Effects of dialogue groups on physicians’ work environment

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Abstract

Purpose – The purpose of this study is to evaluate whether dialogue groups for physicians can improve their psychosocial work environment.

Design/methodology/approach – The study assessed the impact of eight dialogue groups, which involved 60 physicians at a children’s clinic in one of the main hospitals in Stockholm. Psychosocial work environment measures were collected through a validated instrument sent to all physicians (n = 68) in 1999, 2001 and 2003. Follow-up data were collected after the termination of the groups.

Findings – The overall score of organizational and staff wellbeing, as assessed by the physicians at the clinic, deteriorated from 1999 until 2003 and then improved 2004. This shift in the trend coincided with the intervention. No other factors which might explain this shift could be identified.

Research limitations/implications – In a naturalistic study of this kind it is not possible to prove any causal relationships. A controlled survey of management programmes concerning the work environment among physicians would be of interest for further research.

Practical implications – The results suggest that dialogue groups may be one way to improve the psychosocial work environment for physicians.

Originality/value – There is a lack of intervention studies regarding the efficacy of management programmes directed toward physicians, concerning the effects on professional and personal wellbeing. This is the first time dialogue groups have been studied within a health care setting.

Keywords Doctors, Health services sector, Workplace, Work psychology, Group discussion, Sweden

Introduction

Health care systems have undergone major technological, organisational and financial changes in many countries during the last decades. These changes have had a substantial effect on the work environment for employees, not the least for physicians.

This study was supported by Per Sandstedt, head of Sachs’ Children’s Hospital and by the head and staff office at Södersjukhuset, Stockholm. The authors are grateful for the physicians’ participation in this study.
Financial productivity incentives have been introduced, which might result in an increased organisational efficiency but, at the same time, also an impairment of the physicians’ working conditions (Forsberg et al., 2000). Other professional groups are increasingly competing for management positions that, traditionally, have been the exclusive domain of physicians (Forsberg et al., 2001, Friedman, 1995). Several reports have described a decreasing autonomy, influence and participation, a loss of control and a decreasing power of the medical profession (Akre et al., 1997, Burdi and Baker, 1999, Forsberg et al., 2001, Linzer et al., 2001, Schmoldt et al., 1994). There are signs that the health and well-being among physicians is declining, and that this is, at least partly, work-related (Filipsson, 1999, Johnson, 1997). An increase in the sickness absentee rates for physicians has also been observed (Stockholm County Council, 1998, 2001).

It has been suggested that a decrease in physician well-being could affect quality of patient care (Akre et al., 1997; Arnetz, 1999; Gundersen, 2001; Linn et al., 1985; Schultz and Schultz, 1988; Thomsen, 2000). An extensive international study found that the majority of physicians express concern that quality of care, as a result of physicians impaired work environment, has deteriorated over the last five years (Blendon et al., 2001).

New technologies, such as computerised images and computer-based information systems, have further challenged the role of physicians (Arnetz, 1997; Bonn and Bonn, 2000; Davenport, 2002). Due to the fast scientific development in medicine, most physicians are forced to specialise with a corresponding demand to collaborate closely with colleagues and other professionals. Physicians have become increasingly dependent on working in teams with other physicians and personnel with different competence. Despite this, physicians are to a great extent socialised into a role where they expect themselves to manage all situations on their own (Lehto and Norlin-Mistander, 2001). In medical education, limited time is devoted to skills belonging to behavioural science, psychology, leadership and management. In a previous project for young male physicians it was concluded that one part of the problems of the work environment is related to leadership, but that physicians lack leadership education and training (Lehto and Norlin-Mistander, 2001).

Studies from the non-medical sector have suggested that management programmes could be beneficial to increase influence, authority and well-being on both an individual and an organisational level (Dolan, 1999; Kovner et al., 1996; Lutz, 1995; Peluchette and Jeanquart, 2000; Umiker, 1998). Management programmes might thus be one strategy to enhance organisational influence, health and well-being among physicians (Edmonstone and Western, 2002). However, there is a lack of intervention studies regarding the efficacy of such programmes. There are few prospective, long-term intervention studies within this field in general, and especially regarding interventions directed toward physicians, concerning the effects on professional and personal well-being (Von Vultee and Arnetz, 2004).

