
Commentary

Stress Among Medical Oncologists: The Phenomenon of Burnout and a Call to Action

The concept of "burnout" typically generates a vision of a scorched earth with no meaningful vegetation and a lack of life. When people experience burnout in their professional lives, they seem to lack interest and enthusiasm. The "fire in the belly" that was once a roaring inferno diminishes to a dimly lit and quickly fading ember. Usually, the concept of "brownout" is more germane to a decrease in joy-filled experiences than to a complete lack of enthusiasm.

Burnout and Its Associated Effects.—The phenomenon of burnout can be described as frustration or a sense of failure in one's profession. It has been well chronicled in the lay press and seems particularly indigenous to persons in high-stress occupations, such as emergency department physicians, air traffic controllers, law enforcement personnel, and fire fighters. A recent survey in the *Journal of Clinical Oncology* documented the magnitude of the problem of burnout among medical oncologists—approximately 60% experience this phenomenon.¹ Persons who struggle with the issue of disillusionment transform from caring individuals to apathetic ones; they replace commitment and compassion for aloofness and emotional indifference; and they exchange openness and warmth for a protective, defensive, and self-serving posture. Trust and faith become eroded by suspicion; optimism and enthusiasm are diluted by feelings of cynicism and sarcasm.

These distressing feelings and attitudes are not limited to only some members of the oncologic community but are certainly prevalent among physicians as a group.^{2,4} Casual conversations in hallways during major meetings or during coffee breaks are often a more revealing barometer of satisfaction than are published surveys. Chemical dependence (especially alcoholism), suicide, and interpersonal discord have been well documented among the ranks of physicians. A recent study found a higher consumption of alcohol among physicians than among the general population, and heavy drinking seems associated with burnout.⁴ Two surveys have documented that 40 to 50% of emergency department physicians and infectious disease subspecialists experience disproportionate levels of stress, depression, and emotional exhaustion.^{2,3} The frequency of alcoholism in the medical profession is a problem.⁵ The palpable discontent and unhappiness among many physicians cannot prudently be ignored. As we enter an era of increasingly burdensome fiscal

constraints and of bureaucratic intrusions into the delivery of health care, these issues will continue to escalate, and professional morale will deteriorate further. Financial, administrative, and legal issues, of which clinicians have minimal control, are clear stressors that cannot be discounted.

Survey of Oncologists.—During the past 5 to 10 years, a general perception of unhappiness has existed among the "rank and file" of the oncologic community; however, minimal efforts had been invested to verify this discontent. In a fascinating study, questionnaires were mailed to 1,000 randomly selected subscribers of the *Journal of Clinical Oncology*.¹ Respondents were asked to describe their expectations and training and frequency of burnout in their professional activities. The causes of burnout and suggestions for alleviation were also addressed. The questionnaire included both multiple-choice and open-ended questions. The surprisingly high rate of completion of the questionnaire (60%) may be evidence of the deep emotional chord that was struck by this study. Of the responses, 85% were received in the first 2 weeks. Of special importance is that most respondents were active, practicing clinicians who devoted a median of 70 to 79% of their time to patient care. Only 1 to 9% of them were involved predominantly in clinical or laboratory research.

Overall, 56% of respondents reported that they felt burnt-out. The largest subgroup who experienced this phenomenon was the 60% (N = 219) who completed their training between 1970 and 1979. The correlation between the frequency of burnout and the geographic location was not significant between urban and rural practitioners. In contrast, institution- or university-based oncologists reported a 47% burnout rate in comparison with a 66% rate for practitioners in oncology and in internal medicine ($P = 0.0003$). Undoubtedly, this difference reflects, at least in part, more intense clinical responsibilities.

Focus of Oncology Programs.—Several possible explanations exist for the disturbing finding of burnout among medical oncologists. The most consistent factor provoking burnout was related to palliative or symptomatic-supportive care. Some respondents (56%) were frustrated and had a sense of failure. This percentage correlated directly with hours of patient care.

