

## Caring for the oncologist: caregiver stress and staff support in oncology

C. Langenaeken, MD<sup>1</sup>, W. Rombouts, MA<sup>2</sup>

**Although oncology is a very rewarding profession, it can be demanding and stressful. Work-related stress, a lack of meaning in work and problems with work-life balance may lead to distress and burnout. The phenomenon of oncologist distress and burnout is reviewed with a focus on care for the caregiver. A person-oriented approach focusing on promoting personal wellness, factors that bring satisfaction to work, resilience, and positive emotions may provide important coping strategies, adding to the standard focus on job-related factors. Guided intervision may benefit the oncologist and his team by providing a forum for discussing job- and team-related issues, gaining insight through reflection and providing support and meaning-making.**

*(Belg J Med Oncol 2014;8(2):38-43)*

### Tidal Wave

So many have passed this way before,  
ocean rising behind the door,  
the sea forestalled no more.  
What do you want of me?

So many have passed this way  
knowing what's behind the door  
needing solace and nothing more.  
What do you expect of me?

So many have passed,  
wanting my miracle,  
not seeing the Sirens behind the door.  
Oh God, what do you demand of me?

Where in the lexicon of learning  
was I taught

the wave action of this moment.

Never,

never more

Did I learn the pulling of the tide  
on those entrusted to me,

To me.

I am not young anymore

God damn, summon me.

So many have passed this way,  
and I, one more.

Stand-down and let it pass.

Ocean falling behind the door.

Tidal wave,

taunt me no more.

By Frank L. Meyskens, MD

© 2003 by American Society of Clinical Oncology.

<sup>1</sup>Department of Medical Oncology, AZ KLINA, Iridium Cancer Network, Brasschaat, Belgium, <sup>2</sup>UZ KU Leuven, Leuven and Perspectief, Holsbeek, Belgium.  
Please send all correspondence to: C. Langenaeken, MD, AZ KLINA, Department of Medical Oncology, Augustijnslei 100, 2930 Brasschaat, Belgium, tel: +32 3 650 50 53, email: Christine.Langenaeken@klina.be.

**Conflict of interest:** The authors have nothing to disclose and indicate no potential conflict of interest.

**Keywords:** burnout, distress, guided intervision, oncology, personal coping strategies.

## Introduction

People outside the field of oncology often ask: “How do you do it?” or “Isn’t it depressing?”.

Generally speaking the answer is ‘no’. Caring for patients with cancer is a very rewarding profession. Dealing with patients facing a life-threatening illness, evaluating complex diagnostic problems and discussing multimodality treatment plans is both challenging and exciting. Advances in imaging techniques, molecular diagnostics and targeted therapies have transformed oncology from a discipline where failure often lurked around the corner, to an intellectually stimulating field. Improved cancer communication skills, advances in pain and symptom management and increased awareness of palliative care have created opportunities for building relationships with patients and better supporting them throughout the course of the disease.

Yet oncologists may feel overwhelmed by tidal waves of bad news, treatment failure, patient suffering and death.<sup>1</sup> Although progress has been made and cure rates have significantly increased, improvement in survival, disease stabilisation and palliation of symptoms are more realistic objectives in many patients. The increasing administrative burden, drug budgets under pressure and shortage of basic chemotherapy drugs add to the stress of the oncology workplace. How do we cope ?

The aim of this review is to discuss ways of supporting the oncologist in dealing with work-related stress (including emotional stress) and burnout by promoting personal wellness and providing group support. The concept of guided intervention is discussed. A discussion of organisational and job-related factors is beyond the scope of this review, however excellent publications on that topic can be found elsewhere in the literature.<sup>2-6</sup>

