Combating Compassion Fatigue and Burnout in Cancer Care
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Posted: 06/06/2011

Editor's Note:

This text has been excerpted and adapted from: Emanuel LL, Ferris FD, von Gunten CF, Von Roenn J, eds. EPEC™-O: Education in Palliative and End-of-life Care for Oncology(Module 15:Cancer Doctors and Burnout), Copyright The EPEC™ Project, Chicago, IL, 2005). The EPEC™-O curriculum was produced by The EPEC™ Project, with major funding provided by the National Cancer Institute, and with supplemental funding provided by the Lance Armstrong Foundation.

Compassion Fatigue and Burnout in Cancer Care

Working as a healthcare provider with patients who have cancer has many rewards, but can also be challenging and stressful. Healthcare providers caring for persons with cancer and their families are at increased risk of developing burnout and compassion fatigue, with potentially devastating consequences not only for themselves, but also for patients and families.

This oncologist is showing evidence of burnout -- anger, exhaustion, and detachment. His coworkers voice concerns.

Burnout

Burnout, a psychological syndrome, is a response to chronic interpersonal stressors on the job.[1] The concept of burnout was first developed in the 1970s.[2]

The 3 key dimensions of this response are:

- Individual: overwhelming exhaustion; feelings of being overextended and depleted of one's emotional and physical resources;
Interpersonal: cynicism (or depersonalization) and detachment from the job. Cynicism refers to a negative, callous, or excessively detached response to various aspects of the job; and

Self-evaluative: sense of ineffectiveness and lack of accomplishment -- Ineffectiveness refers to feelings of incompetence and a lack of achievement and productivity at work.

Pines suggests, "The root cause of burnout lies in people's need to believe that their lives are meaningful, and that the things they do -- and consequently they themselves -- are important and significant."[3] Most healthcare professionals who are treated for burnout do not come in saying they are burned out.[4] Typically, they say, "There's something wrong with me. I don't care anymore. Terrible things happen in front of me, and I feel nothing."

Compassion Fatigue

Compassion fatigue is related to, but distinct from, burnout. Figley describes compassion fatigue as "a state experienced by those helping people in distress; it is an extreme state of tension and preoccupation with the suffering of those being helped to the degree that it is traumatizing for the helper."[5] Compassion fatigue is conceptualized as consisting of 2 parts: 1) symptoms associated with burnout, such as exhaustion, frustration, anger and depression; and 2) secondary traumatic stress, the negative effects of which may include fear, sleep difficulties, intrusive images, or avoidance of reminders of past traumatic experiences.[6] Healthcare workers are at increased risk for compassion fatigue, especially those involved with highly emotionally charged situations.

How Common Are Burnout and Compassion Fatigue?

Several review articles have examined the literature related to compassion fatigue, caregiver stress, and burnout in health professionals caring for patients with cancer. The evidence suggests that prevalence rates for burnout, psychosocial distress, and compassion fatigue are high among oncology physicians and nurses, oncology social workers, hospice nurses, palliative care physicians, and allied health professionals working with cancer patients. Findings are similar in several countries, including Great Britain, Canada, and the United States.[7-9]
In a large study of stress among oncologists, 56% of subscribers to the *Journal of Clinical Oncology* reported experiencing burnout in their professional lives.[10] Burnout was measured using an investigator-constructed questionnaire, as opposed to the Maslach Burnout Inventory, which is typically used to measure burnout.[11] When asked to define the specific nature of their burnout, 56% of respondents mentioned frustration or a sense of failure; 34% cited depression; 20% said disinterest in practice; and 18% blamed boredom. Almost 50% believed that burnout was inherent to the practice of oncology. Institution- or university-based oncologists on salary reported a lower incidence of burnout (47%) than those in private adult oncology practice (63%).

