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DO OUR DOCTORS AND NURSES COPE WELL WITH THEIR STRESS?

MAHMOOD NAZAR MOHAMED
SABITHA MARICAN

ABSTRACT

Stress exists in all spheres of life. One which is most researched is stress related to work. This study investigates the experience of stress among the health profession in the state of Kedah and how they cope with the stress. Data was collected from a total of 346 doctors, nurses and administrators by using Demographic Profile Questionnaire, Stress Inventory (Gmelch, 1982) and the COPE Scale (Carver, Scheier & Weintraub, 1989). The most common stressors are of organizational-type, that is, the health professionals feel stressed by their role conflict, by limitations in the organizational structure and by the amount of workload. Overall, stress that originates from family and their own personal life ranked fourth. As for coping strategies, most of the health professionals turn to religion (such as praying and meditating) when they feel stressed followed by some cognitive-behavioral approach such as planning, strategizing and directly handling the problem at hand. Poor coping strategies such as the use of denial (defense mechanism) and drugs were not preferred and were least used as a form of coping strategy. This study concluded that health professionals in the state of Kedah faced some organizational-type stress and used health coping mechanism to overcome their stress.

ABSTRAK

Tekanan wujud dalam pelbagai skop kehidupan manusia. Satu aspek yang sering dikaji adalah tekanan yang berkaitan dengan kerja. Kajian ini meneliti pengalaman tekanan di kalangan profesion perubatan dan kesihatan di Negeri Kedah, dan cara mereka mengatasi tekanan ini. Data dikumpul daripada 346 orang pegawai perubatan, jururawat dan pentadbir kesihatan dengan menggunakan Soalselidik Profail Demografi, Inventori Tekanan (Gmelch, 1982), dan Skala COPE (Carver, Scheier & Weintraub, 1989). Punca tekanan yang sering dialami adalah dari sumber organisasi. Mereka merasa tertekan dengan konflik peranan, batasan-batasan dalam struktur organisasi dan juga bebanan kerja yang tinggi. Secara keseluruhannya, tekanan yang berpunca daripada keluarga dan diri peribadi berada

di paras keempat di belakang punca dari organisasi. Mengenai strategi daya tindak, kebanyakan daripada pekerja bidang perubatan dan kesihatan menggunakan pendekatan keagamaan (sembahyang, berzikir) apabila berhadapan dengan tekanan. Ini diikuti dengan strategi-strategi kognitif-tingkah laku seperti perancangan, merangka strategi dan menguruskan masalah secara langsung. Strategi daya tindak yang tidak produktif seperti penafian (mekanisme bela diri) dan dadah tidak menjadi pilihan mereka apabila berhadapan dengan tekanan. Kajian ini merumuskan bahawa profesion kesihatan di Negeri Kedah berhadapan dengan tekanan yang berpunca daripada organisasi kajian, dan mereka berjaya mengatasinya dengan menggunakan strategi daya tindak yang produktif.

INTRODUCTION

Work stress has been a topic of great interest as it covers a wide range of factors such as role conflict and ambiguity (Gutek, Searle & Kelpa, 1991), work overload (Caplan *et al.*, 1995), underutilization of skills (Everly & Falcione, 1976; Karasek, 1979; Lancero & Gerber, 1995), resource inadequacy (Friend, 1982), and lack of participation (Leiter & Maslach, 1988; Peterson, Hasley, Albrecht & McGough, 1995). These stressors are predictive of numerous negative attitudinal and behavioral outcome, such as job dissatisfaction (David, James & Robert, 1986), job-related tension and anxiety (McGarth, Reid & Boore,1989), lower performance and a greater propensity to leave the organization (Brief & Aldag, 1976; Friend, 1982; Jamal, 1984; Zohar, 1995). Additionally, stress-related problems among workers contribute to dysfunctional organizational consequences such as increased absenteeism and turnover and lower productivity and morale (Beehr & Newman, 1978; Perkins, 1994; Peterson *et al.*, 1995).