## Stress and burnout in oncology: concept and overview

Work-related stress occurs in oncology as it does in other occupations. This may lead to personal distress (manifesting as depression, anxiety, fatigue, etc.) and eventually burnout. Based on the work of Maslach and Schaufeli, burnout can be conceptualised as a prolonged response to chronic emotional and interpersonal stressors on the job.<sup>3</sup> The three key dimensions are (1) an overwhelming exhaustion, (2) depersonalisation, i.e. feelings of cynicism and detachment from the job, and (3) a sense of ineffectiveness and lack of accomplishment. Exhaustion is the key component, though insufficient as a sole criterion for burnout. Exhaustion isn’t simply

experienced, but prompts actions to distance oneself emotionally and cognitively from the job. Burnout is usually assessed by the Maslach Burnout Inventory (MBI).<sup>7</sup> Burnout is not a rare phenomenon in oncology. Studies of burnout (assessed by MBI) in oncology-focused specialties suggest a prevalence of 25% to 35% in medical oncologists, 38% in radiation oncologists, and 28% to 36% in surgical oncologists.<sup>8</sup> However, as a result of the way the MBI is performed, a third of the evaluated persons will have a low, normal and high score respectively. Thus a third of the evaluated persons will have a high score and hence be considered burnout. Therefore crude prevalence rates overestimate the issue and should be interpreted cautiously. This problem might be overcome by analysing MBI scores as continuous variables.<sup>9</sup>

Burnout may occur as early as during medical training and residency. In a survey of oncology residents in France, emotional exhaustion and depersonalisation were reported by 26% and 35% respectively. The prevalence of burnout, defined as a severely abnormal level of either emotional exhaustion or depersonalisation, was 44%.<sup>10</sup> In cancer care workers in Ontario, emotional exhaustion and depersonalisation were reported by 53% and 22% of the physicians: this was significantly higher than among allied health professionals (37%, 4% respectively) and support staff (30%, 5% respectively) ( $p \leq 0.003$ ). Feelings of low personal accomplishment were significantly higher among physicians (48%) and allied health professionals (54%) than among support staff (31%) ( $p \leq 0.002$ ).<sup>11</sup>

In a survey of cancer care professionals in Flanders, 51 % of the medical oncologists suffered from emotional exhaustion and 31 % from depersonalisation.<sup>12</sup> As in the Ontario survey, an elevated score on these two subscales was more frequent among physicians as compared to other cancer care professionals (nurses, psychologists, social workers).

In a systematic review and meta-analysis of studies evaluating the presence of burnout in cancer care professionals (ten studies - 2,375 participants), severe involvement by any one of the three dimensions ranged from 8% to 51%.<sup>13</sup> The prevalence of burnout syndrome was elevated among cancer professionals throughout the world but varied substantially among studies.<sup>6</sup>

In a review by Sherman et al., prevalence rates for burnout and psychosocial distress were high among oncology staff, though not necessarily higher than in non-cancer practice settings.<sup>14</sup>

## Causes and consequences

Burnout is an individual's experience in relation to the work context. The risk of burnout is largely related to characteristics of the job and the organisation. Job factors include quantitative demands (overload), qualitative demands (role conflict, ambiguity), and lack of resources.<sup>3</sup> Individual factors such as demographics (age, sex, being single), personality characteristics (level of hardiness, self-esteem, internal versus external locus of control, type of coping) and job attitude (expectations) have an impact as well, albeit to a lesser extent than situational factors.<sup>3</sup> Recent research on burnout has focused on the degree of match or mismatch between the person and several domains of the professional environment.<sup>6</sup> Six areas of work life cover the major organisational aspects and precedents of burnout: workload, control, reward, community, fairness, and values. The greater the gap or mismatch between the person and the environment, the greater the likelihood of burnout. Burnout may occur when there is a chronic mismatch between people and their work settings in one or more of these areas. Studies in oncologists have suggested that stressful situations, emotional stress, and ethical issues one doesn't feel comfortable with, may increase the risk of burnout.<sup>8</sup> The stress of feeling inadequately trained in communication skills or dealing with death and end-of-life issues may add to the existing stress factors.

Burnout may have important professional and personal consequences.<sup>2,8</sup> Distress and burnout seem to erode professionalism, decrease empathy, increase the risk to engage in unprofessional conduct, have a negative impact on medical knowledge, increase the risk of medical errors, and diminish altruistic views on serving patients.<sup>8</sup> An association between burnout and medical errors has been reported, although a causal relationship and the direction of effect can often not be established.<sup>15</sup> Burnout also seems to be an important factor influencing oncologists to consider leaving the field or retire early, both of which have significant implications on manpower, particularly in specialties with projected physician shortages, such as oncology.<sup>5,11,16</sup>

At the personal level, burnout may have a negative impact on the oncologist's quality of life and relationships with others.<sup>8</sup>

## Coping strategies

Burnout can happen to anyone. Even the best oncologist may not be immune to the phenomenon. Given its detrimental effect on people both at the professional and

personal level, it is important to recognise the problem. Recovery from burnout is possible, but is likely to involve a laborious and prolonged process. So prevention is the better strategy. How do we avoid burning out?

