

Burnout: Caring for the Caregivers

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ABSTRACT

Shortly before his death in 1995, *Kenneth B. Schwartz*, a cancer patient at Massachusetts General Hospital (MGH), founded The Kenneth B. Schwartz Center at MGH. The Schwartz Center is a nonprofit organization dedicated to supporting and advancing compassionate health care delivery, which provides hope to the patient, support to caregivers, and encourages the healing process. The center sponsors the Schwartz Center Rounds, a monthly multidisciplinary forum where caregivers reflect on important psychosocial issues faced by patients, their families, and their caregivers, and gain insight and support from fellow staff members.

Burnout describes the end result of stress in the professional life of a physician or caregiver and combines emotional exhaustion, depersonalization and low personal accomplishment. This problem is common in health

care workers in every specialty and may affect not only personal satisfaction, but also the quality of care delivered to patients. Burnout is particularly relevant in oncology where caregivers work closely with patients who have life-threatening illnesses and therapy often has only a limited impact. Burnout was discussed in the rounds with an emphasis on factors which precipitate or prevent stress among health care workers. Presentations were made by *Dr. Canellos* of the Dana Farber Cancer Institute, and *Dr. Picard* of the Institute for Health Professions. Staff discussed the main issues contributing to burnout including the health care system, lack of time and inadequate training. They considered preventative measures including psychological support of the health care team, communication and management skills, and effective coping mechanisms. *The Oncologist* 2000;5:425-434

PRESENTATION

Facilitator: Today we are going to discuss a topic that affects just about everyone in every aspect of our practice, "Are we connecting with our patients or are we too damn busy?" We are now asked to see more patients than we ever have before, nurses are asked to treat more patients in a shorter period of time, pharmacists are asked to mix more medication in a tighter period of time, physicians are asked to give more complicated therapies with less

time to do it. And yet, our profession demands that we still try to connect with patients and meet their needs on a personal level. How do we do that without losing our ability to function as individuals? We invited *Dr. George Canellos*, the William Rosenburg Professor of Medicine at Harvard and the Dana Farber Cancer Institute, and *Dr. Carol Picard*, Associate Director of the Institute of Health Professions, who have both written extensively about overburdened caregivers to address this issue as guest speakers.

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Dr. Canellos: The issue of burnout was really not a major interest of mine until comments from some of the younger faculty members at the Dana Farber suggested to me that in a very short period of time they were getting burned out dealing with cancer patients. I thought I would do a study to address the problem and made up a questionnaire that went out to 1,000 subscribers of the Journal of Clinical Oncology [1]. About 60% of them were medical oncologists and the rest were radiation or surgical oncologists. We asked them, without detailed consultation with a psychologist, if they felt burned out, what their symptoms were and what they thought were the explanations for it. The questionnaire included a choice of options that might improve their sense of burnout.

We got a phenomenal response. Within two weeks we received 660 responses out of the 1,000 that were sent out, so we felt we must have hit a tender nerve. Fifty-six percent of the respondents said that they were burned out.

When we asked them about the nature

of their burnout, more than half of them had a sense of failure and frustration and about a third of them said that they were depressed. Twenty percent said that they had lost interest in practice and 18% of them said that they were totally bored. Half of them thought that this problem was inherent in the work that they did. Eighty-five percent said that it was affecting their personal and social life.

The pressure to see more patients is greater both in academic institutions and in office practices as the reimbursement per patient goes down and the volume has to go up. People are working harder for the same or less income. However, the patients aren't willing to accept a 10- or 15-minute consultation. The system therefore needs support staff which runs up the cost. Nurse practitioners are expensive and the practices that hire them have to pay them out of their revenue. The whole thing is a catch 22. Often physicians are in multispecialty group practices and nobody else in the practice wants to see their patients or even cover them. *Dr. X* is, therefore, obligated to stay close to his/her patients in a very intense way because the colleagues are totally turned off with the idea of dealing with cancer patients and don't want to cover him for two weeks

while he goes to Bermuda. It can become an endless treadmill.

