

RESEARCH ARTICLE

Prescribing Hormone Replacement Therapy: The Role of Occupational Stress

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Abstract

This study investigates whether physicians' levels of occupational stress may influence the likelihood of their prescribing hormone replacement therapy (HRT). One hundred and one physicians answered a cross-sectional, mailed, self-administered survey that measured occupational stress using Occupational Stress Indicator 2. Questions concerning HRT—including the possibility of recommending HRT to treat menopausal syndrome—were also asked. We found the likelihood of prescribing HRT for menopausal syndrome positively correlates with 'coping' ($p < 0.01$) and 'other indications' ($p < 0.001$). The likelihood of prescribing is also greater when the patient is a younger menopausal woman ($p < 0.0001$) and if the physician is more experienced ($p < 0.05$). Multiple regression analysis reveals that the 'coping' scale ($p < 0.05$) is the most significant factor, whereas 'seeking support' is the significant subscale ($p < 0.0001$). Our results indicate that 'seeking support' from the 'coping' scale is the most important factor that influences the prescribing of HRT. Copyright © 2010 John Wiley & Sons, Ltd.

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Keywords

occupational stress; hormone replacement therapy; menopause; climacteric

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Occupational or work-related stress exists in every occupation. The sources of occupational stress have changed substantially in recent years. In general, work load, internal or external consumer demands, higher-level mandates or restrictions, institutional regulations, peer evaluations, conflicts at work, anxiety over job security and change of social environment can all be sources of occupational stress. However, job security has recently replaced work load and resource acquisition as the major cause of occupational stress (Tytherleigh, Webb, Cooper, & Ricketts, 2005).

Physicians practice a profession that has one of the highest levels of occupational stress (Ro, Gude, Tyssen, & Aasland, 2008; Taylor, Graham, Potts, Richards, & Ramirez, 2005; Weinstein & Wolfe, 2007). Not only are value conflicts common within the medical profession, nowadays physicians must also become more familiar with complicated technologies. Moreover, the greater emphasis recently placed on the recognition of a patient's rights and on cultural diversity, along with the growing acknowledgment of the importance of

communication skills and practical competences, has resulted in medicine being described as a multidisciplinary profession with significant societal dimensions and responsibilities (Lancet Editorial, 2009).

The improvements of therapeutic methods and advances in medical technology have also increased patients' expectations that their illnesses will be managed perfectly. These factors, when combined with other problems such as limited resources and excessive legal regulation, may place doctors in difficult ethical dilemmas that can cause them much distress (Forde & Aasland, 2008). In fact, heavy work load (Tinti et al., 2009; Virtanen et al., 2008), poor job satisfaction (Cyr-Taro, Kotwall, Menon, Hamann, & Nakayama, 2008; Kankaanranta et al., 2007; Volker et al., 2010), perception of unrealistic expectations from patients and their families, communication with colleagues (Falkum & Vaglum, 2005; McIntosh & Macario, 2008; Smith, Waldman, Hood, & Fottler, 2007), poor lifestyle (Hebbard & Wirtzfeld, 2009), limited resources (Forde & Aasland, 2008), interaction with patients

(Geller, Bernhardt, Carrese, Rushton, & Kolodner, 2008; Mjaaland & Finset, 2009), and the threat and reality of medical malpractice litigation (Papadopoulos, 2007) can all be causes of job insecurity and resulting occupational stress in a medical practice. High levels of occupational stress may result in a medical practitioner's negative perception of job satisfaction and a more negative attitude about health care as a profession (Richardson & Burke, 1991). Undue levels of stress have also been reported as impairing the decision making process in medical and surgical practices (Howie, Hopton, Heaney, & Porter, 1992; Wetzel et al., 2006; Zantinge, Verhaak, de Bakker, van der Meer, & Bensing, 2009).