Still other studies by Graham and Ramirez have found prevalence rates on 3 dimensions of burnout from 13% to 38%, with an estimated prevalence of psychiatric diagnoses among oncologists of 28%.[12]

Another study of 395 head and neck surgeons, also using an investigator-constructed questionnaire, found that 34% of respondents reported feeling burned out, 27% indicated frustration with disease, 67% indicated frustration with government, and 58% indicated frustration with the economics of medical practice.[13]

In the United Kingdom, the percentage of clinicians reporting high levels of exhaustion on the Maslach Burnout Inventory was similar to that of the normative sample (31% vs 33%, respectively).[14,15] Among both the cancer clinicians and the normative sample, 33% reported a sense of low personal accomplishment. Significantly fewer of the UK cancer clinicians reported high levels of depersonalization compared with the US sample (23% vs 33%, respectively). In general, North Americans reported higher levels of burnout than did Europeans.[1]

In a study by Cancer Care Ontario, the comparable figure for physician exhaustion was 53.3%; for allied health professionals, 37.1%; and for support staff, 30.5%. Almost half (49%) of physicians reported having low feelings of personal accomplishment, as did 54% of allied health professionals and 31.4% of support staff.[16] The feelings of depersonalization in the Canadian group were similar to those of the UK sample, with 22.1% of physicians (vs 4.3% of allied health personnel and 5.5% of support staff) reporting feelings of depersonalization. These figures may be unique to Ontario, or may indicate an increase in stress in oncology partly as a result of ever-increasing workloads and limited resources.

A study of oncologists, housestaff, and oncology nurses from Memorial-Sloan Kettering Cancer Center reported that housestaff experienced the most burnout, emotional exhaustion, feeling of emotional distance from patients, and a poorer sense of personal accomplishment.[17] Nurses reported more physical symptoms than housestaff or oncologists; however, they were less emotionally distant from patients.

Potter and coworkers[19] investigated the prevalence of compassion fatigue and burnout among oncology nurses, using the Professional Quality of Life Revised, version IV (ProQOL R-IV) scale, a commonly used instrument for measuring the positive and negative effects of working with people who have experienced extremely stressful events.[20] It consists of 3 subscales, measuring compassion satisfaction, compassion fatigue, and burnout. Among the 153 respondents (mostly registered nurses [RNs]), staff working on inpatient nursing units had the highest percentage of high-risk compassion
satisfaction scores. High-risk scores for compassion fatigue were equal among inpatient and outpatient staff (37% and 35% respectively); but 44% of inpatient staff (vs 33% of outpatient staff, a non-significant difference) were at high risk for burnout. Other studies of oncology nurses found between 37% and 47% reporting high emotional exhaustion, 11%-47% reporting high depersonalization, and 20%-55% experiencing low personal accomplishment.

Simon[21] examined the prevalence of secondary traumatic stress among oncology social workers, and found that they experienced compassion fatigue and burnout, which was inversely related to compassion satisfaction and that empathy was compromised by compassion fatigue.

Some studies[22-24] seem to indicate that hospice and palliative care physicians and nurses fare better than their oncology associates when it comes to compassion fatigue and burnout, whereas other studies dispute this. In studying hospice nurses, Abendroth and Flannery[25] found 80% to be at moderate to high risk for compassion fatigue.

Taken together, these studies illustrate that healthcare providers caring for persons with cancer (physicians, nurses, social workers, and others), experience significant rates of compassion fatigue and burnout.

**Risk Factors for Burnout and Compassion Fatigue**

A number of individual, cultural, and personality characteristics are associated with burnout and compassion fatigue. Organizational factors also play a role.

**Individual Risk Factors**

Individual characteristics can be related to burnout. However, these associations are weaker than those for burnout and situational factors, suggesting that burnout is more a social phenomenon than an individual one.[1]

**Age.** People younger than 40 years of age have more burnout than those older than 40 years of age. Age is confounded with work experience, so burnout may be a greater risk earlier in one's career.[1] However, in another study,[14] age younger than 55 years was an independent risk factor for burnout.[14]

**Stage in work life.** Residents report higher levels of burnout than attending physicians.[17,26] Oncology nurses with 6-10 years of experience exhibited more high-risk burnout and low compassion satisfaction scores than those with 11-20 years experience. Conversely, compared with baccalaureate-prepared RNs, graduate-prepared nurses were at higher risk for burnout.[19]