As burnout is an individual's response to chronic stressors on the job, prevention strategies obviously need to focus on work-related factors. Colombat et al. suggest both primary and secondary preventive measures in cancer care professionals.<sup>2</sup> Primary prevention aims at preventing burnout at the level of the team by adequate organisation of the workload and appropriate management of the team. The objective of secondary prevention is to prevent burnout from spreading out from the affected person to other members of the team. An important item in the expert recommendations listed in their review is promoting the cohesion of the team by enhancing communication within the team, promoting team spirit through team meetings and projects, and defining the team's values, while at the same time allowing time for informal encounters, sharing emotions, and being considerate for individual needs. Participatory management is also strongly advocated as a preventive strategy. This includes participation in working groups (addressing team or organisational issues), staff meetings, and support groups.

Preventive and coping mechanisms can be identified at a personal level too. These include personal coping strategies, focus on elements bringing satisfaction in work, personality constructs of resilience versus hardiness and the skills to use positive emotions.<sup>6</sup>

Personal coping strategies are variations on the theme of promoting personal wellness.<sup>6,8</sup> To be able to truly care for our patients we need to be able to care for ourselves. What are the mechanisms that allow us to continue working with the sick, critically ill, dying, and bereaved? Findings in caregivers and medical oncologists are very similar: primary coping mechanisms include a sense of competence, control and pleasure in one's work, team philosophy, building and support, lifestyle management (recreation, hobbies, etc.), strategies related to work-life balance and developing an approach/philosophy of dealing with death and end-of-life care.<sup>6,17</sup> Relationships, religious/spiritual practice and personal philosophies are also important coping strategies. Whether it is one of these, or something else, we all need a 'safe haven'; a place where we can truly be ourselves; a place to lay down emotions, feelings of failure and vulnerability, ethical/moral dilemmas; a place that

helps in sorting things out and walking away with a feeling of accomplishment. The partner/family may provide such a place, but it is worthwhile to have it with a group of peers as well.

Another strategy is to look at what brings satisfaction and meaning in our work. Specific aspects of oncology may differ in the extent to which they are providing the individual oncologist with satisfaction in his/her work. Some will thrive on the intellectual challenge of a difficult case, whereas others will find the personal interaction with the patient and his family more rewarding. Some will focus on specific tumour types, whereas others will have pleasure in providing palliative and end-of-life care. Some will aim for a leadership position, whereas others will engage in teaching or research. A survey of oncology professionals in Flanders found that having time to perform research decreases the risk of burnout.<sup>12</sup> Finding meaning in one's work is also helpful in reducing the risk for burnout and achieving satisfaction in life; obviously this is more difficult once burnout is established. What is meaningful in work may vary from one physician to another and may vary over time. Generally, relationships with patients and others, and the intellectual stimulation of practice appear to be the foundation of professional meaning.

Personality is another important factor in coping. Hardiness, a sense of coherence, and resilience are different personality constructs.<sup>6</sup> Hardiness is associated with determination, commitment and energy. A sense of coherence refers to seeing one's life as being comprehensible, manageable and meaningful, whereas resilience is the ability to bounce back, to cope successfully despite considerable adversity. In a study of palliative care nurses, resilience was associated with hardiness in some and with a sense of coherence in others: the key difference is response to change.<sup>18</sup> Those with hardiness were not afraid of change, whereas those with a sense of coherence disliked change. This concept recognises that different people may have different personality structures and may have different coping strategies.

It also implies that support may need to be different for different people, and will need to be adapted to the individual(s)/group involved.<sup>6</sup> Obviously this is not limited to the palliative care setting, but also applicable to the oncology field.