For menopausal women, although hormone replacement therapy (HRT) may effectively relieve menopausal symptoms such as hot flashes, cold sweats and palpitation or dryness of the genital organs (Chen, Chang, & Chow, 2008; Martin & Manson, 2008; Roberts, 2007; North American Menopause Society, 2010; Speroff, Kenemans, & Burger, 2005) it may also be associated with certain side effects. In 2002, a Women's Health Initiative (WHI) study argued that, because of possible side effects, HRT's risk-benefit profile was not consistent with the requirements for a viable intervention for the primary prevention of chronic disease (Writing Group for the Women's Health Initiative Investigators, 2002). After its publication, and despite decades of accumulated observational studies that suggested that HRT actually reduced a woman's risk of cardiovascular disease, the resulting perception of risk caused significant changes in the use trend for HRT (Guay, Dragomir, Pilon, Moride, & Perreault, 2007; Hartsfield et al., 2005; Studd, 2009). A patient's belief that she will be treated with a perfect medication that effectively relieves symptoms without increasing risk can thus become a source of occupational stress for contemporary physicians who, when prescribing HRT, must respond to such expectations at the same time they are dispensing a remedy that the patient may perceive as inherently risky. Because HRT is an option for menopausal women with moderate to severe menopausal symptoms, it is important to determine whether or not occupational stress may affect a doctor's attitude towards its prescription.

Methods

Participants

In this study, we used a self-administered questionnaire as our survey method. The target subjects were 175 active members of the Taiwan Menopause Society; we received in reply a total of 101 responses (recovery rate of 57.7%). This response rate is well within the typical range reported for mail surveys (52.7%, with a standard deviation of 20.4) used in the behavioral sciences (Baruch & Holtom, 2008). Our study was approved by the Medical Ethics Committee of our medical center (200902054R).

Measures

Occupational stress

The Occupational Stress Indicator (OSI) has been used widely and successfully (Cooper & Bramwell, 1992; Cooper, Rout, & Faragher, 1989; Cooper, Sloan, & Williams, 1988; Rees & Cooper, 1994; Steiler & Paty, 2009; Williams & Cooper, 1998). We used the OSI-2 (90 items) as the questionnaire set for our study (Lu, Tseng, & Cooper, 1999). Its original item bank contains over 200 items that are scored on a six-point Likert-type scale (Cooper et al., 1988; 1989; Cooper & Bramwell, 1992). The OSI-2 is thus a revised and shortened version of the original OSI, and consists of the same sections found in the original; these include job satisfaction, mental well-being, physical well-being, Type A behavior, perceived job control, sources of stress and coping strategies.

The job satisfaction scale contains 12 items that measure satisfaction with the job itself and with the workplace. Higher scores indicate greater satisfaction. The mental well-being scale has 12 items that measure contentment, resilience and peace of mind. Higher scores denote greater well-being. The physical well-being scale is composed of six items that measure a person's calmness and energy. Higher scores indicate better physical health. The Type A behavior scale contains six items that measure an individual's patience and drive; the scores for items 1, 3 and 5 on this scale are counted in reverse order before their summation. Higher scores show a greater tendency towards Type A behavior. The perceived job control scale has four items that measure a person's perception of their control over how their job is done; the scores for items 1, 2 and 3 are counted in reverse order before their summation. Higher scores signify a greater perceived control over one's work environment. The sources of stress scale consists of 40 items that measure daily work hassles, home/work balance, managerial role, organization climate, personal recognition, personal responsibility, workload and workplace relationships. Higher scores indicate more sources of stress. The ten items on the coping strategies scale were divided into two subscales that measure 'control' (ability to direct actions to solve problems) and 'seeks support' (likelihood of seeking social support to regulate emotions). Higher scores indicate a more frequent use of coping strategies. All of these items were scored on a six-point Likert-type scale.

Likelihood of prescribing HRT

The section of our questionnaire that assesses the likelihood of prescribing HRT for menopausal syndrome consists of four sections: the attitude towards prescribing medication for menopausal syndrome, the attitude towards prescribing such medication given the possibility of adverse side effects, the attitude towards prescribing such medication while considering physical

benefits other than alleviation of menopausal syndrome, and the attitude towards prescribing such medication while considering the patient age.

The section addressing the attitude towards prescribing medication for individual menopausal syndrome contains the 20 items that are the most common menopausal symptoms: cold sweats, a creeping sensation in the skin, crying spells, depression, difficulty concentrating, waking up early in the morning, feelings of unhappiness, headache, hot flashes, insomnia, joint pain, lack of harmony, lack of vitality, dissatisfaction with life, palpitations, poor memory, reduced sexual interest, tension or nervousness, vaginal dryness and waking up sweating (Chen et al., 2008). All of these items were scored on a six-point Likert-type scale. Higher scores indicated a greater tendency towards prescribing HRT.

The section that deals with attitudes towards prescribing HRT medication given the possibility of adverse side effects has five items (Prentice et al., 2008). These items include possible side effects such as breast cancer, endometrial cancer, thromboembolism and the possible legal problems resulting from these side effects. Items were scored on a four-point scale, with higher scores signifying a greater likelihood that a physician's perception of adverse side effects will result in HRT not being prescribed.