There has been one other study from Britain that draws roughly the same conclusion [2]. When you talk to Europeans about burnout, it seems much less of a problem. Cancer care tends to be centralized and you only go to these centers if you are going to be treated, evaluated, transplanted or whatever. All the rest is done by the primary care physician, especially in the UK. Whether it is done well or not is another story. The oncologists practicing in these centers really do not deal a whole lot with death and dying and anguished families on a continual basis. They do so for a window of time but not as much as a practicing medical oncologist in

this country, who is both oncologist and total care physician to their patients.

Those who felt the greatest level of burnout were those that were in full-time practice. Individuals who were not in full-time practice, for example in academic practice or administration, reported less burnout. The relationship seemed to

correlate with the amount of clinical work being done. Interestingly, the sense of burnout was greater in those who had graduated since 1980 than those that had finished their training before 1980. We interpreted these findings as indicating that some of the old doctors, who went into oncology really to look after cancer patients, had very few illusions about the impact of their therapy. Many of those who had more recently come into a growing field had greater expectations that the science that was evolving around them, both immunological and pharmacological, was going to produce magic bullets at a rather fast rate and that the management of cancer would be improved dramatically. When they realized that it wasn't the case, this sense of frustration may have contributed to burnout.

Joe Halperin reported a similar study with the same conclusion [3]. When he asked, "How would you alleviate burnout?" the number one response was having an effective health care team. I feel that an effective health care team is analogous to why the academics feel less burned out. There is a dilution of the frustration; the one on one; the difficult patients. In *Joe Halperin's* series, the most difficult and stressful aspect that contributed to burnout was difficult patients or difficult

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families. In academic practice you can dilute that out by having either residents, fellows, your health care team or nurse practitioner fielding the calls and dealing with the patients and families at times so that you are buffered a little bit.

We asked the oncologists in our survey what would help to alleviate burnout. We gave them many options: administration, teaching, clinical research, research, treating nonmalignant disease, and we gave them the option of just more time away from the office. Approximately 70% of them said they needed more time away. One of the questions asked, “Would you be willing to spend less time with patients?” The answer was typically “no” for economic reasons or, “yes, I really need it to alleviate my burnout.” There was space for commentaries and we had hundreds of suggestions and comments.

I think that the challenge for all of us is how to stay energized and continually restored.

Dr. Picard: Today we are talking about being kind to yourself as you do this really unremitting sort of work. Even *Mother Theresa* had to make choices about how many people she would see in a day and I think that the challenge for all of us is how to stay energized and continually restored. How do we nourish ourselves so we can maintain ourselves, as most of us don’t have the luxury of reducing our hours or taking a sabbatical? It is what we want to do but we want to do it well. *Hildegard* of Bingen was a saint, healer, and mystic of the Middle Ages who was consulted by popes and kings, and whose spiritual writings have only recently been translated into English. I was struck by a term she used to describe the activity of cultivating one’s inner life: *viriditas*, or “greening power.” She believed that you must nourish your inner life, keeping it green. Without such attention, it would become brittle, dry up and die. When I read her work, I thought this was a wonderful description of what health care professionals needed to do to maintain themselves; to stay green through restorative self-care.

Judith Jamison, artistic director of the Alvin Ailey American Dance Theater, spoke at Harvard a few years ago. She said excellence in dance was not about the height of one’s leap, or leg extensions. That’s just technique. Excellence is about making oneself vulnerable to the audience. If we are truly present to hear the stories of how our patients are struggling with their experience of illness, we make ourselves vulnerable. Self-care practices provide ways to maintain that vulnerability, but not

to be so wounded in the process that we are unable to be available to patients. *Henri Nouwen* has beautifully formulated the concept of the “wounded healer”; one’s own woundedness, being a sympathetic source of wisdom. However, without self-care the health care professional may lock his/herself in protective armor to shut out the pain, which risks shutting out the patient.

