Stress and Burnout in Oncology

Review Article [1] | November 01, 2000
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This article identifies the professional stressors experienced by nurses, house staff, and medical oncologists and examines the effect of stress and personality attributes on burnout scores. A survey was conducted of 261 house

The study by Drs. Kash, Holland, Breitbart, et al describing stress and burnout in oncology is unique in that it compares not only oncologists and nurses, but also house staff. I have found no other studies that included house staff in the sample.

**Negative Work Events**

In a 1999 study of emotional distress and burnout in professionals working in oncology and internal medicine services, Lopez-Castillo et al[1] found that oncology professionals worked under a higher number of stressful circumstances, which led to a higher level of perceived stress. Also in 1999, Lewis[2] identified constant patient loss in oncology as a cause of personnel conflicts, job dissatisfaction, and workplace burnout in the field of oncology nursing. These findings support the authors’ conclusions regarding the emotional impact of routinely dealing with negative work events, such as the high number of patient deaths and difficult ethical decisions. These negative events have been shown to contribute most to burnout and demoralization.

Whippen and Canellos[3] identified the following contributing factors to burnout in oncologists: the administration of palliative or terminal care, reimbursement issues, and heavy workload. In their study, however, Kash et al found that, of the three groups tested, oncologists experienced the lowest levels of burnout.

**Personal Relationships and Ethnicity**

Ramirez et al[4] reported three sources of stress associated with burnout and psychiatric comorbidity: feeling overloaded and the effect of this sentiment on home life, feeling poorly managed and resourced, and coping with patient suffering. Furthermore, burnout was associated with low levels of satisfaction in the three following domains: relationships with patients, relatives, and staff; professional stature/self-esteem; and intellectual stimulation. In their article, Dr. Kash and colleagues do not identify ways in which work stress affects the social and domestic lives of practitioners. However, Miller and Gillies[5] reported that one-third of practitioners who were not in a long-term relationship felt that their work formed a barrier to personal involvement. Of those practitioners who were in a relationship, 50% reported conflicts caused by discussions of work-related topics.

Ethnicity, either as a contributor to burnout or as a factor included in demographics, is another issue that is not addressed in the article by Kash et al. In 1993, van Servellen and Leake[6] reported that being white was associated with a greater feeling of accomplishment in hospital nurses. However, their study supported the findings of Kash et al regarding high burnout levels of professionals who feel they have little influence in work-related decision-making. Interestingly, Dr. Kash and coauthors also cite a feeling of disenfranchisement as a reason for increased burnout in house staff and nurses. Besides dealing with the details of daily patient care, these individuals also serve as a buffer among oncologists, patients, and family. Even though they provide the most intimate care to patients, they had the lowest sense of pride and accomplishment.

**Psychological Morbidity**

The authors cite the study by Halperin et al on the psychological morbidity of oncologists, but they do not provide any data on the psychological morbidity of nurses. Catalan et al[7] reported that one-third of the physicians and nurses in their study experienced substantial levels of psychological morbidity, whereas Barni et al[8] showed a higher prevalence of anxiety and depression among nurses. None of the studies I reviewed offered any data on psychological morbidity among house staff.

**Gender and Age**

Although the majority of nurses in the Kash et al study were female, this did not factor into their
burnout rate. Nevertheless, female house staff did show the greatest level of demoralization and the least sense of accomplishment, perhaps due to a lack of peer support from their male counterparts. Since the numbers of female house staff are increasing, supportive measures need to be found. Age and marital status also figured into the study by Kash et al. Younger age and single status in both house staff and nurses were found to contribute to differences in burnout, compared with oncologists. One wonders if the results would have been different with a sample of older nurses. Ramirez et al[4] identified an age younger than 55 years and a single status as independent risk factors for burnout. They also reported a higher burnout rate in physicians who felt insufficiently trained in communication skills. This is not addressed in the article by Kash et al.

**Hardy Personality and Religion**

It is not surprising that a hardy personality, with its attributes of commitment, control, and challenge, was found to be a buffer against stress. Hardiness was related to a greater sense of accomplishment. Likewise, religion was found to be a positive factor in reducing stress and burnout. Interestingly, nurses perceived themselves to be significantly more religious than other groups. The more religious respondents reported less emotional exhaustion and more empathy. Perhaps religiously inspired altruism plays a part in the career choice of some nurses and oncologists. In any case, it was good to see this factor studied.

**Recommendations for Prevention and Treatment of Burnout**

More recommendations could have been made for ways to prevent and treat burnout. For example, Felton[9] recommended that individual workers have more group meetings, better up-and-down communication, job redesigns, more recognition of individual worth, flexible work hours, full orientation to job requirements, and employee-assistance programs. Lewis[2] suggested offering support to help staff deal with conflict, to help foster a sense of understanding among colleagues, and to provide support mechanisms for closure and acceptance of perpetual patient loss. Ramirez et al[4] advocated training in communication and management skills for physicians. Whippen and Canellos[3] recommended that oncologists take more personal and/or vacation time. Vachon[10] suggested that nurses develop supportive collaborative work relationships, and Cohen[11] reported that when oncology nurses are able to articulate the meaning of their work and understand how these meanings affect patient care, they are more satisfied with their jobs.

**Summary**

Overall, Kash et al accomplish their goals: Stressors, consequences of stress, and factors that moderate these consequences are all well identified. The authors do an excellent job comparing data among oncologists, oncology nurses, and house staff. Now that the stressors for oncology house staff and nurses have been identified, solutions need to be found to decrease the rate of psychological morbidity and burnout among these professionals.

**References:**


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