The section addressing attitudes towards prescribing HRT while considering physical benefits other than the alleviation of menopausal syndrome is composed of nine items (Martin & Manson, 2008). These items include osteoporosis, coronary heart disease, colon cancer, sexual dysfunction, premature aging of the skin, diabetes mellitus, senile dementia, urinary tract problems and other diseases. These items were scored on a four-point scale, with higher scores denoting a greater likelihood for prescribing HRT after taking into account these benefits.

The scale that deals with attitudes towards prescribing HRT while considering a patient's age consists of six items that evaluate the likelihood of prescribing it for various age groups (Ettinger, Pressman, & Silver, 1999). The following age group divisions were used: younger than 55; 56–60; 61–65; and older than 65. These items were scored on a four-point Likert scale, with higher scores indicating a greater likelihood that HRT for menopausal syndrome would be prescribed after consideration of a patient's age.

In addition, questions relating to possible correlations between demographic information (such as a physician's age, sex, education level, marital status, occupation, tenure, rank, organization size, personal health habits, exercise program, degree of absenteeism and drinking and smoking habits) and the medical profession were included in the questionnaire.

Statistical analyses

All statistical analysis was performed using the Statistical Package for Social Sciences 16.0 software (SPSS

16.0, SPSS Inc., Chicago, IL, USA). The statistical significance of differences was determined by a two-tailed Student's *t*-test. For categorical variables, we created a contingency table and used either the Chi-square test or, if the table had at least one expected cell frequency less than 5, a Fisher's exact test. Relationships between demographic data, OSI-2 and HRT items were analysed by Pearson's correlation coefficient and linear regression. We used one-way analysis of variance (ANOVA) to compare differences between various groups of data. If the initial ANOVA result was significant, we performed a post hoc test using Scheffe multiple comparison. We used multiple regression analysis to identify which baseline characteristic factors, OSI-2 items and HRT items correlated with a greater likelihood of HRT prescription. We used stepwise multiple regression analysis to assess the significance of the relevant variables. We conducted a reliability test by using coefficients of Cronbach. A *p*-value of less than 0.05 was considered as statistically significant.

Results

Demographic characteristics

The study subjects were gynecologic physicians who had been practicing medicine for a long time. Study subjects were equally distributed in terms of practice type, and worked slightly longer hours than the average 40-hour workweek (the statutory workweek in Taiwan is 40 hours per week). Mean number of work hours per week was 42.20 (SD 17.60) in private clinics, 42.62 (SD 15.27) in regional hospitals and 51.33 (SD 15.03) in medical centers ($p < 0.05$, one-way ANOVA). Detailed sample characteristics are presented in Table I.

Scale reliability

Table II shows the reliability of the scales used in this study. Scale reliability was high for both the OSI-2 (Cronbach's alpha = 0.913) and HRT (Cronbach's alpha = 0.918) scales. With the exception of the Type A scale, each of the individual scales had adequate internal consistency. Previous studies using the OSI-2 have also reported psychometric difficulties with the Type A scale, thus results that rely upon this set of behavioral patterns should be interpreted with due caution (Baruch & Holtom, 2008; Steiler & Paty, 2009).

Physician's stress

Among the eight categories of work stressors measured by the OSI-2, the physicians reported 'personal responsibility' as the most stressful (item mean 4.16 on a six-point scale), followed by 'workload' (item mean 3.99), 'organizational climate' (item mean 3.89), 'relationships' (item mean 3.88), 'hassles' (item mean 3.81), 'recognition' (item mean 3.79), 'home/work balance' (item mean 3.78) and 'managerial role' (item mean 3.51).

