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Editorial Comment

Can we reduce burnout amongst cancer health professionals?

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Cancer doctors, in common with doctors generally, are at particular risk of poor mental health,[1–5] compared with the general working population.[6] This includes both work-related burnout and more pervasive psychiatric problems such as clinical depression and anxiety. In 2002, about a third of United Kingdom (UK) hospital consultants were estimated to experience psychiatric morbidity[2] compared with 15% of the general working population.[6] In this issue, Blanchard and colleagues confirm high levels of burnout exist amongst junior oncology doctors in France. Whether working in cancer care in itself increases the risk of poor mental health amongst doctors is unclear. A large cohort study of UK consultants reported higher levels of estimated psychiatric morbidity amongst medical, clinical and surgical oncologists compared with other specialty groups.[2] By contrast other studies have reported comparably high rates of poor mental health in other high pressured specialty groups.[4,7]

The high levels of poor mental health amongst doctors as a professional group matters not only because of the consequences for them and their family, but also because of the impact it has on their ability to deliver high quality patient care. Hospital consultants, including cancer consultants with poor mental health are twice as likely to report harmful consumption of alcohol, being irritable with patients, being irritable with colleagues, reducing their standards of care at work and/or planning to retire early.[8] Male consultants and mid-aged consultants are particularly at risk.

Fortunately the majority of cancer doctors alongside other doctors enjoy good mental health. Senior doctors can tolerate high levels of job stress in terms of work overload, as long as they experience high levels of job satisfaction.[1,2] They thrive on hard work and long hours (working 60 h a week on average), provided they can enjoy significant autonomy and variety in their job and, above all, good relationships with patients and colleagues.[1,2,9] What is it that makes some doctors develop burnout or more pervasive poor mental health such as clinical depression or anxiety? It is likely to be a combination of nature and nurture. Female doctors, those who are unmarried (especially unmarried male doctors), those with a previous history or family history, and those with a 'neurotic' personality are at increased risk of developing of poor mental health. These factors are well known from general epidemiological studies of common mental disorders and are not specific to being a doctor.[10] Alongside these individual factors there is nurture, and occupational risk factors are particularly relevant to doctors whose lives are spent predominantly at work. These probably do not act alone to cause poor mental health but may provoke episodes of poor mental health in those who are vulnerable. Contrary to popular belief, it is not working with patients' who are dying that creates signif-

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icant stress for cancer doctors. Interestingly, palliative physicians, who are of course particularly exposed to care of the dying, do not experience poorer mental health than their acute trust oncology colleagues.[11] Cancer doctors who are most likely to develop mental health problems are those that report high levels of job stress coupled with low levels of job satisfaction.[1,2] Indeed, the deterioration in mental health observed from 1994 to 2002 in a cohort of UK cancer consultants was explained by an increases in reported job stress that was unmatched by equivalent improvement in job satisfaction. The changes to job stress and satisfaction over time appeared to be the result of the reconfiguration of cancer services and introduction of new policies such as waiting times targets and peer review, rather than changes relating to relationships with patients and dealing with their distress.[2]

We know less about the prevalence and causes of poor mental health in cancer nurses; much is written, but little has been robust enough to draw firm conclusions. Cancer nurses appear to have levels of burnout and psychiatric morbidity comparable to that of doctors.[12,13] It is not clear whether this is attributable to occupational risk factors or that they are predominantly female. In a study of colorectal cancer teams in the UK, clinical nurse specialists had similarly high levels of job stress to consultants but that they also reported the highest job satisfaction across all team members.[14] The high levels of job stress may reflect a lack of clarity about the content and boundaries of their job, leading to excessive expectations from others.[15–18] Their high job satisfaction is likely to be derived from spending most of the working time delivering patient care[15] as well as the positive impact on their professional status and esteem of being recognised as a core member of the multidisciplinary team in recent cancer policy. Having professional status and esteem have been shown to be a key source of satisfaction for doctors.[1,2]

We need approaches to both treat and prevent the mental health problems experienced by cancer health professionals. A recent systematic review concluded that there was some limited evidence for the benefit of interventions such as teaching relaxation techniques and coping skills, and for work-directed interventions such as communication skills training.[19] Most of the included studies were focussed on nurses who may be more open to receiving interventions than doctors. Doctors notoriously avoid seeking help for mental health problems.[20] This is evidenced in Blanchard's study where a fifth of oncology junior doctors reported taking hypnotic or anxiolytic medication that nearly all (88%) had self-prescribed. Ways of effectively supporting vulnerable doctors need to be found which circumvent the stigma and fear of prejudicing their career that a referral to a conventional mental health service brings.

Approaches designed to prevent poor mental health amongst cancer doctors and nurses should be prioritised. Attention should be focussed on the way in which cancer care is delivered, to achieve not only patient benefit, but also to optimise the well being of cancer health professionals. Arguably the most widespread change to the way in which cancer health professionals practice has been the establishing of multidisciplinary teams. Multidisciplinary teams have been introduced in many countries throughout Europe, United States and Australia as the core model for managing the treatment of cancer patients. They bring together all key professional groups in individual clinical decision making for patients. Evidence is accumulating to demonstrate the benefit of multidisciplinary teams on clinical decision making and clinical outcomes.[21] Less, however, is known about their impact on the team members themselves. In the national UK cohort study that included 724 cancer consultants,[2] 75% stated that 'working in a multidisciplinary team' was a predominant source of job satisfaction whilst only 17% stating it was a predominant source of job stress. Furthermore, in the study of colorectal cancer teams in England,[14] 'working in a multidisciplinary team' and 'providing better care as a result of multidisciplinary team-working' were the predominant sources of job satisfaction across all team members. There is, however, anecdotal evidence of professional enmities, autocratic practice, and hierarchical boundaries making teams dysfunctional and participation stressful. This anecdotal evidence sits alongside national data, for example from the UK National Peer Review Programme which shows that there is great variation in the functioning of teams against national standards.[22]

A well-functioning multidisciplinary team has the potential to improve care for cancer patients, and also improve the working lives of team members. In the UK, work has been undertaken to define the components of an effective cancer MDT, based upon clinical consensus from over 2000 MDT members.[23,24] This provides a framework from which multidisciplinary team working can be assessed and improved.

Approaches to improving multidisciplinary team working will need to support and sustain all those who participate in multidisciplinary teams, including the different medical specialists, nurses and coordinators. Given the wide variation in background, knowledge, skills and perspectives of the members of multidisciplinary teams, this will be a considerable challenge. More formal sharing of good practice guidelines, and the development of proformas to standardise aspects of multidisciplinary team working (such as reporting of diagnostic imaging, summarising patient management decisions and the communication of these decisions) may serve to improve the quality and patient-centredness of decision making by multidisciplinary teams. Educational packages should address the significant shortfalls in perceived adequacy of training multidisciplinary team members have received in the core skills required for effective team working, including communication skills, team working, handling complaints and leadership.[14] We might apply evidence-based training approaches using constructive positive feedback based on the practice of skills which have been used to improve patient safety and communication skills.[25,26] Ensuring that individual cancer health professionals are adequately trained, and multidisciplinary teams are able to work effectively is likely to be fundamental to any solution that aims to protect the mental health of the oncology workforce.

Conflict of interest statement

None declared.

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