A general experience, however, is that such a programme, in order be successful, should focus mainly on implicit knowledge involved in relational behaviour and not on teaching theories (Dowton, 2004). In a small-scale pilot study it was for example demonstrated that “supervision groups” for managers that met once monthly during a one- to two-year period seemed to have an effect in the organisation. At the follow-up, stress among co-workers was reduced and they felt more support from their superiors who had participated in the supervision groups (Sandahl and Lindgren, manuscript in
preparation). It seemed that the managers had learned something that was not only in their minds, but that it had had some effect on their behaviour, which had influenced their co-workers in a positive way.

The supervision groups used in this study were based on “dialogue groups” as described by De Maré et al. (1991), Bohm (2004), Isaacs (1999) and Olausson (1996). Dialogue in groups is not only a technique to improve organizations, enhance communication, engender consensus or solve problems. During the dialogue process people are given the opportunity to think together – not only to analyse common problems or to create new parts of shared experiences but also to create a collective sensitivity in which thoughts, feelings and acts do not belong to a specific person but to all in the group (Senge, 1994).

In dialogue groups the participants can learn from each other, develop new perspectives and create new knowledge together about the organisation they all are part of. This knowledge is not possible to create from only one person’s perspective or experience. The collective learning processes create synergy effects, on which action can be taken in order to improve work environment (Wilhelmson and Döös, 2002). Research in this field is scarce and there is a need for systematic collection of empirical data related to the subject.

Experience suggests that sometimes the result of a dialogue process can be common creative solutions and a common commitment to the organisational development and work environment development, but dialogue groups for physicians have never been evaluated systematically against such an outcome. Therefore the aim of this study was to evaluate if dialogue groups for physicians can improve their psychosocial work environment, in terms of a better social climate, participation, workload and leadership.

**Methodology**

The outcomes presented are the results of a five year study at a children’s clinic, Sachs’ Children’s Hospital, at one of the main hospitals in Stockholm, Södersjukhuset, which is serving a catchments area of 600,000 inhabitants. Baseline measures of psychosocial work environment were collected 1999 and 2001. Two dialogue groups for resident doctors met ten times from late 2001 until the end of 2002 (see Figure 1). In the beginning of 2003 the same psychosocial measurement instrument was distributed to all physicians at the clinic. Thereafter six new dialogue groups started and met ten times during one year. The groups were open for all physicians at the clinic. From 2001 to 2003 the group of resident doctors at the clinic increased from 22 to 33 physicians thus 11 new resident doctors were invited to the dialogue groups that started in 2003.

![Figure 1. Study design](image)

**Notes:** Two dialogue groups for resident doctors (n = 20) started in October 2001 and in January 2002. Six new dialogue groups for all physicians (n = 60) started in March 2003. All dialogue groups met in total 10 times during one year. The QWC-questionnaire was sent to all physicians in February 1999, 2001, 2003 and in 2004.
Follow-up data were collected after the termination of the groups in 2004. The ethics committee of the county council approved the project.

**Participants**

During the time for the main intervention, in 2003, Sachs’ Children’s Hospital had a total of 350 employees of which 76 were physicians. Fifty-six of the physicians were employed at the inpatient clinic and 20 were employed at four different outpatient clinics in the southern area of Stockholm. Each outpatient clinic had a physician as a manager who reported to the head of the hospital. Of the 76 physicians at the clinic eight were excluded from the study due to various reasons, among others that they were not active as clinical doctors even if they were still at the employment list.

Both in 2003 and 2004, the same 53 physicians of the 68 who received the questionnaire responded (78 per cent) of which 47 participated in the dialogue groups. Of the 53 respondents a slight majority, 30 (57 per cent), were women and 23 (43 per cent) men; 39 were physicians working at the inpatient clinic of the hospital and 14 were physicians working at the outpatient clinics in southern Stockholm. Thirty-one (58 per cent) of the respondents were specialist doctors and 22 (42 per cent) were resident doctors. The distributions of mean age, gender, number of physicians and professional group identity among the respondents were representative for the group of physicians at the Sachs’ Children’s Hospital during the time period of this study from 1999 to 2004. There were no major changes of these data at the clinic from 1999 to 2004.

**Procedure**

Two dialogue groups with ten physicians per group started in October 2001 and in January 2002 respectively, in all 20 resident doctors. Each group consisted of six female and four male resident doctors at the Sachs’ Children’s Hospital. The two groups met with the same pair of supervisors, three hours once a month, in total ten times during the first project year.