Stress also occurs at all levels of the medical profession. Severe exposure to stress and job pressure puts doctors in the U.S. three times higher in committing suicide than the general public, high risk for major depression, alcoholism and drug abuse (Pincus, 1995). Sutherland (1995) also reported that there is a decrease in the job satisfaction and a remarkable increase in somatic anxiety and depression amongst general practitioners in the United Kingdom. In another study of over 2,000 Canadian physicians it was found that doctors under stress had more problems with patients, obtained less satisfaction from medical practice, and rated low for their quality of care. However, very little of the variance in job stress was accounted for by demographic or work-related variables (Burke & Richardson, 1990). Similarly,

in a study of 1,817 general practitioners, it was found that aspects of job stress and personality (Type A behaviour pattern) were significant predictors of psychological distress (Cooper & Baglioni, 1988).

Nurses are also severely exposed to stress. Various studies showed that amongst stress faced by nurses are low decision latitude (Karasek, 1979) which has been described in various ways including feeling unable to influence administrative decisions (White, 1980; Peterson *et al.*, 1995), underutilization of skills and abilities (Everly & Falcione, 1976), no open expression of views or joint problem-solving (Revicki & May, 1984), and little say about career development, classifications and assignments of tasks (Sexton, 1982).

In general, health professionals face a type of occupational stress, which is not experienced by most other professions (Burke & Richardson, 1990). They deal with people in extreme situations, which have profound implications such as involving death and suffering. Thus stress endured by health professionals at work can lead to burnout (Schaufeli, Maslach & Marek, 1993), a situation which has no universally agreed definition, but is said to be comprised of emotional exhaustion and a reduced sense of personal accomplishment (Leiter, 1988).

There are different ways in which individuals cope with the stress that they experience, some of which are more effective than others. But what is an effective coping attempt? The definition of an 'effective' coping strategy may vary depending on one's perspective. Schonflug (1993), for example argued that stress itself is seen as a state of inefficiency; and coping attempts, although effective or ineffective in solving these problems are also seen as capable of generating new stress.

The two functions of coping, according to Folkman (1984) are to regulate stressful emotion's (emotion-focused coping) and to alter the troubled person-environment relationship causing the distress (problem-focused coping). Folkman and Lazarus (1980; 1985) have shown that both forms of coping are used in most stressful interactions and that the relative proportions of each form vary according to how the encounter is appraised. Folkman and Lazarus (1986) found that individuals used more problem-focused forms of coping in encounters they appraised as changeable, and more emotion–focused forms of coping in situations they viewed as unchangeable.

Although most stressors elicit both types of coping behaviors (problem and emotion-focused coping), that is problem-focused coping tends to predominate when people feel that something constructive can be done, whereas emotion-focused coping tends to predominate when people feel that the stressor is something that must be endured (Folkman & Lazarus, 1980).

The question is how does the medical profession cope with all these stressors? This is an important aspect to understand because the task that the medical professions are involved in require them to be in a healthy state of being to enable them to be effective and efficient in their job.

In view of the significant level of job-related stress experienced by health professionals, this study attempts to identify the main sources of stress and how they cope with these stressors.

METHODOLOGY

The research is designed to solicit respondents to report their past stressful situations based on an inventory, and how they cope with these stressful experiences. Thus, a cross-sectional survey design is employed for this study.

The data for the study were obtained mainly from doctors and nurses. Samples were drawn from nine hospitals located throughout the state of Kedah (Alor Setar, Sungai Petani, Jitra, Yan, Sik, Kuala Nerang, Kulim, Baling and Langkawi). An available list provided by each hospital administrators were used as the population frame and samples are drawn randomly from this list, with specific strata reference to doctors and nurses, male and female.

Biographical data such as age, sex, ethnic background, marital status, and the level of education, were obtained by using a Demographic Profile Questionnaire.

Stress descriptive items were obtained from Gmelch's (1982) Stress Inventory, which focused on five broad categories of job stress: private life, environmental, organizational, interpersonal and personal variables. The measurement of those items was accomplished through a five-point Likert scale. The subscales of the inventory are as presented in Table 1.

Table 1
Subscales of the Stress Questionnaire (Sources of Stress)

Subscales	No. of Item
1. **Private Life**	10
2. **Work Environment**	8
3. **Organization**	
Work Overload	6
Work Underload	6
Job Ambiguity	6
Organizational Structure	6
Role Conflict	6
Managing People	6
Travelling	6
4. **Interpersonal**	10
5. **Personal**	10

The COPE scale (Carver *et al.*, 1989) was used to assess the coping strategies. Embedded in the ways of coping is a distinction between two general types of coping: Problem-Focused Coping is aimed at problem solving or doing something to alter the source of stress; Emotion Focused Coping, is aimed at reducing or managing the emotional distress that is associated with (perceived by) the situation. The subscales of the COPE Scale are as presented in Table 2; the subscales as noted by Carver *et al.* (1989) with loadings on each items are as indicated in Table 3.

