

# **Caring for patients with incurable cancer: What stresses us**

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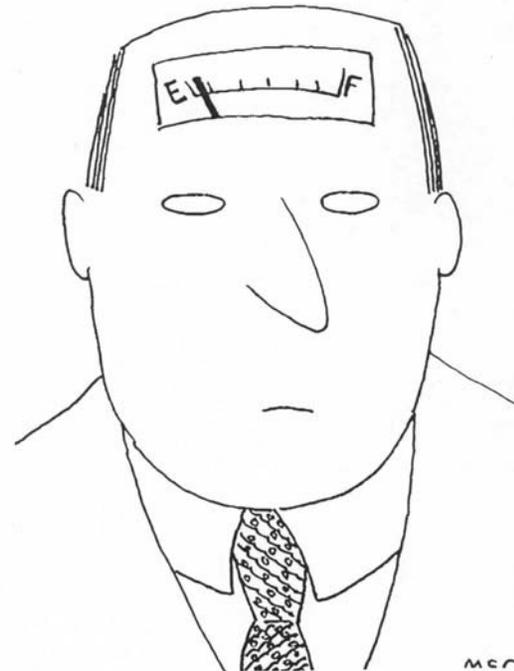
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# Thus far Covered

1. What is burnout
2. Prevalence of burnout
3. Cases of oncologist stress and burnout

# My Agenda

1. Role of End of Life care in burnout
2. The ESMO survey on oncologists and end of life care
3. New paradigm
4. Implications



# Role of End of Life Care in Oncology Burnout

# Anticipated Model

Heavy involvement  
in end of life care



Emotional fatigue  
and burnout from  
dealing with too  
many deaths

# NCCTG Survey 238 Oncologists

| STRESSOR  | STRESSOR RANK BY ONCOLOGISTS (N=238) |
|---|--------------------------------------|
| Patient load                                    | 1                                    |
| Balancing personal and professional lives       | 2                                    |
| Keeping current with medical literature         | 3                                    |
| Dealing with death/suffering of patients        | 4                                    |
| Delivering bad news to patients                 | 5 (tie)                              |
| Mastering knowledge of the specialty            | 5 (tie)                              |
| Governmental and insurance reimbursement issues | 7                                    |
| Sleep deprivation                               | 9                                    |
| Administrative duties/office management         | 10                                   |
| Finding meaning in work                         | 11                                   |
| Working with secretarial/administrative staff   | 12                                   |
| Applying for/maintaining grant support          | 14                                   |
| Academic pressure to publish                    | 15                                   |
| Financial pressure caused by student loan debt  | 16                                   |

NCCTG = North Central Cancer Treatment Group

# ASCO surveys

- **2 surveys 1991, 2002**
- **Not matched demographically**
- **2002 survey**
  - **participants much more experience**
  - **Selecion bias (RR 12%)**

# Comparative results 1991 vs 2002

|           | <b>1991</b> | <b>2002</b> |
|-----------|-------------|-------------|
| % Burnout | 56%         | 31%         |

## Causes

|                        |     |     |
|------------------------|-----|-----|
| Lack personal/vac time | 57% | 40% |
|------------------------|-----|-----|

|                           |     |     |
|---------------------------|-----|-----|
| Exposure to fatal illness | 53% | 37% |
|---------------------------|-----|-----|

|                          |     |     |
|--------------------------|-----|-----|
| Frustration with limited | 45% | 22% |
|--------------------------|-----|-----|

|                     |  |  |
|---------------------|--|--|
| therapeutic success |  |  |
|---------------------|--|--|

|                             |     |     |
|-----------------------------|-----|-----|
| Sense of frustrat'n/failure | 56% | 36% |
|-----------------------------|-----|-----|

Table 4. Sources of job stress: proportion rating item as contributing ‘quite a bit’ or ‘a lot’ to overall job stress<sup>a</sup>

| Item | Physicians<br><i>n</i> = 122 (%) | Allied health<br>professionals<br><i>n</i> = 278 (%) | Support<br>staff<br><i>n</i> = 220 (%) |
|------|----------------------------------|--|--|
|------|----------------------------------|--|--|

The ESMO survey of oncologist attitudes and practice in EoL care and its implications...

# AIMS

- **to evaluate**

- the degree to which ESMO oncologists are involved in the management of advanced cancer
- the degree with which they collaborate with PC clinicians
- their personal involvement in PC
- their attitudes to PC

# Survey tool

- Demographics
  - age
  - sex
  - experience
  - place of work
  - involvement in advanced cancer

# Survey tool 2

- Collaboration with PC
  - 7 items
- Practice of PC
  - 16 items
- Attitudes
  - 24 items
- 895 respondents

# Demographics 1

- N=895
- European 82.4%
- Sex: F 194 (21.7%) M 701 (78.3%)
- Median age: 45-49
- Median experience: 15-19 years

# Proportion of my practice involved with advanced (incurable) cancer

|                          |     |       |
|--------------------------|-----|-------|
| None                     | 4   | 0.4%  |
| A small proportion       | 78  | 8.7%  |
| A substantial proportion | 615 | 68.8% |
| Most of my practice      | 197 | 22.0% |

# Collaboration with Palliative Care and Supportive Care Clinicians

# PC Collaboration

often

|                                       |      |
|---------------------------------------|------|
| A social worker                       | 47.9 |
| A home hospice (palliative care) team | 37.8 |
| A palliative care medical specialist  | 35.1 |
| A psychologist                        | 33.3 |
| A palliative care nurse specialist    | 31.7 |
| An inpatient hospice                  | 26.4 |
| A psychiatrist                        | 14.9 |