Table 1. Subject characteristics

Variables	n	Mean \pm SD or %
Physician age	101	51.3 \pm 7.9 (Range 33–76)
Sex		
Female	19	18.8
Male	82	81.2
Education		
College	67	66.3
Postgraduate	33	32.7
Other	1	1.0
Marital status		
Single	11	11.2
Married	86	87.8
Divorced, widowed	1	1.0
Not reported	3	—
Spouse works		
No	44	51.8
Yes	41	48.2
Not reported	16	—
Location of practice		
Private clinic	38	37.6
Regional hospital	33	32.7
Medical center	30	29.7
Tenure (years)	101	14.7 \pm 9.8 (Range 0.5–40)
Position		
Fellow	2	2.0
Attending physician	99	98.0
Work hours (per week)	101	45.1 \pm 16.5 (Range 8–100)
Work hours set by		
Supervisor	42	42.4
Oneself	57	57.6
Not reported	2	—
Surgery performed		
No	18	17.8
Yes	83	82.2
Exercises		
Never	10	9.9
Occasionally	35	34.7
Sometimes	11	10.9
Usually	24	23.7
Always	21	20.8
Smokes		
No	91	94.8
Yes	5	5.2
Not reported	5	—
Drinks		
No	74	73.3
Yes	27	26.7
Days of sick leave taken in last 3 months		
0	61	60.4
1	19	18.8
2	10	9.9
3	5	4.9
>3	6	6.0
Thinks of resignation		
Never	29	28.7
Occasionally	33	32.7
Sometimes	31	30.7
Usually	7	6.9
Always	1	1.0

SD: standard deviation

Table II. Reliability of all scales

Scales	Mean	SD	Item no.	Alpha
OSI-2			90	0.913
Job satisfaction	48.26	9.10	12	0.940
Mental health	49.78	9.42	12	0.876
Physical health	26.90	5.53	6	0.843
Type A behavior	20.04	3.57	6	0.430
Perceived job control	11.91	1.89	4	0.627
Stressors	154.34	27.07	40	0.962
Daily work hassles	15.22	2.99	4	0.750
Home/work balance	22.69	5.01	6	0.734
Managerial role	14.04	3.03	4	0.752
Organizational climate	15.57	2.78	4	0.752
Personal recognition	15.14	3.14	4	0.751
Personal responsibility	16.63	3.58	4	0.745
Workload	23.97	5.02	6	0.729
Workplace relationships	31.07	6.41	8	0.715
Coping strategy	43.19	5.81	10	0.893
Control*	26.77	3.61	6	0.781
Seeking support [†]	16.42	2.99	4	0.776
HRT prescription likelihood			40	0.918
Menopausal syndrome	74.21	15.24	20	0.947
Adverse effects	12.34	3.90	5	0.846
Other uses	17.94	5.22	9	0.822
Patient age factor	14.78	3.20	6	0.744

* Directing actions to solve problems.

[†] Seeking social support to regulate emotions.

Alpha: Cronbach's alpha; SD: standard deviation; OSI-2: occupational stress indicator-2; HRT: hormone replacement therapy.

Table III. Distribution of the number of physicians likely to prescribe hormone replacement therapy by patient age group*

Age group	Never	Occasionally	Sometimes	Usually
≤55	3 (3.0)	31 (30.7)	36 (35.6)	31 (30.7)
56–60	12 (11.9)	53 (52.5)	27 (26.7)	9 (8.9)
61–65	31 (30.7)	61 (60.4)	6 (5.9)	3 (3.0)
>65	61 (60.4)	34 (33.7)	4 (4.0)	2 (2.0)

* $p < 0.0001$, χ^2 test.

The numbers in parentheses denote percentages.

Overall, the physicians were 'satisfied' with their jobs (item mean 4.02 on a six-point scale, Table II).

Within the OSI-2 scales

Within the OSI-2 scales, there are nine significant positive correlations and two significant negative correlations: job satisfaction correlates positively with mental health ($r = 0.433$, $p < 0.001$), physical health ($r = 0.281$, $p < 0.01$), job control ($r = 0.278$, $p < 0.01$) and coping ($r = 0.402$, $p < 0.001$); mental health correlates with physical health ($r = 0.629$, $p < 0.001$), job control ($r = 0.347$, $p < 0.001$) and coping ($r = 0.348$, $p < 0.001$); and job control correlates with physical health ($r = 0.217$, $p < 0.05$) and coping ($r = 0.236$, $p < 0.05$). Mental health correlates negatively with stress ($r = -0.265$, $p < 0.01$) and physical health correlates negatively with Type A behavior ($r = -0.216$, $p < 0.05$).

Within the HRT scale

Within the HRT scale, questionnaire responses revealed that there is a lesser likelihood of prescribing HRT after considering patient age ($r = -0.399$, $p < 0.001$) and a greater probability of prescribing it when concomitant benefits aside from alleviating menopausal syndrome (other indications) are taken into account ($r = 0.361$, $p < 0.001$). When addressing menopausal syndrome alone, 97.0% of the physicians were found to be likely to prescribe HRT medication if the patient was younger than 55. However, only 39.6% were likely to prescribe such medication if the patient was older than 65. Thus, among the physicians who responded to our questionnaire, the likelihood of prescribing HRT for menopausal syndrome was greater if the patient was younger ($p < 0.0001$, Table III).