Finding a way to restore ourselves is particularly challenging, but I think there are some effective ways that you can build it into daily practice. One way is to consider doing some sort of mindfulness meditation to conserve some of your energy in the moments that you are with patients. There are a variety of traditions, such as transcendental meditation, various Buddhist traditions

such as *Vipassana*, as well as practices which incorporate movement such as yoga and *tai chi*. Each practice emphasizes the present moment and becoming more fully aware

of what we are placing our attention on. I had the pleasure of studying the *Vipassana* practice of mindfulness with *Jon Kabat Zinn*, noted author and researcher on meditative practices and health at the University of Massachusetts Medical Center. He shared a story of an ophthalmologist from San Francisco who practiced mindfulness meditation. As a result of his daily practice, he was able to place all of his attention on the task at hand during surgery. Although he thought his operating time was lengthening, in fact it was quicker because of his ability to focus intently on what he is doing. You can fit a mindfulness practice into your day even if it is only for two or three minutes between patients. I use the time waiting for the elevator. There is a Buddhist proverb that says, “Movement creates life. Stillness creates love. To be still and still moving, this is everything.” Mindfulness can be a path to finding your center again.

Mike Samuels, a physician and artist said, “Art and healing are sisters...they are tied together by a silver thread.” Listen to the music that soothes you or stimulates you, live or on tape. The restorative power of beauty in music and art are things to consider not only after work hours but here at the hospital. Duke University, UCLA, and locally the Hasbro Children’s Hospital all have programs where artists come into the hospital to engage in dialogue with both staff and patients, creating healing environments for all. *Yo Yo Ma* played his cello in the coronary care unit here at the hospital for an ill colleague last year. A nurse who works on the unit told me that everyone was at peace for that period of time: patients

and staff. The beauty of his playing transformed the environment. What would happen if live music were part of your work environment?

As a clinical specialist in psychiatric nursing the most difficult situation that I have to deal with is stillbirth. I can do just about everything but that really takes more out of me than anything else. I know that I have to do something in advance to do well with that person. There are some foods that are soul foods for each one of us, for me it is a lobster roll! I make sure that I am in touch with my husband who travels all the time or talk with a dear friend who makes me laugh. I surround myself with beautiful images, good poetry, fresh flowers and *Bach*. This self-care allows me to feel more energized to bear the story of a woman living with neonatal loss. Hearing the stories takes something out of me, if I really “show up.”

And restorative practices enable me to be at my best at work and be open to

receive the stories that suffering patients need to tell. All of these practices are of course health promoting for patients as well. I frequently will share with patients poetry or music I think might be helpful for them.

It is important to have some other sort of restorative practice that keeps you green outside of work. Whatever helps you to disengage you from the routine of the day can also restore. I know that a lot of people end up taking their work home with them or pieces of work to do on route to home. It can be healing to find something very different from what you ordinarily do. Do something physical, like jogging. Attend to your senses. In my French Canadian tradition, my children know that if I make my grandmother's *Grandsoupe* it is a particularly stressful period and I do it as something that is going to restore me both in its aroma and its taste, so that I can continue to give the compassionate care patients so urgently need. Consider a regular massage and a sauna as a cleansing way to restore both body and soul. Reflect on those things that have inspired and comforted you in the past. When we are at a frantic pace sometimes we forget the things that have worked before. Remember self-care is a vital piece of professional practice.

DIALOGUE

The System—Medicine: Business or Profession?

Social Worker: I'm struck by the fact that in thinking about this topic everyone is thinking about what they

can do about it when, in fact, it's a result of the system and is bigger than any one individual. When you talk about families being angry, it is not just you that caused them to wait for an hour and a half. The question is how do we get an alliance with people? How do we get the patients and us on the same side? There are a lot of times that you really can't do that, either you're too dependent on the system or the patient is too dependent or there is too much frustration or anger or terror or whatever. How do you understand that and accept it and not personalize it?