Six new dialogue groups started in March 2003 with ten physicians per group, in all 60 physicians. All 68 physicians at the Sachs’ Children’s Hospital were invited to participate. Fourteen of the resident doctors from the two previous groups participated during the second project year. They were randomly assigned to the six new groups. All six groups were equal in distribution of age, sex and medical experience as doctors. They met with the same two professional supervisors per group, three hours once a month, in total ten times during a 12-month period.

In February 2003 the quality work competence (QWC) questionnaire was sent to all 68 physicians at the Sachs’ Children’s Hospital. At this time, both dialogue groups with resident doctors had finished. The same questionnaire was sent again to the same study participants after the second intervention, in March 2004. The anonymous and coded questionnaire was mailed to their respective home addresses. The QWC questionnaire had also been used in 1999 and 2001 to evaluate the work environment for all employees at Sachs’ Children’s Hospital.

**Dialogue groups**

The supervisors acted as facilitators for the group process. Their role was to observe, to give structure to the meetings and to contribute to the process with theoretical knowledge.
and experience in the area of leadership and organizational development. Specific areas that were aims for the dialogue groups were the physicians’ mental energy, social climate, workload, feedback from managers, feeling of participation, work-related exhaustion, goal clarity at workplace, organisational efficacy, and leadership at workplace. The version of dialogue groups that was used was originally developed by Fleck (Olausson, 1996). A central aspect of the method is to give all participants the same ability to contribute. The participants were encouraged to learn from each other, to reflect over different perspectives of the matters with the goal to create new common knowledge and understanding about the organisation. A key point in the method is to base the process on the participants’ own questions at issue. Each participant chose his or her own theme. The instruction was to bring up dilemmas the participants experienced in their everyday work, among others the role as a leader of other personnel.

**Questionnaire**

The quality work competence (QWC) questionnaire has been frequently used in Sweden and has been validated in the Swedish health care system (Arnetz, 1999). The published version of the questionnaire has been designed for the assessment of organizational and staff well-being using staff ratings of the following eleven key enhancement areas/indices: mental energy, social climate, workload, feedback, participation, work-related exhaustion, skills development, quality of the internal communication process, goal clarity, organizational efficacy, and leadership. Each enhancement index consists of the summarised score of three to seven multi-point questions with standard Likert check-off scales. A focus score enhancement index (FSEI) for the overall score of organizational and staff well-being is calculated based on the sum of the weighted scores on each of the listed eleven indices, with the exception of quality of the internal communication process and work-related exhaustion. Higher scores indicate more well-being for all indices except for the indices work-related exhaustion and workload where lower scores indicate more well-being for the employees. To reduce the number of questions two of the eleven indices were excluded, namely “skills development” and “quality of the internal communication process” as it was assessed that the dialogue groups would not affect these indices. The total number of questions in the QWC-questionnaire was thereby reduced to 40 questions (see Table I). The percentage scores on the enhancement indices range from a possible low of 0 per cent to a high of 100 per cent.

**Statistical analyses**

Statistical analyses of the data from the four different data collection occasions (1999, 2001, 2003, 2004) were performed using SPSS statistical software 13.0 for Windows 2000 Professional. Repeated measurements ANOVA were used to evaluate the mean differences in total scores and time effects between groups of physicians. Two-sample independent t-tests were used to assess the differences in means between time points from 1999 to 2003. Paired t-tests were used to assess differences in means from 2003 to 2004 since the data were paired for these time points. \( P < 0.05 \) was considered a significant result. Since the majority of the respondents were the same from 1999 to 2003 the use of an independent t-test for this period may have caused bias for this period. This potential bias is not possible to measure.
Results
The responses from the questionnaire of 2003 were compared with the ones from the questionnaire that was distributed 2004. Data of the overall focus score enhancement index (FSEI) from the surveys of 1999 and 2001 was also compared with the data from 2003 and 2004.

For all physicians at the clinic there was a deterioration ($p = 0.008$) in the general index for the work environment (FSEI) from 1999 (Mean = 66, SD = 11.5), to 2001.