Positive emotions may play an important role too. In contrast to the oncologist's 'tidal waves' of negative

emotions; hope, joy, trust, gratitude and compassion are just a few examples of the positive counterparts. Positive emotions "serve not only as breathers, providing a psychological break or respite, but also as restorers, replenishing resources".<sup>6</sup> Resilient people may use positive emotions as a mechanism for coping.<sup>19</sup> In oncology, resilience involves cherishing positive memories: the gratitude of patients, thanking you for supporting and motivating them, patients inviting you to share their joys, families thanking you for the team's compassionate and respectful care.

### **Intervision and staff support in oncology**

The value of sharing experiences, sitting together to discuss problems, and reflection amongst peers has long been recognised, both from the learning and support point-of-view. 'Intervision' is a working method for staff to formally, yet 'safely' meet with others, have a place where issues can be discussed in a tolerant way without fear of being reprimanded, where one can be vulnerable, and admit emotional stress or a sense of failure.

Do we oncologists need support? Can intervision be of any help to us? The need for staff support in oncology was recognised as long ago as the early days of the discipline. In 1981, Amaral et al. reported on their pilot project of a staff support group on a cancer ward.<sup>20</sup> The study combined group support and the provision of information in weekly meetings for eight months. Both unstructured and didactic sessions were used. Participants expressed great satisfaction with the project, although this was not corroborated by the statistical analyses.

More than thirty years later, the group is still one of the pillars of staff support. In their study of burnout in French oncology residents, Blanchard et al. refer to support groups as a way of addressing the problem.<sup>10</sup> Schraub et al. also mention support meetings and talking groups as strategies to prevent and tackle burnout in oncology.<sup>21</sup> Peer-supported storytelling is another group-based format that has been used for meaning-making and staff support. In a study of paediatric oncology nurses', participants reported receiving and providing support during sessions.<sup>22</sup> They also indicated that sessions had an impact on their grief and meaning-making.

Intervision may be a useful support tool for oncologists and oncology teams. Intervision must be distinguished from supervision: intervision is problem-oriented with a focus on group support and professional development, whereas supervision is person-oriented. In supervision,

## Key messages for clinical practice

1. Distress and burnout are not uncommon in oncology.
2. Stressful situations and chronic mismatch between the individual and several domains of the work environment (workload, control, reward, community, fairness, and values) increase the risk.
3. Preventive strategies include addressing job-related factors as well as promoting personal wellness and resilience, focusing on factors that bring satisfaction to work and using the power of positive emotions.
4. Guided intervision may benefit the oncologist and his team by offering a forum for addressing job-related factors, gaining insight through reflection and providing support and meaning-making.

the supervisor is the expert, passing on his expertise and knowledge to others. In intervision, a group of peers gather to discuss issues, reflect on their experience and knowledge, gain insight through reflection and feedback, and support each other. Intervision can either be unstructured, or guided, i.e. coached. Guided intervision has the advantage of a helmsman at the wheel: the intervisor monitors the agenda, timing, and particularly the process. The intervisor helps the group by structuring the process and promoting reflection.

Intervision may benefit the oncology team by sharing their approach of a difficult case, discussing difficult moments, deaths, interactions with families, defining role models of different functions in the team, etc. Intervision may also benefit the oncologist by learning that he/she did the best possible job under the circumstances, even if they felt dissatisfied with the outcome, helping him/her to have a sense of accomplishment instead of failure, feeling supported by the group.

Shanafelt et al. suggest not discussing stressful aspects of work with colleagues, as this could result in excessive complaining and focusing on the negative aspects of work.<sup>8</sup> Still, appropriate discussion of such issues within the framework of guided intervision may prove to be an important prevention strategy. Work organisation and proposals for improvement, as well as adapting institutional measures to the team's needs are but a few examples of subjects for intervision.

## Conclusion

Stress and burnout are not uncommon in oncology.

Addressing job-related factors as well as promoting personal wellness, resilience, and using positive emotions are important coping strategies. Guided intervision may benefit the oncologist and his team by providing a forum for discussing job- and team-related issues, gaining insight through reflection and providing support and meaning-making. A suitable format could be regular group meetings guided by an intervisor. There is increasing interest in the concept, and intervision groups are being set up in academic centres in Belgium.