Table 2
Subscales of the COPE Scale

Subscales	No. of Items
1. Active coping	4
2. Planning	4
3. Suppression of competing activities	4
4. Restrain coping	4
5. Seeking support for instrumental reasons	3
6. Seeking social support for emotional reasons	4
7. Positive reinterpretation and growth	4
8. Acceptance	4
9. Turning to religion	4
10. Focus on and venting of emotions	4
11. Behavior disengagement	4
12. Mental disengagement	4
13. Alcohol – drug disengagement	1
14. Denial	4

Table 3

COPE Scale: Items Listed by A Prior Scale Assignment, with Loadings on the Factor to Which Each Item Pertains

	Scale name and items*	Loading Factor
1.	**Active** coping	
	I take additional action to try to get rid of the problem	.42
	I concentrate my efforts on doing something about it	.37
	I do what has to be done, one step at a time	.33
	I take direct action to get around the problem	.29
2.	**Planning**	
	I try to come up with a strategy about what to do	.73
	I make a plan of action	.68
	I think hard about what steps to take	.53
	I think about how I might best handle the problem	.49
3.	**Suppression** of competing activities	
	I put aside other activities in order to concentrate on this	.68
	I focus on dealing with this problems, and if necessary let other things slide a little	.55
	I keep my self from getting distracted by other thoughts or activities	.51
	I try hard to prevent other things from interfering with my efforts at dealing with this	.48
4.	**Restraint** coping	
	I force myself to wait for the right time to do something	.71
	I hold off doing anything about it until the situation permits	.67
	I make sure not to make matters worse by acting too soon	.62
	I restrain myself from doing anything too quickly	.40
5.	Seeking social support for **instrumental** reasons	
	I ask people who have had similar experiences what they did	.66
	I try to get advice from someone about what to do	.65
	I talk to someone to find out more about the situation	.60
	I talk to someone who could do something concrete about the problem	.55
6.	Seeking social support for **emotional** reasons	
	I talk to someone about how I feel	.71
	I try to get emotional support from friends or relatives	.71
	I discuss my feelings with someone	.69
	I get sympathy and understanding from someone	.58
7.	Positive reinterpretation & **growth**	
	I look for something good in what is happening	.75
	I try to see in a different light, to make it seem more positive	.59
	I learn something from the experience	.53
	I try to grow as a person as a result of the experience	.19

Table 3
COPE Scale: Items Listed by a Prior Scale Assignment, with Loadings on the Factor to Which Each Item Pertains
(Continued)

	Scale name and items*	Loading Factor
8	**Acceptance**	
	I learn to live with it	.68
	I accept that this has happened and that it can't be changed	.60
	I get use to the idea that it happened	.43
	I accept the reality of the fact that it happened	.38
9	Turning to **religion**	
	I seek God's help	.95
	I put my trust in God	.88
	I try to find comfort in my religion	.84
	I pray more than usual	.81
10	Focus on & **venting** of emotions	
	I get upset and let my emotions out	.79
	I let my feelings out	.76
	I feel a lot of emotional distress and I find myself expressing those feelings a lot	.57
	I get upset and am really aware of it	.45
11	**Denial**	
	I refuse to believe that it has happened	.75
	I pretend that it hasn't really happened	.72
	I act as thought it hasn't even happened	.52
	I say to myself "this isn't real"	.46
12	**Behavioral** disengagement	
	I give up the attempt to get what I want	.49
	I just give up trying to reach my goal	.42
	I admit to myself that I can't deal with it, and quit trying	.37
	I reduce the amount of effort I'm putting into solving the problem	.30
13	**Mental** disengagement	
	I turn to work or other substitute activities to take my mind off things	.45
	I go to movies or watch TV, to think about it less	.43
	I daydream about things other than this	.28
	I sleep more than usual	.23
14	Alcohol-**drug** disengagement	
	I drink alcohol or take drugs, in order to think about it less	

Note: Items are listed in order of strength of loading. Loadings for active coping and planning come from a single factor that incorporated both scales. Loadings for seeking social support for instrumental reasons and seeking social support for emotional reasons come from a single factor that incorporated both scales.
(Source: Carver, Scheier & Weintraub, 1989; 272).