**Sex.** In the Physician Work Life study, women were 1.6 times more likely to report burnout than men.[27] The odds increased by 12%-15% for each additional 5 hours worked per week over 40 hours. Female oncology housestaff and nurses reported higher levels of emotional exhaustion and psychological distress than staff physicians of any sex or male housestaff. Of all groups, female housestaff showed the greatest sense of demoralization and the least sense of accomplishment within a highly stressed environment.[17] In only a single study were male oncologists at more risk for burnout than female oncologists.[28]

**Marital status.** For oncologists of either sex, being unmarried was an independent risk factor for burnout.[18]

**Cultural Factors**

When physicians in The Netherlands were compared with those in the United States, older physicians in the United States reported a greater sense of control over their work environment compared with younger physicians, while in The Netherlands this age differential was much less pronounced.[29]
In the United States, male physicians described having significantly more work control than female physicians. European workers generally tended to have lower average levels of exhaustion and cynicism compared with similar North American samples. Some aspects of burnout, particularly cynicism, may be more acceptable in the strongly individualized North American culture, or the orientation toward higher achievement in North American society may cause more stress.\[1\]

**Personality**

**Compulsiveness.** The compulsive characteristics of physicians, "when present in conjunction with other characteristics of overly controlled emotions and low need for relaxation and pleasure, makes the medical student, and later the physician, more vulnerable than others to depression, alcoholism, psychiatric disorders, and suicide."[30] An oncologist said, "Lots of us who feel overloaded and overworked create it ourselves. We start dancing to a tune that you're called to play by yourself."[31]

**Psychological health.** People who were psychologically healthier in adolescence and early adulthood are more likely to enter, and remain, in interpersonally demanding jobs (eg, emotionally demanding "helper" roles or jobs that deal with people in stressful situations), and show greater involvement and satisfaction with their work.[32]

**Developmental stability.** Physicians with the least stable childhood and adolescent adjustment have been identified as being the most vulnerable to occupational hazards.[33]

**Personality characteristics.** The personality characteristic of hardiness, consisting of commitment, control, and challenge, is associated with improved coping among house staff.[30,34,35] Hardiness is associated with less demoralization and a greater sense of accomplishment. Housestaff and nurses have a lower sense of accomplishment than oncologists.[17] Resilience has been found to be an important characteristic in coping with negative circumstances. In his study of pediatric oncology nurses, Zander found that the resilience correlated with hope, self-efficacy, control, competence, and coping. Those with a range of positive coping strategies fared better than their counterparts who employed a narrow range of coping strategies, or who used negative coping strategies.[36]

**Level of Social Support and Spirituality/Religion**

Female physicians with young children are 40% less likely to experience burnout when they have the support of colleagues, spouses, or significant others in balancing work and home issues.[27] In an evaluation of burnout among nurses, fellows, and oncologists, those who reported being "quite a bit" to "extremely" religious had lower levels of diminished empathy or depersonalization and less emotional exhaustion on the Maslach Burnout Scale, compared with those who were not as religious.[17]

**Work Life**
Long hours. Burnout is strongly associated with long work hours and work-home interference in both the United States and The Netherlands.[29]

Volume of work. Too high a volume of work, with inadequate staff to do the job properly, leads to pressure to make deadlines, conflicting demands on time, and disruption of home life as a result of extended work hours.[16] The combination of being overloaded, experiencing interference with one’s home life, dealing with suffering, and feeling low levels of satisfaction with work from not having adequate resources to perform one’s role leads to burnout.[14]

Subspecialty. Radiation oncologists report that work-related stress is increased by treatment toxicity and errors, whereas medical oncologists report more stress from organizational responsibilities or conflicts.[14]

Patient population. Dealing with chronically ill, incurable, or dying patients, with a potential lack of hope, can create burnout.[28] New research has focused explicitly on emotion-work variables (eg, requirement to display or suppress emotions on the job, requirement to be emotionally empathic), and has found that these emotional factors account for additional variance in burnout scores over and above job stressors.[1,37]

Models of Burnout
Recent research has focused on the degree of match or mismatch between the individual and 6 domains of the job environment. The greater the gap or mismatch between the person and the environment, the greater the likelihood of burnout. The greater the match or fit, the greater the likelihood of engagement with work. Mismatches arise when the process of establishing a psychological contract leaves critical issues unresolved, or when the working relationship becomes unacceptable to the individual. Mismatches lead to burnout.