# PC Practice by Oncologists: often 1

**often**

|   |      |
|---|------|
| Treating cancer pain                                  | 93.3 |
| Managing the complications of chemotherapy            | 91.1 |
| Managing nausea and vomiting                          | 90.6 |
| Managing fatigue                                      | 83.8 |
| Managing constipation or diarrhea                     | 82.1 |
| Treating dyspnea                                      | 72.0 |
| Managing the psych consequences of adv cancer         | 64.9 |
| Discussing end of life care preferences with patients | 56.6 |

# PC Practice by Oncologists: often 2

Often

|  |      |
|--|------|
| Directly administering EoL care to dying cancer patients | 43.2 |
| Coordinating meetings with the family of dying patients  | 39.4 |
| Managing intestinal, biliary or ureteric obstruction     | 38.3 |
| Managing spinal cord compression                         | 29.2 |
| Recommending an inpatient hospice                        | 27.6 |
| Managing existential or spiritual distress               | 27.5 |
| Managing delirium  | 11.8 |
| Managing patients who request elective death             | 2.1  |

# Attitudes To Palliative Care and End of Life Care

# Attitudes: >75% agree

Agree +  
Strongly  
agree

|  |      |
|--|------|
| All adv.ca patients should receive concurrent PC even if receiving anti tumor treatment                      | 92.0 |
| I derive satisfaction from managing the physical symptoms of my patients.                                    | 89.3 |
| All cancer centers should have a PC service.   | 89.1 |
| MOs should coordinate the care of cancer patients at all stages of disease including end of life care.       | 88.4 |
| MOs <u>should be</u> expert in the management of the physical and psychological symptoms of advanced cancer. | 88.1 |
| I am usually successful in managing my patient's pain  | 86.9 |
| I read journals and papers related to the palliative care of advanced cancer                                 | 83.6 |
| I own a textbook of palliative care  | 76.0 |

# Attitudes: 50-75% agree

**Agree +  
Strongly  
agree**

|   |      |
|---|------|
| The MO is the best person to coordinate the PC of patients with advanced cancer.              | 74.5 |
| I derive satisfaction from my work managing patients with advanced cancer and dying patients. | 74.0 |
| I am interested in participating in research in palliative treatments of advanced cancer      | 73.3 |
| I have a close working relationship with the PC (or hospice) services in my region            | 70.3 |
| I am expert in the management of the physical and psychological symptoms of advanced cancer.  | 60.4 |
| I received good training in PC during my oncology fellowship (residency)                      | 52.8 |

# Attitudes: >66% disagree

**Disagree +  
Strongly  
Disagree**

|   |      |
|---|------|
| Palliative care begins where medical oncology ends.   | 84.3 |
| Dying patients do not belong in the oncology ward   | 73.5 |
| I deal with palliation in the non-dying patients (“symptoms management”), but not with the palliation of the dying patient (“end of life care”) | 70.4 |
| Managing patients with advanced cancer and dying patients depresses me.   | 68.2 |
| Palliative care specialists “steal” patients who would otherwise benefit from medical oncology  | 68.0 |
| I would rather have someone else look after my dying patients.  | 66.0 |

# Attitudes: No Consensus

|   | Agree + | Disagree + |
|---|---------|------------|
| I received good training in PC during my oncology fellowship (residency)  | 52.8    | 42.0       |
| I feel emotionally burned out by having to deal with too many deaths.   | 33.8    | 55.6       |
| Most MOs I know <u>are</u> expert in the management of the physical and psychological symptoms of advanced cancer.  | 37.5    | 41.8       |
| A palliative care specialist is the best person to coordinate the palliative care of patients with advanced cancer.   | 36.3    | 39.4       |
| Palliative care (or Hospice) physicians don't have enough understanding of oncology to counsel patients with advanced cancer regarding their treatment options. | 35.2    | 39.2       |

Analyses

# Indices

- Palliation Practice Index
- Palliation Attitudinal Index

# ANOVA multivariate analyses

- Dependant variable
  - Positive attitude to the oncologist role in PC
- Contributing variables
  - Private Practice or Teaching Hospital vs CCC P<0.001
  - Involvement in PC administration P<0.001
  - Male P=0.015
  - Collaboration with PC clinicians P=0.028
  - Involvement with Advanced Cancer P=0.047
  - R squared=.230

# ANOVA multivariate analyses

- Dependant variable

- I feel emotionally burned out by dealing with too many deaths

- Contributing variables

- poor overall attitude to oncologist role in PC  $P < 0.001$
- Female  $P = 0.004$
- Young age  $P = 0.011$

R squared = .135

# Revised model of the relationship between EoL care and burnout

# Anticipated Model

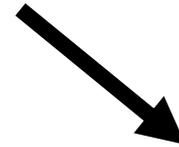
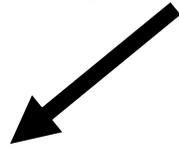
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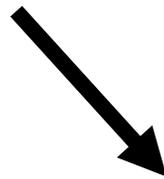
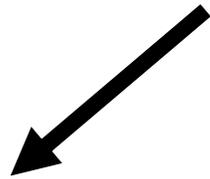
# Observed Model

Poor attitude to oncologists role in providing palliative care



Avoidant behaviors

Catastrophisation about impact of terminal care



Low level personal involvement in care

Little collaboration with PC services

Emotional fatigue and burnout from patient mortality and sense of failure

# Conclusions

- End of life care is a source of stress
- The degree of stress is not proportionate to direct involvement in EoL care
- Influenced by individual vulnerability or resilience factors.
- Resilience factors, such as having a sound personal philosophy that incorporates one's positive role in dealing with death and EoL issues is protective against burnout from EoL care.

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