* Bold letters are used to specify the subscales in the analysis

RESULTS

A total of 346 health-professionals respondents were used in this study: 19.3% (n=67) doctors; 45.2% (n=156) nurses; 34.6% (n=120) trainee (nurse); and 0.9% (n=3) hospital administrators (who are also doctors but performing a plethora of hospital administrative task); 12.4% (n=43) are male and 87.6% (n=303) female respondents; among which 45.1% (n=156) are still single and 54.1% (n=190) are married. Their mean age is 29.5% years (SD=12.39 years) and have been in the health service for 8.48 years (SD=7.98). On the average, they work about 7.76 hours (SD=3.15) a day. Most of them who are already married, having two to three children (modes are 29.8% and 22.8% respectively).

Reliability analysis was performed on all the subscales of the Stress Inventory (Gmelch, 1982) and the COPE Scale (Carver *et al.*, 1989) and the data are as presented in Table 4. Cronbach Alpha values as shown in the table indicated a moderate to good consistency of the Stress and COPE subscales. Intercorrelations between the stress subscale as presented in Table 5 indicated significant relationships among all stress constructs (subscales), thus lending evidence of convergent validity to the measurement. Similarly with the COPE subscales, most of the correlations of the subscales (different constructs) yield significant relationship, again lending evidence of convergent validity (Table 6). In addition, all subscales yielded positive and significant relationships with its total score (except for "drug use" subscale of the COPE scale and COPE total score).

The first objective is to identify the most common stressor or source of stress as identified by the respondents. Table 7 shows the ranking of each subscales (mean scores of each subscale divided by number of items of each subscales). As can be seen from this table, the medical professions stated that work conflict, organizational structure and work overload are three main causes of their stress. The least causes of stress are work under load and travelling.

The second objective is to identify the most frequently employed coping mechanism to combat these stressful experiences. Table 8 indicates the ranking of each subscales. Religion is the "coping mechanism of choice" among the health profession, that is turning to God; followed by planning (cognitive strategy), seeking

social support for instrumental reason, (such as asking others for advice who had similar experience), cognitive rationalistic approach (which is looking for something good out of the experience), and finally is the use of drugs or alcohol.

Table 4

Reliability Analysis for Stress Subscales and COPE Scales

Subscale	No. of items	Alpha
Private	10	0.6021
Work	8	0.7780
Overload	6	0.7134
Underload	6	0.6742
Ambiguity	6	0.8261
Structure	6	0.8091
Conflict	6	0.7843
People	6	0.4991
Travel	6	0.7971
Interpersonal	10	0.7634
Personal	10	0.6777
Active	4	0.5455
Planning	4	0.7606
Suppression	4	0.6679
Restrain	4	0.5976
Instrumental	3	0.7599
Emotional	4	0.7897
Growth	4	0.7050
Acceptance	4	0.7190
Religion	4	0.8102
Venting	4	0.7840
Behavior	4	0.8500
Mental	4	0.6752
Denial	4	0.8084

Table 5
Mean, and Correlation of Stress Subscale and the COPE Scales

	(Unwtd) Mean	SD	Priv.	Work	Over	Under	Ambig.	Struc.	Cont.	Peop.	Trav.	Interp.	Per.
Private	27.61	4.88	-										
Work	21.82	5.54	0.308**	-									
Overload	18.36	4.13	0.360**	0.530**	-								
Underload	13.74	3.73	0.295**	0.308**	0.202**	-							
Ambiguity	17.13	4.72	0.329**	0.437**	0.420**	0.513**	-						
Structure	18.52	4.19	0.348**	0.488**	0.459**	0.440**	0.639**	-					
Conflict	19.21	4.64	0.363**	0.526**	0.560**	0.318**	0.534**	0.674**	-				
People	16.13	3.30	0.255**	0.395**	0.400**	0.298**	0.343**	0.354**	0.458**	-			
Travel	12.97	4.36	0.154*	0.214*	0.133*	0.282**	0.276**	0.272**	0.360**	0.412**	-		
Interpersonal	25.94	6.03	0.385**	0.401**	0.467**	0.369**	0.491**	0.547**	0.518**	0.541**	0.419**	-	
Personal	30.44	5.14	0.356**	0.408**	0.552**	0.343**	0.465**	0.473**	0.527**	0.477**	0.264**	0.544**	-
COPE	147.49	16.52	0.108	0.047	0.068	0.176**	0.155**	0.191**	0.116	0.158*	0.317**	0.183**	0.225**
STRESS	369.95	42.95	0.491**	0.600**	0.544**	0.572**	0.680**	0.733**	0.702**	0.578**	0.542**	0.726**	0.672**