Physician: If patients have waited for 80 minutes because you are double-booked, you end up spending 8 out of the 10 minutes not talking about their disease but apologizing for the wait. Clearly, giving attention to clinical systems will relieve stress.

Physician: During the time that I've been here the growth of the cancer center has been

remarkable. I wonder if we are still providing the same level of care with the increased number of patients that we are seeing, with patients waiting an average of an hour to see us for appointments. There comes a time when we have to rethink how many patients each of us can take care of.

Physician: We need to create an environment where people aren't forced to practice turnstile medicine, especially in cancer. We have to accept that it is going to cost more money in the current environment, or change the reimbursement system and pay people based on the time spent with the patient.

Physician: I think that when those in leadership in hospitals come across some extra dollars, which are very hard to find, instead of saying, “Oh, let's get another big machine or recruit another four million dollar scientist,” they should from time to time use the money to double the size of the infusion room or double the size of the nursing staff or, as the three oncologists can't possibly see all of these particular patients, maybe we'll hire a fourth just so they don't have to see so many each day.

Clinical Nurse Practitioner: The frustrating part is that we've had patients' families say, “This is no way to run a business. You know my appointment was at 10:00 and now it is 11:30.” We are not a business but it is hard for people to understand that.

Physician: We say that oncology shouldn't be a business but the trouble is that it is a business. We are now in

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“marketplace medicine” and I think it is our responsibility to see if we can turn that around. That should be our number one priority.

TIME

Physician: The busyness has become so overwhelming that sometimes, when another patient walks in that hasn't been scheduled, I find myself getting angry and I think, “Oh my God, I'm getting angry at the patient for showing up at my door. I'm supposed to be wanting to take care of him.” Or you realize that there are 20 patients waiting and you only have five chairs in which to seat them. You want to treat them the best way possible and it is almost impossible to do that.

Physician: I think all of us have been through that. If you spend the time with the patient explaining whatever is happening then I think you go a long way in making that patient feel better and you're not frustrated either. Yesterday I had to tell a newlywed 33-year-old girl that she had a fatal illness. You know you can't do that in 15 or 20 minutes with intelligent people who want information. The luxury of my job is that I don't have to worry about the time. They left well informed and feeling better about it. Today I saw a young man with malignant disease whose mother-in-law was a social worker and she said, “Thank you for being so thorough with us and answering our questions. We feel better for that.” The doctor in the community can't give them the time. I find that people will say, “I feel better for talking to you” as they walk out and you haven't done anything. I mean you haven't injected them with anything but you've taken the time to talk with them. The whole system and the reimbursement system in particular, is built against giving us time. The reimbursement system is completely warped. If you can convince someone that the disease is too far advanced and all that chemotherapy is going to do is make them miserable, you have done a human being a favor. But that takes a lot of time and costs you money.

REFLECTION

Social Worker: I think the hardest part is that there is very little time for reflection built into the schedule anymore. If someone dies there are four more patients filling that

space. I think there is something insidious about the unrelenting trauma, the vicarious loss that we all carry. We have to be able to build in spaces where we don't see patients or some other respite, for example time to catch up on your paper work or to connect with the team who we haven't talked with for a month or so. If you don't find ways to do that, I think it will impact on our ability to work and communicate, not only with each other but also our patients and families that we care deeply about.

Nurse: I never really thought about taking a moment of meditation but that's not a bad idea at all. It is important to remind ourselves of why we went into these careers. When we are really busy, I think we need to remind ourselves what we get out of our work, what is it that makes us feel good. You are always going to have tough days but I get far more out of my work than it takes out of me.