Between the demographic and OSI-2 scales

In our study, there are three negative correlations and seven positive correlations between physician characteristics and OSI scores. A negative correlation exists between subject's age and Type A behavior ($r = -0.283$, $p < 0.01$), consideration of resignation and physical health ($r = -0.212$, $p < 0.05$), and consideration of resignation and coping ($r = -0.272$, $p < 0.01$). However, a positive correlation exists between physician's age and physical health ($r = 0.210$, $p < 0.05$), education level and coping ($r = 0.217$, $p < 0.05$), tenure and job control ($r = 0.208$, $p < 0.05$), capability of performing surgery and either Type A behavior ($r = 0.216$, $p < 0.05$) or job control ($r = 0.318$, $p = 0.001$), and exercise and either mental health ($r = 0.246$, $p < 0.05$) or physical health ($r = 0.401$, $p < 0.001$).

Between the demographic and HRT scales

Physicians who had taken more sick leaves within the past 3 months expressed a greater desire to prescribe HRT for the treatment of menopausal syndrome ($r = 0.254$, $p < 0.05$). Physicians who had more tenure, and thus were more experienced, were accordingly found to be more likely to prescribe HRT for the treatment of menopausal syndrome ($r = 0.201$, $p < 0.05$).

Between the OSI-2 and HRT scales

Likelihood to prescribe on the HRT scale is influenced by the coping variable on the OSI-2 scale ($r = 0.263$, $p < 0.01$). The effect a patient's age has upon prescrib-

ing HRT is also influenced by coping on the OSI-2 scale ($r = 0.293$, $p < 0.01$). Except for the coping variable, none of the other six categories of occupational stress (including job satisfaction, mental health, physical health, type A behavior, OSI-control and stressors) seem to be linked with a physician's likelihood to prescribe HRT (all p values > 0.05).

Multiple regression analysis

We used a multiple regression analysis in order to discover which independent factors correlated with a higher likelihood that a physician would prescribe HRT. The probability of prescribing HRT for menopausal syndrome was used as the dependent variable. The following were used as predictors: the seven OSI-2 scales (which include job satisfaction, mental health, physical health, Type A behavior, job control, stressors and coping); three prescription considerations (which include adverse effects, other indications and patients' age); and the two subject characteristics that are linked with prescribing HRT (taking of sick leave and tenure). Our results revealed that the overall regression model is statistically significant ($F = 3.426$, $df = 12, 86$; $p < 0.001$). We found 'coping' ($p < 0.05$) and 'other indications' ($p < 0.05$) to be the two most significant predictors of the likelihood of prescribing HRT for menopausal syndrome (Table IV). After further analysing the correlations between prescribing HRT for menopausal syndrome and the coping strategies subscales, we found that the 'seeking support' subscale of the coping variable is linked to HRT prescription ($r = 0.341$, $p < 0.0001$), whereas the 'control' subscale is not ($r = 0.139$, $p > 0.05$).

Table IV. Multiple regression analysis of how likely the prescribing of hormone replacement therapy for menopausal syndrome* is influenced by variables such as occupational stress, hormone replacement therapy and subject characteristics†

Model	Unstandardized coefficients		Standardized coefficient Beta	<i>t</i>	Sig.
	B	Std. Error			
Job satisfaction	-0.274	0.181	-0.164	-1.517	0.133
Mental health	0.173	0.213	0.108	0.815	0.418
Physical health	-0.485	0.325	-0.177	-1.492	0.139
Type A behavior	-0.259	0.423	-0.058	-0.612	0.542
Perceived job control	-1.198	0.833	-0.149	-1.439	0.154
Stressors	-0.035	0.054	-0.063	-0.653	0.516
Coping	0.695	0.286	0.268	2.425	0.017
Considering adverse effects	-0.155	0.370	-0.040	-0.417	0.677
Considering for other indications	0.716	0.324	0.245	2.212	0.030
Considering of patient age	0.791	0.523	0.169	1.512	0.134
Tenure	0.240	0.149	0.156	1.618	0.109
Sick leave	1.291	0.948	0.134	1.362	0.177

* Dependent variable: Likelihood of prescribing hormone replacement therapy.