* $p<0.05$
** $p<0.01$

Table 6

Mean, SD and Correlations of the COPE Subscale and with Total Stress Scores

-	(Unwtd) Mean	SD	Activ.	Plan	Supp.	Restr.	Instr.	Emot.	Reinf.	Accep.	Relig.	Vent.	Beh.	Ment.	Drug	Deny.
Active	12.68	2.00	-													
Planning	13.32	2.30	0.581**	-												
Suppression	11.27	2.50	0.349**	0.389**	-											
Restrain	11.79	2.46	0.303**	0.353**	0.418**	-										
Instrumental	9.90	1.89	0.383**	0.358**	0.226**	0.402**	-									
Emotional	12.06	2.84	0.170**	0.153**	0.205**	0.293**	0.452**	-								
Growth	13.17	2.28	0.456**	0.519**	0.334**	0.387**	0.426**	0.296**	-							
Acceptance	11.47	2.78	0.114*	0.086	0.100**	0.227**	0.098	0.194**	0.305**	-						
Religion	14.25	2.40	0.197**	0.205**	0.124**	0.225**	0.200**	0.204**	0.294**	0.217**	-					
Venting	10.68	2.95	0.023	-0.015	0.220**	0.270**	0.170**	0.364**	0.143*	0.223**	0.148**	-				
Behavior	8.01	3.23	-0.147**	-0.204**	0.084	-0.023	-0.015	0.118*	-0.118*	0.210**	-0.067	0.313**	-			
Mental	10.17	2.87	0.013	-0.101	0.132*	0.148**	0.135*	0.266	0.062	0.178**	0.126*	0.368**	0.378**	-		
Drugs	1.24	0.67	-0.127*	-0.157**	-0.004	0.014	-0.150**	-0.021	-0.257**	0.026	-0.313**	0.063	0.359**	0.074	-	
Denial	7.79	3.13	-0.143*	-0.154**	0.042	0.106	-0.006	0.102	-0.148**	0.096	-0.035	0.229**	0.379**	0.387**	0.435**	-
COPE	147.49	16.52	0.425**	0.364**	0.538**	0.602**	0.537**	0.592**	0.538**	0.479**	0.412**	0.607**	0.382**	0.528**	0.048	0.365**
STRESS	369.95	42.95	0.011	0.046	0.351**	0.296**	0.273**	0.398**	0.204**	0.346**	0.269**	0.447**	0.401**	0.413**	0.012	0.328**

* $p<0.05$
** $p<0.01$

Table 7
Rank of Weighted Mean for the Stress Subscales

Subscales	Weighted Mean	Rank
Work Conflict	3.20	1
Organizational Structure	3.08	2
Work Overload	3.06	3
Personal Problems	3.04	4
Job Ambiguity	2.85	5
Private	2.76	6
Work Environment	2.72	7
People	2.69	8
Interpersonal Relationship	2.59	9
Underload of Work	2.29	10
Travelling	2.16	11

Table 8
Rank of Weighted Mean for the COPE Subscales

Subscales	Weighted Mean	Rank
Religion	3.56	1
Planning	3.33	2
Instrumental	3.30	3
Growth	3.29	4
Active	3.17	5
Emotional	3.01	6
Restrain	2.94	7
Acceptance	2.86	8
Suppression	2.81	9
Venting	2.67	10
Mental	2.54	11
Behavior	2.00	12
Denial	1.94	13
Drug	1.24	14

The following objective, is to see if there are any gender differences in relation to the source of stress and coping mechanism frequently used by the health professionals in Kedah. Table 9 presents the result of the t-test for the stress subscales in relations to gender. There are three significant differences; men feel more stressed by the general work environment than women; women feel more stressed by work ambiguity (they are not sure of their role and work load) than men; and women feel more stressed by the frequency of outstation travelling as compared to men. Table 10 presents the result of the t-test for the COPE Subscales in relation to gen-