TRAINING

Physician: I've never been sure that we train people appropriately. Oncology programs that have fellows rotating excessively through bone marrow transplant units and not in the area of symptomatic care are not being completely honest. I think you have to look at some of the young people coming into the field, who have spent three years in a laboratory and come to us with an M.D., Ph.D., and need their union card before they go back into the lab to do wonderful things. If you don't make it in science, the only thing you have to fall back on is your union card. You are not equipped emotionally to handle this sort of work and you are a disaster as an oncologist. You didn't want to do it in the first place.

Physician: It's not just selection. I think a large part of the problem is the training—orientating the new doctors coming into the field as well as sizing up their desires and needs.

Nurse: We have a couple of newer nurses who have said, “Isn't it funny that when we were in school they told us not to get too close to the patients because if you get too close you're going to get burned out,” or, “Don't share too much about yourself, because if you share too much about yourself, you are going to get burned out.” I have found that it is actually the opposite. I find it necessary

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to show them that we are human. I find it helps to show them a little bit about yourself and your personality and to ask about other things apart from just what is going on in terms of their health care.

EFFECTIVE HEALTH CARE TEAMS

Fellow: We have a very tight team and that is what saves all of us. We all have bad days but thank God we don't all have them on the same day! The more formal venues, such as the rounds or the chemo meetings, are not just meetings where we talk about what therapy someone's on, they become, "Oh my God. She is 38. She has two kids and she has cancer." I think having set times when we can discuss these issues stops us working in isolation.

Nurse: I'd underscore that, but would say that sometimes you have to go beyond your team to find support. It is important to find some humor and camaraderie and that won't always come from your team. I value opportunities to get to know people in the cancer center whom I don't know well and I find that even the small gestures, like saying hello to people in the morning, can build us up.

Physician: The creation of multidisciplinary teams, nurse practitioners and infusion staff made our job easier. The culture is changing. It is very different from how we were trained and were taught in practice. In the past, we used to fight with the radiotherapists, not work with them.

Physician: Teams are great but ultimately someone has to be responsible. Someone has to talk to *Mrs. Bloggs* and say this or that is happening. You can't walk in as a committee and say that the committee voted six to two to give you chemotherapy!

Physician: If you are already seeing more patients that you can see, then it is only a matter of time before you will burn out. As a person who has burned out, let me tell you how I survived. Instead of very ambitious medical student style colleagues, I had some very good friends who looked out for my patients when I couldn't and I think we should look around and see people not as competitors but colleagues whom we are here to help.

RELATIONSHIPS WITH PATIENTS

Clinical Nurse Practitioner: The thing that keeps you going, even in the middle of a busy, frustrating day

when you can't help all of the patients, is being able to connect with people. That is the only thing that keeps me coming back every day. Just to be able to say that I was able to help, not everyone, but with one or two people I made a real difference in being able to help them with something very specific.

Social Worker: I've been here at MGH for about four years and have seen incredible changes. I've been thinking about how you survive in a place like this that seems to keep growing and growing and getting busier and busier every year. The sense of being overwhelmed depends on how you set your goals. If your goal is to see 30 patients and to do it well and, at 5:00 pm you still have 10 patients sitting in the waiting room, that doesn't make you feel good about your work. The goal for the day can be that you'll connect with someone. I have the great

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privilege that my job is to connect with patients and families. I don't have to bill in the way that other people do and so I have time. If I spend an hour with one person who needs it that day that is what I do. In the course of doing that I hear incredible things. Not only incredible losses and traumas that patients and families are experiencing, but I hear the positive perceptions that patients have of their care providers, something that doesn't get talked about very often. In the past two weeks I've had about four unsolicited conversations where people have said, "You know the people here have been great, from the person that parks the cars to my doctor and everyone in between. It makes such a difference." I'm not sure that we all hear that enough. Each of us creates a holding environment for people that are facing tough times and it makes an incredible difference.

Social Worker: The regular newsletter "Hotline" occasionally publishes encouraging letters from patients. Reading these really makes you feel good because they identify the people that the patient had come into contact with.

