are death and taxes, and the former, if people live long enough, is inevitably preceded by a period of decay in one or several parts of the body. Of the three most common causes of death—coronary disease, cancer, and stroke—the origins are ill understood, but their very commonness suggests that they are something to which the flesh is heir—a consequence of having been born. Yet in the present climate of opinion, when nobody need accept responsibility for himself, there must always be not only a cause but something to blame—a scapegoat, the basis of the ills that each person suffers. Nothing can be a natural process and much less a result of the individual's own actions or omissions; a malign outside agency is responsible, the person the innocent and defenceless victim. In the absence of any obvious cause, such as injury or infection, stress may always be invoked—and who can refute the claim?

Stress is universal

The board makes impossible demands of the managing director; the minister hounds the under secretary; the manager

expects the impossible from his office staff; his secretary persecutes the typing pool; those at the bottom of the totem pole, having no one to sit on, find endless ways of frustrating the wishes of their immediate and more remote superiors. Stress is universal—none can escape it. So if Mr Smith has a stroke on his way to work it was not an inevitable consequence of vascular disease evolving over most of his lifetime, but of the unpleasant conditions in his office, a 10-hour day, the annual stocktake, the new manager, or some other factor causing his blood vessels to collapse under the strain.

How would the stress of daily life compare with that of unusual conditions? Former prisoners of war, the survivors of concentration camps, and Kampuchean refugees understand what real stress is. Against this scale how does one calculate the tribulations of the bored, frustrated, disgruntled employee, whether he be labourer or chief executive?

It seems likely that the medical profession will come under pressure to recognise stress as a contributing factor in illness in many cases where workers' compensation or retirement on health grounds is at issue. This question should be approached like any other in medicine. Where is the proof that stress "causes, aggravates, or accelerates" the development of such conditions as hypertension, atheroma, or cancer? Moreover, if stress as a contribution to any illness is to be recognised it must be seen in relation to the ability of the person to tolerate it. The labourer promoted to acting foreman may be under much greater stress, for him, than is the accountant promoted to manager or the departmental head to under secretary. Before stress becomes the key to the treasury, we should look for evidence of its effects and a means to measure it. And if we are to accept a role for stress, with or without the evidence, we should make sure that its benefits, as well as its ill effects, are available to all comers.

Hospital Topics

Changing attitudes in the management of urinary incontinence—the need for specialist nursing

ANGELA M SHEPHERD, JANET P BLANNIN, R C L FENELEY

Abstract

Much interest has been shown recently in the plight of the incontinent patient and how incontinence should be managed. Incontinence has a complex aetiology and may be part of many medical and social problems. Because there is a delay between completing investigations and making a diagnosis we have established a system of nursing care. Initially this was meant to provide the person protective garments and appliances, but it now covers management in both the community and the hospital. The preliminary results show that patient assessment is effective and that specialist nurses and a co-ordinated scheme to educate both doctors and nurses are needed.

Introduction

Urinary incontinence is common and yet its management has been largely ignored. Thomas¹ showed a wide disparity between those who were recognised to be incontinent and those who reported in a postal survey that they were. About 2.5% of women over 65 were recognised as incontinent, but the survey showed a prevalence of 11.6%. Almost three-quarters of those who complained of moderate or severe leakage were receiving no help.

Even those people who do reach the health service often

receive poor treatment. They are seen by many different doctors who may find diagnosis difficult and management unsuccessful. The patients and their relatives do not receive immediate help in what for them is an urgent and distressing condition.

Recognising this failure to manage incontinence in Bristol, we started a nursing clinic where patients were given early help with their immediate problems and where diagnosing the specific mechanism of bladder dysfunction was of secondary importance. The clinic was organised (together with ward assessment and community care) as part of a large Medical Research Council study into all aspects of urinary incontinence. The service has prospered and seems to be satisfying an important but often unrecognised need.

Setting up the clinic

The clinic is held once a week and was started by a nursing sister appointed to research into the aids available for managing incontinence. She is helped by two trained nurses from the urology outpatient department, and there are no doctors. Men and women with incontinence are referred from hospital consultants, family doctors, and community nurses, and occasionally patients or their relatives come seeking advice on their own.

Certain patients benefit from a short stay in hospital, and for these we have three beds in the urology ward. The second ward sister was appointed with a specific interest in managing incontinence, and part of her job is to liaise with community nurses and visit her patients before and after their stay in the ward.

Patient assessment

The main task of these clinics is the individual assessment of the patient in a relaxed and unhurried atmosphere. It is not a diagnostic clinic, and investigation is usually limited to urine analysis alone. The

Clinical Investigation Unit, Ham Green Hospital, Bristol BS20 0HW
ANGELA M SHEPHERD, MD, MRCP, clinical assistant
JANET P BLANNIN, SRN, research sister
R C L FENELEY, MCHIR, FRCS, consultant urologist