Table 9
t: Test for Stress Subscales with Gender

Scale	Sex	N	Mean	Std. Deviation	†	p
PRIVATE	MALE FEMALE	42 283	28.0090 27.5795	5.0760 4.8447	0.669	NS
WORK	MALE FEMALE	3 268	23.7949 21.5187	5.5449 5.5184	2.405	0.017
OVERLOAD	MALE FEMALE	43 291	19.0698 18.2165	5.3692 4.1694	0.998	NS
UNDERLOAD	MALE FEMALE	42 291	13.2381 13.8179	4.4272 3.6518	-0.935	NS
AMBIGUITY	MALE FEMALE	42 290	15.3095 17.4207	4.9951 4.6648	-2.717	0.007
STRUCTURE	MALE FEMALE	41 267	17.3659 18.6966	5.1515 4.8907	-1.611	NS
CONFLICT	MALE FEMALE	38 287	18.3158 19.3589	4.6621 4.6462	-1.300	NS
PEOPLE	MALE FEMALE	41 266	16.2195 16.1504	3.0291 3.3769	0.124	NS
TRAVEL	MALE FEMALE	38 246	10.2105 13.3455	2.8490 4.4104	-5.745	0.001
INTERPESONAL	MALE FEMALE	42 259	25.9762 25.9459	6.0707 6.0480	.030	NS
PERSONAL	MALE FEMALE	40 287	30.2000 30.4808	6.1319 5.3584	-0.305	NS

der, and there are seven significant differences. Female respondents use more of the instrumental, emotional, religion, venting, mental and denial coping strategies, whereas men use more of the drug strategy to cope with their stress.

Table 10
t Test for COPE Subscales with Gender

	Sex	N	Mean	Std. Deviation	t	p
ACTIVE	Male	42	12.5000	2.2003	-0.658	NS
	Female	287	12.7143	1.9366		
PLANNING	Male	41	13.0976	2.2562	-0.758	NS
	Female	290	13.3862	2.2849		
SUPPRESS	Male	42	11.2143	2.3430	-0.248	NS
	Female	285	11.3158	2.4976		
RESTRAIN	Male	42	11.3571	2.3563	-1.272	NS
	Female	283	11.8728	2.4649		
INSTRUMENTAL	Male	41	9.0488	1.8568	-3.073	0.002
	Female	286	10.0140	1.8843		
EMOTIONAL	Male	42	10.3333	2.7020	-4.269	0.000
	Female	284	12.2923	2.7861		
GROWTH	Male	42	12.7857	2.3325	-1.245	NS
	Female	281	13.2491	2.2381		
ACCEPTANCE	Male	41	10.8537	2.9117	-1.534	NS
	Female	274	11.5693	2.7677		
RELIGION	Male	42	12.0476	3.3998	-4.805	0.000
	Female	279	14.6308	1.9591		
VENTING	Male	42	9.3095	2.9424	-3.254	0.001
	Female	269	10.8848	2.9138		
BEHAVIOR	Male	42	7.8810	3.0460	-0.238	NS
	Female	270	8.0074	3.2320		
MENTAL	Male	42	8.9048	2.7833	-3.127	0.002
	Female	273	10.3736	2.8413		
DRUG	Male	42	1.4762	.7067	2.319	0.024
	Female	270	1.2074	.6464		
DENIAL	Male	42	6.7143	2.6986	-2.338	0.020
	Female	266	7.9248	3.1780		

DISCUSSION

Interestingly, stress experienced by the health professions is mostly due to organizational factors such as role conflict (usually relationship with superiors and job demand), organizational structure (too hierarchical and regulation), work overload (qualitative and quantitative), and job ambiguity (unclear on job role, target and objectives).

Why are medical professions mostly stressed by role conflict? Aren't they sure of their respective roles? Role conflict means at times they are confused by different demands placed on their job and they are unsure of the extent of their roles when obtaining different directives from different superiors. On top of that, they are also stressed by the organizational structure. This occurs as a result of poor or improper working relationship with superiors, a very hierarchical work structure or too much orientation to rules and regulation.