<table>
<thead>
<tr>
<th>Area</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental energy</td>
<td>Employee-ratings of: feelings of restlessness, irritability, worry, feeling low, moodiness, difficulty concentrating during the last month (4-point scale). The fewer of these symptoms, the higher the score</td>
</tr>
<tr>
<td>Social climate</td>
<td>Atmosphere at work, cohesion among co-workers, supportive atmosphere among co-workers</td>
</tr>
<tr>
<td>Work-related exhaustion</td>
<td>Are employees: Mentally exhausted after work? Worn out after work? Tired when they think about work?</td>
</tr>
<tr>
<td>Feedback</td>
<td>Clear work directives from immediate supervisor, feedback from supervisor when task has been done well and poorly, respectively</td>
</tr>
<tr>
<td>Participation</td>
<td>Opportunity to influence workplace decisions, actual influence over workplace decisions in relationship to desire, latitude for deciding how work should be done, latitude for deciding what tasks should be done, sufficient influence in relationship to responsibilities, access to adequate information to carry out work duties efficiently, information from immediate supervisor sufficiently concrete to be useful in one’s work</td>
</tr>
<tr>
<td>Goal clarity</td>
<td>Workplace goals are: well defined, realistic, influenceable, assessable</td>
</tr>
<tr>
<td>Leadership</td>
<td>Immediate supervisor: clear in his/her communication, acts consequently, has described how to achieve departmental goals, provide opportunities to develop employee’s professional skills, open for change in workplace organisation and work habits</td>
</tr>
<tr>
<td>Workload</td>
<td>Time for planning work duties in advance, sufficient time to execute tasks, time to reflect upon/consider how tasks had been carried out, time to consider how work processes could be improved in one’s department</td>
</tr>
<tr>
<td>Organisational efficacy</td>
<td>Planning of work duties, employees strive toward the same goals, resources used optimally at work, the decision-making process is functional</td>
</tr>
<tr>
<td>Focus score enhancement index (FSEI)</td>
<td>Index for the general work environment, the overall score of organizational and staff well-being calculated based on the sum of weighted scores on each of the listed nine indices, with the exception of work-related exhaustion</td>
</tr>
</tbody>
</table>

**Notes:**
- All such multi-point questions used standard Likert check-off scales;
- Positive scores, that is, higher percentage more desirable, converted to percentage;
- Response alternatives: No; Yes; sometimes; Yes, multiple times; Yes, daily;
- Response alternatives: Disagree strongly; disagree somewhat; agree somewhat; agree strongly;
- Response alternatives: No, never; no, rarely; yes, sometimes, yes, always;
- 3-point scale: if less influenced than desired (1 point), if influence = desire (4 points), if influence larger than desired (2 points);
- Not at all, not really, to a certain degree, yes, to a high degree

**Table I.** Areas covered by specific questions included in the organisational enhancement indices (QWC)
(Mean = 62, SD = 15.3) until 2003 (Mean = 58, SD = 13.0) and then an improvement ($p = 0.037$) to 2004 (Mean = 61, SD = 12.0) (see Figure 2).

For the resident doctors at the clinic the FSEI deteriorated ($p = 0.007$) from 1999 (Mean = 63, SD = 13.5) to 2001 (Mean = 49, SD = 3.2), stayed at the same level until 2003 (Mean = 52, SD = 12.3) and then improved ($p = 0.016$) until 2004 (Mean = 56, SD = 14.1) (see Figure 3). However, for the specialist doctors there were no significant changes in the FSEI for the work environment from 1999 to 2004 (see Figure 3).

For the period from 1999 to 2003 the indices goal clarity, organizational efficacy and FSEI deteriorated ($p < 0.01$) for all physicians.

**Figure 2.** Focus score enhancement index (FSEI) for all responding physicians ($n = 53$) at the Sachs’ Children’s Hospital 1999-2004

**Figure 3.** Focus score enhancement index (FSEI) for responding resident specialist doctors at the Sachs’ Children’s Hospital 1999-2004
For the period 2003 to 2004 there were improvements ($p < 0.05$) for the indices feedback, leadership, FSEI and a nearly significant improvement ($p = 0.051$) for the index work-related exhaustion for all physicians at the clinic. The improvements for the physicians working at the inpatient clinic of the hospital were stronger than for the physicians working at the outpatient clinic. There were no significant differences in the indices for the group of the 14 responding physicians working at the outpatient clinic of the hospital (see Table II).