## References

1. Shanafelt T, Adjei A, Meyskens FL. When your favourite patient relapses: Physician grief and well-being in the practice of oncology. *J Clin Oncol* 2003; 21:2616-19.
2. Colombat P, Altmeyer A, Barruel F, et al. Syndrome d'épuisement professionnel des soignants. *Oncologie* 2011;13:845-63.
3. Maslach C, Schaufeli WB, Leiter MP. Job burnout. *Annu Rev Psychol* 2001;52:397-422.
4. Schaufeli WB, Bakker AB. Job demands, job resources and their relationship with burnout and engagement: A multi-sample study. *J Organ Behav* 2004; 25:293-315.
5. Bakker AB. Hoe werkomstandigheden van invloed zijn op burnout: het WEB-model. In: C.A.L. Hoogduin ea. *Behandelingsstrategieën bij burnout*. Bohn Stafleu Van Loghun, Houten/Diegem, 2001, p.21-39.
6. Vachon ML. Four decades of selected research in hospice/palliative care: have the stressors changed? In: I. Renzenbrinck. *Caregiver Stress and Staff Support in Illness, Dying and Bereavement*. Oxford University Press, 2011, p1-24.
7. Maslach C, Jackson S, Leiter M. *Maslach Burnout Inventory Manual*. 3rd ed. Palo Alto, CA: Consulting Psychologists Press; 1996.
8. Shanafelt T, Dyrbye L. Oncologist Burnout: Causes, Consequences, and Responses. *J Clin Oncol* 2012;30:1235-41.
9. Blanchard P, Rodrigues M, Colombat P. On the prevalence and causes of

- oncologist burnout. *J Clin Oncol* 2012;30:3029-30.
10. Blanchard P, Truchot D, Albiges-Sauvin L, et al. Prevalence and causes of burnout amongst oncology residents: A comprehensive nationwide cross-sectional study. *Eur J Cancer* 2010;46(15):2706-15.
11. Grunfeld E, Whelan TJ, Zitzelsberger L, et al. Cancer care workers in Ontario: prevalence of burnout, job stress and job satisfaction. *CMAJ* 2000;163(2):166-9.
12. Eelen S, Baillon C, Bauwens S, et al. Burn out in oncology in Flanders, Belgium: first results of a study amongst 550 professionals in oncology. *Psycho Oncology* 18 (Suppl 2), S224-225, 2009.
13. Trufelli DC, Bensi CG, Garcia JB, et al. Burnout in cancer professionals: a systematic review and meta-analysis. *Eur J Cancer Care* 2008;17(6):524-31.
14. Sherman AC, Edwards D, Simonton S, et al. Caregiver stress and burnout in an oncology unit. *Palliat Support Care* 2006;4(1):65-80.
15. Shanafelt TD, Balch CM, Bechamps G, et al. Burnout and medical errors among American surgeons. *Ann Surg* 2010;251:995-1000.
16. D'Hondt V, Benahmed N, De Wever A, et al. Imbalance between supply and need of medical oncologists in Belgium. *Belg J Med Oncol* 2013;7(2):38-45.
17. Shanafelt TD, Novotny P, Johnson ME, et al. The well-being and personal wellness promotion strategies of medical oncologists in the North Central Cancer Treatment Group. *Oncology* 2005;68(1):23-32.
18. Ablett J, Jones R. Resilience and well-being in palliative care staff: a qualitative study of hospice nurses' experiences of work. *Psycho-oncol* 2007;16:733-40.
19. Sabo B, Vachon MLS. Care of professional caregivers. In: Davis MP, Zimmermann C, Feyer P, Ortner P, editors. *Supportive Oncology*. Philadelphia: Elsevier; 2011.
20. Amaral P, Nehemkis AM, Fox L. Staff support group on a cancer ward: a pilot project. *Death Educ* 1981;5(3):267-74.
21. Schraub S, Marx E. [Burn out syndrome in oncology] [article in French]. *Bull Cancer* 2004 Sep;91(9):673-6.
22. Macpherson CF. Peer-supported storytelling for grieving paediatric oncology nurses. *J Pediatr Oncol Nurs* 2008;25(3):148-63.