They also experienced stress as a result of work overload. The medical professions feel that they have too much work to handle, taking much time away from their family and recreational activities. The least stressful experience, however, is travelling, which the medical profession may see it as a way to escape their stress experiences. These stressors as experienced by our medical professions are also quite common among medical professionals elsewhere, as identified by Cherniss (1980), White (1980), Gray-Toft and Anderson (1981), Sexton (1982), Ganster (1989), Schaufeli *et al.*,1993 and Peterson *et al.*, 1995 in different population.

To the question of "how do they cope with all this stress", the coping strategies that were frequently used by health personnel in the Kedah State are seeking God's help (religion); planning (like strategizing, action planning— a cognitive-behavioral approach); instrumental strategy (such as looking for the good and positive aspects of the experience, look at it with a different perspective — a rationalization and cognitive approach), and finally active strategy (which is actively getting rid of the problem and doing something else — a behavioral approach).

There are logical explanations for using such strategies. Most Malaysian hold strongly to their religion, be it Muslim, Hindu, Buddhist or Christian. Usually, when a devoted person feels he is limited by some circumstances, one will turn to one's religion for hope and recovery. Most of the respondents are Muslims, and for Muslims, putting one's hope and faith in God is their first choice of action

above all others. That seems to be the "the strategy of choice" when one is in a stressful situation. After their prayers, the professionals use cognitive and behavioral strategies to combat their stress. This are common amongst professionals, who are also above average individuals and quite intelligent in nature, to find the most appropriate solution to their problem. These professionals do not prefer emotional strategies, and such strategies are placed further down the list of preferred coping choices.

Another common style of coping that is observed among health professionals is seeking social support. Studies by Jupta & Beehr (1990), and McCleave (1993) showed that constant social support either from the workplace or home helped health professionals to alleviate the stress they are experiencing. The least used coping strategy by these health professions is the use of drugs and alcohol, in which presumably they knew of the long term side-effects of these substances, thus avoiding them at all cost. Thus one can say that the medical professionals cope well with their stress.

Looking at the differences of the experience of stress between the two genders, men were found to feel more stressed by the work environment probably because their preference to work in a more "robust" environment than what is preferred by women. For women, even though the work environment maybe less tolerable, they tend to show that they are not disturbed by the conditions as long as other factors such as peer, super-subordinate and general human relationship are good. This is similar with conclusions made by Rapaport & Rapaport (1978). On the other hand, women feel more stressed by the job ambiguity and the amount of travelling that is related to the job. Being more comfortable with the job, women probably seek for jobs which are less ambiguious. Men, however need to be on the "independent" side of the job, as their work roles seldom intrude into their personal and family life as compared to their spouses (Pleck, 1977). Thus, they don't mind travelling away from home as compared to their female counterparts.

Women also use more of the instrumental, emotional, religion, emotional venting, mental and denial coping strategies, whereas men use more of the drugs and alcohol as a strategy to cope with their stress. The probable reason is that men, being more of the sociable and easy going gender-type would have the tendency for short cuts (problem-solving focused), for example by the use of drugs and alcohol (there are more male drug addicts than female). On the other hand, women have the tendency to try out a range of coping mechanisms such as cognitive,

behavioral, rationalization, even defense mechanism (emotional-focused). They will employ whichever one works best for them. This is probably because they face more stress (as reported by Davidson & Cooper, 1985) or they are eager to overcome stress by using any way that works.

Finally, since a multitude of cognitive and support based coping strategies were employed, some practical recommendation could be directed towards such strategies. Family is an important support system among Malaysians. Coping patterns, which maintain, strengthen, and restructure the family system, are important especially in dual-career living. Working out a 'fair' schedule of household tasks for all family members and specifically planning family activities for all to do together are two examples or behaviors dual-career family members engage in to restructure and strengthen the family. This can resolve a multitude of family, work and private life stress.

Individuals also need to have a repertoire of behaviors, which enable them to manage the psychological tensions and strains. Coping behaviors which allow them to attend to personal needs (e.g. Jogging, relaxation activities) and those which focus on reducing the demands of the present situation like discussing work-related problems with hospital's management are vitally important. This will help keep their tension at a lower level. Another coping pattern, which involves obtaining support from outside of the work or family sphere such as having empathetic friends with similar values can be a real source of support for stressed out doctors or nurses. Women, in particular, seem to see this support as very important. Therefore socialization and social events can be a good source of relief.

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