Nurse: Connecting with the patient is the most important thing. I remind myself everyday that we are all human and that I'm not going to connect with all of my patients. I hate that. I don't feel good about that but I feel really good about those patients that I do touch and I feel really blessed that we are in the position that we don't see a patient just once. It is a rare occasion that I see a patient just once. If I didn't connect that day, I know that at the next treatment we will be building a

relationship. That is important to me. I couldn't work in business. I'm a people person. It kills me at the end of the day to do my paperwork.

REFRAMING

Physician: I think that what we have been talking about are certain elements of the cognitive restructuring that both patients and physicians have to do. Patients have to reappraise things. They have to start to be able to look at things in a somewhat different way. So do we. But I think there are patients who may continually complain about having to wait too long. We have to realize our limitations. Patients and physicians often have unrealistic expectations and can feel a sense of failure when these are not fulfilled. *David Spiegel*, in his book *Living Beyond Limits* [4] discusses the importance of helping patients to confront their disease, allowing them to better manage their life, family relationships and feelings. He highlights the important role for physicians in helping people to live with their disease as well as trying active therapies.

Social Worker: I think there is a wonderful sense of humility here, of acknowledging that we can't win on the track that we are on without stopping and saying, "We can't do this." It isn't going to work out unless I change my attitude, get help from other people and help my patients get that perspective. I think that in that moment of pain and terror and all the things that we are dealing with all the time, our nature is to do something about it, to fix it. Obviously there are times that we can do something and hopefully everyone does it well, but when it's not happening that is the time to say, "This isn't working" and turn to each other for the help to do it.

DISCUSSION

Definition

Psychiatric morbidity is one of the major occupational risks for health care professionals. The incidence of suicide, alcohol abuse, drug addiction and divorce are higher than in the general population [5]. Suicide rates are twice the national average and thought to reflect a higher prevalence of psychiatric disorders [6]. In this same area, many caregivers are thought to be at risk of a syndrome called "burnout," the end result of work-related stress.

The term "burnout" was first used in the medical arena by *Herbert Freudenberger* in 1974 [7]. Burnout comprises three key components: emotional exhaustion, depersonalization (treating people in an unfeeling, impersonal way) and low personal accomplishment [8, 9]. *Freudenberger*, a distinguished psychologist who died earlier this year, formulated this concept having worked alongside volunteers in the free clinic movement that served Vietnam veterans. He observed that the most dedicated and committed caregivers seemed especially at risk from burnout and that the condition was compounded by a sense of loss of idealism. He concludes: "If your idealism, the very motivation that led you to come into an institution... has been lost, then burnout has also within it the dynamics of mourning" [7].

Burnout can impair the quality of care delivered to

Burnout can impair the quality of care delivered to patients as well as have serious consequences for the personal life of the carer.

patients as well as have serious consequences for the personal life of the carer. Several studies have attempted to estimate the prevalence of burnout among oncologists. *Whippen* and *Canellos* reported that

56% of U.S. oncologists felt burned out [1]. This result reveals a higher prevalence than the findings of *Ramirez et al.* who undertook two controlled studies of burnout and psychiatric disorder among oncologists in the UK and reported the prevalence of burnout to be 28% [2, 10].

Oncologists are not the only professionals to suffer from burnout. Burnout has been identified as a common problem in every health care specialty studied including critical care [11], family practitioners [12], radiologists, surgeons and gastroenterologists [9]. In a study of family physicians caring for cystic fibrosis patients, 65% reported unacceptable levels of stress [12].

Workers in professions outside the health care field including air traffic controllers, law enforcement personnel and firefighters also have high levels of stress and psychiatric morbidity [13]. However, it is not only professionals in emotionally demanding situations who suffer burnout. A very similar percentage of business executives burnout, citing travel and isolation as significant stressors [14].

THE SYSTEM—MEDICINE: BUSINESS OR PROFESSION?