† Occupational stress variables include job satisfaction, mental health, physical health, type A behavior, perceived job control, stressors and coping. Hormone replacement therapy variables include likelihood of prescribing after considering adverse effects, other indications, and patient age. Subject characteristic variables include tenure and sick leave, both of which univariate analysis with Pearson's correlation significantly links with the likelihood of prescribing hormone replacement therapy for menopausal syndrome.

Discussion

This study investigated a possible correlation between occupational stress among physicians from a menopausal society in Taiwan and their likelihood to prescribe medication for HRT. We found that coping was the main factor that influenced these physicians' likelihood to prescribe HRT, whereas job satisfaction, mental well-being, physical well-being, Type A behavior, perceived job control and other work stressors were not found to be significant predictors. Moreover, consideration of the possible side effects of HRT was not shown to influence a physician's likelihood to prescribe it either. Among the diverse coping strategies, we discovered that seeking social support as a way of coping was the main factor that determined the likelihood to prescribe. The implication of these results is that, in the post-WHI era, physicians will look into the newer research concerning HRT's benefits and adverse side effects, possibly through talking to and sharing opinions with their peers, and will use that information as the basis for their decision to prescribe it.

The OSI-2 is a well-established system for evaluating occupational stress (Lu et al., 1999). It is a Chinese version of the original English Cooper OSI (Cooper et al., 1988, 1989; Cooper & Bramwell, 1992), which consists of seven specific scales: sources of pressure, Type A behavior, job control, coping strategies, mental health, physical health and job satisfaction. To confirm the utility of the OSI-2 scales in our research, reliability was tested by coefficients of Cronbach; test results were comparable with that found for other studies (Cooper & Bramwell, 1992; Cooper, Clarke, & Rowbottom, 1999; Steiler & Paty, 2009). Additionally, this study is possibly the first to that investigate whether occupational stress can influence the prescription of medication.

The sources of stress in a medical practice are similar to what is found in many other occupations. For example, work load, team climate, procedural justice, perceived psychological distress, long sick leaves (Virtanen et al., 2008), seniority (Tinti et al., 2009), economical problems (Fothergill, Edwards, & Burnard, 2004), work and work-related activity (Cyr-Taro et al., 2008; Kankaanranta et al., 2007; Volker et al., 2010), perception of unrealistic expectations (Falkum & Vaglum, 2005), communication skills (Geller et al., 2008; Smith et al., 2007), malpractice litigation (Annas, 2008; Papadopoulos, 2007), ethical dilemmas and lack of resources (Forde & Aasland, 2008) can all be sources of stress. Therefore, the OSI-2 scales that have been

used for other occupations can also be used to measure the sources of stress in the medical field (Siu, Lu, & Cooper, 1999). However, we admit that, given the small number of subjects who took part in our study, we must be cautious when interpreting these findings.

In our study, among the eight categories of work stressors measured by the OSI-2, 'personal responsibility' was identified as the most prevalent source of stress, followed by 'workload' and 'organizational climate'. These findings are compatible with the occupational stressors found among Taiwanese managers, who have reported 'personal responsibility' (item mean 4.33) as their greatest source of stress, followed by 'workload' (item mean 4.05) and 'relationships' (item mean 4.04). The overall level of work stress for physicians is comparable with the level of work stress for managers in Taiwan (Lu et al., 1999).

It has been suggested that general practitioners have a higher level of occupational stress than hospital physicians (Virtanen et al., 2008). In our study, the stressors relevant to physicians who treat menopausal syndrome were not found to differ between general practitioners and hospital physicians.

Although previous reports claimed that female physicians experienced higher levels of occupational stress (Forde & Aasland, 2008; Hebbard & Wirtzfeld, 2009), we found that the female physicians who participated in our study did not report a higher level of occupational stress than their male counterparts. Moreover, they also did not differ from male physicians as to their likelihood to prescribe HRT for menopausal syndrome.

HRT has been and still is considered by both menopause societies and specialists to be the treatment of choice for the management of menopausal syndrome (Martin & Manson, 2008; North American Menopause Society, 2010; Roberts, 2007; Speroff et al., 2005). Thus, although the prescription of medication for HRT does not seem to be influenced by the level of occupational stress among physicians, the reason why physicians who had taken more sick leave within the past three months expressed a greater likelihood to prescribe HRT for the treatment of menopausal syndrome needs to be investigated further.

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