For the group of resident doctors the indices goal clarity, organizational efficacy, feedback and the overall FSEI deteriorated ($p < 0.05$) during the period from 1999 to 2003. For the period from 2003 to 2004 there were improvements ($p < 0.02$) for the indices feedback (from $M = 33$, $SD = 23$ to $M = 47$, $SD = 21$), goal clarity (from $M = 22$, $SD = 22$ to $M = 39$, $SD = 22$) and the overall FSEI (from $M = 49$, $SD = 12$ to $M = 55$, $SD = 14$).

For the group of all specialist doctors at the clinic the indices goal clarity and organizational efficacy deteriorated but the index for participation improved from 1999 to 2003 ($p < 0.05$). For the period 2003 to 2004 there were improvements ($p < 0.05$) for the indices feedback (from $M = 57$, $SD = 19$ to $M = 66$, $SD = 17$) and leadership (from $M = 65$, $SD = 16$ to $M = 71$, $SD = 15$). The indices for mental energy (from $M = 72$, $SD = 18$ to $M = 79$, $SD = 19$; $p = 0.078$) and workload (from $M = 40$, $SD = 19$ to $M = 35$, $SD = 17$; $p = 0.077$) had nearly improved significantly. For the specialist doctors working at the inpatient clinic of the hospital ($n = 26$) there was an improvement ($p = 0.028$) for the index work-related exhaustion from 2003 to 2004.

When the dialogue groups ended in 2004, 89 per cent of the resident doctors and 56 per cent of the specialist doctors stated that they wanted to continue with supervised group discussions in some form. For the group of all physicians this figure was 69 per cent.

**Discussion**

In the present study, the impact of dialogue groups for physicians was evaluated in terms of its influence on individual and organisational well-being. To our knowledge, it is the first time this type of management program is studied within the health care setting.

The overall score of organizational and staff well-being (FSEI) as assessed by the physicians at the Sachs’ Children’s Hospital deteriorated from 1999 until 2003 and then

### Table II.

<table>
<thead>
<tr>
<th>Index</th>
<th>Mean (M) 2003</th>
<th>SD</th>
<th>Mean (M) 2004</th>
<th>SD</th>
<th>$T$</th>
<th>$P$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental energy</td>
<td>70.5</td>
<td>17.8</td>
<td>73.2</td>
<td>20.4</td>
<td>-0.968</td>
<td>0.338</td>
</tr>
<tr>
<td>Social climate</td>
<td>72.2</td>
<td>13.8</td>
<td>75.6</td>
<td>17.9</td>
<td>-1.298</td>
<td>0.201</td>
</tr>
<tr>
<td>Work-related exhaustion</td>
<td>43.8</td>
<td>19.2</td>
<td>38.5</td>
<td>17.3</td>
<td>2.006</td>
<td>0.051</td>
</tr>
<tr>
<td>Feedback</td>
<td>46.9</td>
<td>23.7</td>
<td>58.0</td>
<td>20.6</td>
<td>-4.406</td>
<td>0.000*</td>
</tr>
<tr>
<td>Participation</td>
<td>73.5</td>
<td>21.5</td>
<td>75.0</td>
<td>17.8</td>
<td>-0.638</td>
<td>0.527</td>
</tr>
<tr>
<td>Goal clarity</td>
<td>34.0</td>
<td>23.1</td>
<td>39.1</td>
<td>20.6</td>
<td>-1.394</td>
<td>0.170</td>
</tr>
<tr>
<td>Leadership</td>
<td>57.8</td>
<td>19.3</td>
<td>64.3</td>
<td>17.8</td>
<td>-2.847</td>
<td>0.007*</td>
</tr>
<tr>
<td>Workload</td>
<td>44.7</td>
<td>20.1</td>
<td>41.0</td>
<td>18.8</td>
<td>1.517</td>
<td>0.136</td>
</tr>
<tr>
<td>Organizational efficacy</td>
<td>54.1</td>
<td>13.5</td>
<td>54.2</td>
<td>14.9</td>
<td>0.998</td>
<td>0.922</td>
</tr>
<tr>
<td>Focus score enhancement index (FSEI)</td>
<td>57.9</td>
<td>13.0</td>
<td>61.0</td>
<td>12.0</td>
<td>-2.173</td>
<td>0.037*</td>
</tr>
</tbody>
</table>

**Note:** $^* p < 0.05$
improved in 2004. This shift in the trend, from deterioration to improvement, coincided with the dialogue group intervention for all physicians at the clinic. In a naturalistic study of this kind it is not possible to prove any causal relationships. In order not to exclude alternative explanations, the head of the clinic was interviewed and the annual reports from 2002 until 2004 have been studied carefully.