The American health care system is characterized by "two goals that are often in conflict: providing health care to the sick and generating income" [15]. The introduction of managed care has given insurers and employers a much greater influence over where and how patients are treated and

what it costs [16, 17]. This trend has led to physicians acting as “double agents,” trying to balance patient needs with the financial pressure to improve coordination and management of care [18]. There is an increasing sense that managed care “shackles” clinical decisions and creates even more pressure on providers to contain the cost of care at the expense of spending time with patients and maintaining quality [19]. Will medicine be a business which earns a profit and incidentally provides care or will it be a professional calling which provides care and incidentally operates in a fiscally responsible manner [20]? Undoubtedly the increase in managed care, with its emphasis on efficiency and its demands for time limited care, contribute to burnout.

Is burnout a modern disease? No longitudinal studies address this issue. However, burnout is likely to increase in the future with greater public expectations and increased workload for physicians. As a result of these changes, the health care system is now identified as the major factor contributing to stress among health care professionals with 46% of physicians saying they, “often think about leaving clinical practice” [19, 21]. This trend is borne out in the study by *Whippen* and *Canellos*

which identifies patient overload as an important element contributing to professional stress [1], and supported by a Finnish report analyzing burnout in medicine in general. In this study, general practitioners and nonspecialists working in health centers were found to have the highest levels of burnout due to heavy patient loads and long hours [22].

TRAINING

Several studies have attributed burnout to inadequate training [1, 9, 13]. A large, questionnaire-based study undertaken in the UK found that senior physicians felt that, although they had been well trained in the treatment of disease and in symptom control, they had received inadequate training to cope with the demands of the modern health care system and particularly lacked formal training in communication and management skills [9]. Fifty-six percent of nonsurgical oncologists felt that they had received sufficient training in communication skills and only 20% considered that they had been trained appropriately in management skills, such as conflict resolution [10].

Training in communication and management skills typically requires experiential learning that can address attitudes and behaviors, such as role playing difficult interpersonal

situations with patients, relatives or other professionals [23]. Continuing education and training are equally important, although the process of keeping up-to-date has been identified as a source of stress [24]. Lastly, the provision of effective clinical supervision or mentoring which addresses the psychological, social, spiritual and communication dimensions of patient care has been identified as a strategy for improving the mental health of professionals [23].

PERSONAL RISK FACTORS

Stress is inherent in the practice of good medicine. Not all types of stress are deleterious; some stress can be beneficial and promote personal development [25]. Burnout results from an imbalance between the demands of the job and the individual’s ability to cope [26]. Some people are more prone to burnout than others. The way in which a physician copes with issues of death and dying is influenced by the emotional “baggage” that they bring to the workplace [13].

Risk factors for psychological and psychiatric morbidity have been identified as a family history of psychiatric disease, childhood experiences of illness, death and emotional neglect and particular personality traits [27,

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28]. Certain demographic factors may be associated with burnout. Studies in the U.S. and the UK have both concluded that younger age groups are more prone to burnout and being single may also be an independent risk factor [1, 9]. Differences in the prevalence of burnout, between males and females have not been addressed, possibly due to the small number of female oncologists. However, data from Finland suggest that suicidal intent is higher among female physicians [22]. Concurrent stressors in other aspects of life can also contribute to susceptibility to burnout and include family commitments and personal relationships [23, 24]. Many physicians need validation and affirmation of their work and are trying to find a “sense of meaning in the face of life’s tragedies” [13]. *Hale* and *Hudson* described the evolution of negative defense mechanisms in junior doctors. These include denial, chronic hypomania, intellectualism, counterphobic behavior, acting out and self-destruction [29].