The conclusions associated with the survey of randomly selected oncologists are subjective and provocative. The targeted thrust of most oncology programs and the areas that receive greatest emphasis are the active treatment of patients with use of complex multimodality programs that involve radiation therapy, chemotherapy, biologic-response modifiers, and surgical intervention. The overwhelming proportion of these patients have diseases that are incurable, and such patients may receive only a limited amount of active anticancer therapy. Their remaining duration of survival

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involves symptomatic and supportive measures. Most oncology programs should probably reorient the focus so that emphasis on palliative care is greater because this type of treatment will consume most of the oncologist's active practicing day. Oncologists must recognize the absolute inevitability of an emotional "meltdown" if they perceive that their primary role is to eradicate malignant disease. Currently, the possibility of outright cure of disseminated disease applies to a few patients with selected neoplasms, such as germ cell tumors, lymphoproliferative disorders, and some breast cancers. The art and science of orchestrating and participating in investigational clinical trials and an appreciation of the statistical nuances of new drug developments are obviously important during oncologic training. A renewed focus for the management of patients for whom active treatment is no longer appropriate because of clinical deterioration and lack of effective therapies might be helpful.

Limited Therapeutic Advances.—Another factor in the phenomenon of burnout may be that discovering the "magic potion," perhaps more a concern of the basic researcher than the pragmatic clinician, has been a frustratingly elusive goal. Undoubtedly, gains in managing patients with malignant disease have been substantial. For most patients with advanced cancer, the quality of life is immeasurably better than it was a decade ago, especially relative to pain management and symptomatic care. Nonetheless, a chasm seems to exist between basic scientists involved in the interesting and newsworthy developments and medical oncologists struggling with the practical realities of clinical medicine and the expectations, sometimes unrealistic, of patients and families.

Prevention of Burnout.—The theme of burnout has been expanded. Several topics have been discussed and methods have been advocated to shore up and salvage the "frontline troops"—clinical oncologists—in the war against cancer.^{6,7}

Individual Psychodynamics.—Medical oncologists must have realistic insights into the emotional "baggage" that they bring to the professional workplace. The effect of early childhood experiences, the need of the physician for validation and affirmation, and the hunger for a sense of meaning in the face of life's tragedies profoundly influence the way in which an individual physician copes with issues of death and dying.

Expansion of Energies and Interests.—Oncologists must expand their energies and interests into identity-strengthening activities distinct from their professional lives. Physicians who are also golfers, runners, photographers, woodworkers, or actors who can totally immerse themselves in their activities may be more productive and sympathetic than tired academic warriors who spend their weekends and evenings on the "seventh" draft of an experimental protocol. The value of consistent, prudent physical activity, rest, and personal time away from work cannot be overestimated.

Importance of Collaborative Input and Realistic Hope.—Oncologists must recognize the importance of seeking collaborative input from colleagues, nurses, and social and pastoral agencies inasmuch as they cannot independently meet all the needs of all their patients. Oncologists should also understand the importance of realistic hope, the small joys and pleasures of each day, the need of patients to have the support of family and friends, and the recognition that they are not omnipotent.

Professional Retreats.—A periodic, nonadversarial forum in which clinicians can verbalize their concerns may be helpful. A professional retreat in which directions and strategies of the group are reviewed has potential value. This type of meeting also provides an opportunity for clinicians to highlight problems in hopes that they will achieve positive and constructive solutions. Sharing mutual difficulties can be an important step in reinforcing group morale as well as respect and concern for individual persons. As in most life situations, sharing a burden, whether physical or emotional, can relieve some turmoil.

Rewards of Being an Oncologist.—Despite the obvious challenges and the depressing aspects of an oncologic practice, there are rewards and satisfaction that few other practitioners can appreciate. The tremendous courage of most patients with cancer and the dogged strength of family members to push on despite spirit-draining experiences are particularly remarkable. Oncologists have the privilege to participate in these struggles. The abilities to care for dying patients, however, are only as good as oncologists' abilities to care for themselves.⁸

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