During a short period of the second project year (2003) the clinic’s existence was threatened by economical decisions of the politicians in Stockholm. The results of such stress factors are usually deterioration in work climate. In spite of this threat the work climate as measured by QWC improved. Previous research has pointed out that organizational support may be an important factor for mitigating work environment stressors (Davidson et al., 1997; Jackson, 1983; Olson, 1988; Anderzen and Arnetz, 2005). The improvement of the work environment among the physicians at the clinic despite the threat to the clinic’s existence might be an effect of the dialogue groups.

In 2000 the head of the clinic was changed, which may have affected the work environment. However, there were no significant changes in the overall FSEI for the specialist doctors during the period from 1999 to 2004 but they improved the indices feedback and leadership from 2003 to 2004. For the group of resident doctors the indices goal clarity, feedback and the overall FSEI for the work environment deteriorated from 1999 to spring 2001, stayed at the same level until 2003 and then improved 2004. This shift in the trend of deterioration to improvement for these three indices also coincides with the start of the dialogue groups for the resident doctors in October 2001. This can be understood as a more general improvement for the resident doctors than for the specialist doctors. One explanation to this could be that the majority of the resident doctors participated in the dialogue groups during two years from 2002 to 2004 while the specialist doctors only participated one year from 2003 to 2004.

It could also be that resident doctors in general may be more susceptible to influences since they are new in their professional role. The resident doctors are in a stage of development where they may be more sensitive to influence and they may be more independent to form their own professional role. Since the resident doctors scored lower than the specialist doctors in six of the ten indices including the overall FSEI in 2003 there was more room for improvement.

Another difference between the groups of doctors is that the project with dialogue groups started as an intervention for the resident doctors the first project year. At the beginning of the first project year some of the specialist doctors were of the opinion that the project was negative for the total group of physicians at the clinic. Despite these controversies in the beginning, the positive experiences of the dialogue groups among the resident doctors were spread to the specialist doctors and a result of this was a second project year with dialogue groups for all doctors at the clinic. These new groups were formed of both specialist doctors and resident doctors. As a result the groups became more heterogeneous during the second year. This heterogeneity in combination with positive expectations from the first year were challenges for the supervisors of the dialogue groups during the second year.

As a result of the participation of all physicians, the schedule for the group meetings in combination with the medical care of patients were more complex the second year. During this period some physicians felt that it was an obligation to participate. In spite of this the attendance was lower the second year. The experiences from the supervisors were that due to the more heterogeneous groups and the lower attendance it took more
meetings during the second year to create cohesion in the groups compared to the first year. Since the participants shifted from one meeting to another, the collective learning process in the groups were more difficult to achieve during the second year compared to the first year. The different circumstances during the two project years may explain the differences between the groups of physicians.

One cannot exclude other causes than the dialogue groups to the improved work environment during this period, but from the data that has been available we cannot find any other external factor than the quite strong and unusual intervention to offer three hours per month to discuss problems at work in small groups for physicians only.

During the period for the dialogue groups from 2003 to 2004 none of the ten work environment indices declined, but four of the ten indices improved for all physicians. These indices were feedback, leadership, work-related exhaustion and the overall FSEI. One explanation for this could be that these areas corresponded with the aims of the intervention and the methods used.

The improvements for the four indices were significant only for the group of physicians working in the inpatient clinic. One reason could be that the group of 14 responding outpatient physicians was too small to show statistically significant differences. It is also a fact that these 14 physicians work in four different outpatient departments in different areas of southern Stockholm.

Conclusion
The results indicate that dialogue groups can be one way to improve the psychosocial work environment among physicians. The effect of such an intervention may be greater if it is offered during two years rather than one year.

Recommendations
Dialogue groups for physicians seem to be a valuable tool to improve psychosocial working conditions. To learn more about the method and its possible potential to influence the work situation for physicians, we recommend its further application in settings where methods for quality assurance or research are available.

References


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