EFFECTIVE HEALTH CARE TEAMS

The prevalence of burnout can be reduced by effective health care teams that provide clinical and emotional support for team members [1]. In his article on dealing with the losses experienced by oncologists, *Mount* details the benefits to be

gained from clarifying team roles, establishing team support meetings and extending the “team” to include other multidisciplinary members, for example, community clergy and volunteers [25]. He emphasizes that it takes time and considerable effort for a strong team to evolve and that an important part of team-building is being able to recognize stress in others. Palliative care nurses have reported that poor relationships with other team members are a major source of stress and typically arise from poorly defined roles [23]. Individuals who have a greater level of autonomy in their job experience less burnout, and it may be possible to reconfigure teams to optimize the contribution of each member [30, 31].

RELATIONSHIPS WITH PATIENTS

Patients are much more than “just the specimen jar” [32]. Dealing well with patients and relatives has been found to contribute most to job satisfaction in a number of surveys [9, 10]. *Graham et al.* found that radiologists experienced greater levels of burnout than gastroenterologists, oncologists or surgeons and suggested that this trend was related to the fact that radiologists derive less satisfaction from relationships with patients due to the nature of their work [33]. In contrast, surgeons have reported lower levels of burnout than other specialists. One third of head and neck surgeons surveyed in a U.S. study [27] reported burnout, a similar figure to that reported among surgeons in the UK [9]. Although this may represent a degree of denial, it may reflect the positive feedback that surgeons receive from patients [27].

Given the constant exposure to death and dying, it is possible that the positive relationships established between patients and oncologists may explain why reported levels of psychiatric morbidity are no higher than those of other health care professionals [10]. Indeed, levels of burnout have been found to be lower among palliative care nurses when compared to other groups of community and hospital-based nurses [34, 35]. While a wonderfully natural empathy cannot characterize every relationship with a patient, making an explicit effort to find a similar “wavelength,” common ground or shared experience may hold significant benefits for the carer as well as delivering compassionate care to the patient.

POSITIVE COPING MECHANISMS

During the rounds, a number of restorative practices were cited. Exercise is well known to reduce stress and relieve depression [25]. *Creagan* highlights the importance for oncologists of involvement in activities distinct from their professional lives and hypothesizes that these individuals make

more productive and sympathetic practitioners [13]. Although sabbaticals, vacation and personal time would clearly alleviate burnout [1], other practical changes including flexible schedules, shared positions, on-premise childcare and prioritizing family time may be helpful [24].

Given that many aspects of the working environment may be hard to change, cognitive restructuring is another means of preventing burnout. Training programs should provide caregivers with more realistic expectations of their role in patient care and should focus in more detail on palliative measures [1, 9, 13]. Many feel that doctors who perceive their role as solely directed toward the remission of cancer by administering anti-cancer agents may not be prepared for the emotional demands of the total care of the cancer patient. Instead of learning by bitter experience, a proactive approach that inte-

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grates reevaluation of goals and expectations, online correction of unproductive or destructive behavior and structured informative review is necessary. It is important that

there are means of positively articulating distress, especially in a medical culture that does not embrace weakness in its professionals. A confidential mental health service which is easily accessible and independent of management is crucial to help alleviate and prevent serious psychiatric morbidity [23]. Such a service available to professionals for direct referral of themselves or colleagues has been established in the UK (British Medical Association Stress Helpline: 0645 200 169).

This Schwartz Round highlighted two main themes. First, we should rage against an unreasonable health care system. The system is bigger than all of us. However, if the system is wrong then it should be changed to serve its function. Second, how health care workers cope with the present pressures significantly influences sense of satisfaction in their professional role and the quality of care that they deliver.

CONCLUSION

Stress and burnout are among the most common occupational diseases in health care professionals. Psychological morbidity affects both the quality of care delivered to patients and the professional and personal lives of the carer. Precipitating factors include the health care system, lack of time and inadequate training. The development of effective health care teams, good relationships with patients and positive coping mechanisms appear to be protective against burnout. The early signs of stress are easy to ignore. It is important that as health care professionals,

we recognize these signs and work to prevent the development of burnout in order to protect ourselves, our colleagues and our patients.

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