The following 6 areas of work life come together in a framework that encompasses the major organizational antecedents of burnout:

1. Workload
2. Community
3. Control
4. Fairness
5. Reward
6. Values

Burnout arises from chronic imbalances between a person's expectations or needs and work life in some or all of these areas. Preliminary evidence suggests that the area of "values" may play a central mediating role for the other areas. Alternatively, people may vary in the extent to which each of the 6 areas is important to them. Some people place a higher weight on rewards than on values; others may be prepared to tolerate a mismatch with respect to workload if they receive praise, and good pay, and have good relationships with colleagues.

**Job Engagement and Burnout**

Some studies have looked at sources of satisfaction among oncologists. These include dealing well with patients and relatives, having professional status and esteem, deriving intellectual satisfaction, and having adequate resources to perform one's role.

Job engagement is conceptualized as being the opposite of burnout. Job engagement represents the individual's relationship with work, and encompasses energy, involvement, and efficacy. It involves a sustainable workload, feelings of choice and control, appropriate recognition and reward, a supportive work community, fairness and justice, and meaningful and valued work. Engagement is also characterized by high levels of activation and pleasure. Engagement is a persistent, positive-affective-motivational state of fulfillment in employees that is characterized by vigor, dedication, and absorption.

**Burnout and Depression**

In contrast to depression, which tends to pervade every domain of a person's life, burnout is a problem that is specific to the work context. However, individuals who are prone to depression (as indicated by higher scores of neuroticism) are more vulnerable to burnout.

Burnout and depression can be differentiated. A reduced sense of superiority and a perceived loss of status are more characteristic of depressed individuals than individuals who are burned out. It seems that burned-out individuals are still "in the battle" for obtaining status and consider themselves potential winners, whereas depressed individuals have "given up."

**Coping With Job Stress**

A number of lifestyle management techniques may help reduce one's vulnerability to burnout. In the study comparing physicians in The Netherlands and the United States, physicians' perceived control over their work conferred substantial
benefit in minimizing stress and increasing satisfaction in both countries, and home support had remarkable benefits on stress reduction in the United States.\(^{[29]}\) In both countries, work control was correlated with job stress and satisfaction, whereas work-home interference was associated with work hours, children, stress, dissatisfaction, and burnout.

**Victimization and Trauma**

In addition to the elements of burnout, compassion fatigue also involves elements of vicarious victimization or secondary trauma that are more akin to post-traumatic stress symptomatology, including fear, avoidance, intrusive thoughts, and sleep disturbances.\(^{[6]}\)

**Signs and Symptoms of Burnout**

To prevent or address burnout early, monitor yourself for signs and symptoms of burnout (Table 1).

**Table 1. Signs and Symptoms of Burnout**

| Boredom     |
Lower quality of care
Depression
Fatigue
Frustration
Gastrointestinal disturbances
Headaches
Insomnia
Staff turnover
Low morale
Physical/emotional exhaustion
Weight loss
Impaired job performance (decreased empathy, increased absenteeism)

Management of Burnout and Compassion Fatigue

A paucity of evidence-based interventions has been shown to be effective for either the prevention or the treatment of compassion fatigue or burnout in healthcare providers caring for persons with cancer. Preliminary investigations and anecdotal and empirical reports offer suggestions such as communication skills training, stress management workshops, self-care behavior coaching, individual counseling, mentoring programs, staff retreats, and sabbaticals.

One program that has been studied and found to be effective is the Accelerated Recovery Program (ARP), a 5-session copyrighted protocol developed to address the symptoms of compassion fatigue and burnout in caregivers. A Certified Compassion Fatigue Specialist Training for ARP was developed, and found to be effective in reducing symptoms of compassion fatigue in participants who attended the train-the-trainer sessions.

Another approach that has shown promise in small observational and a few controlled clinical trials is mindfulness-based stress reduction (MBSR). It combines mindfulness, meditation, and yoga in a structured 8-week program, and has been demonstrated to reduce stress, increase coping, and improve empathy in health professionals who complete the program. Of interest, investigators studying individuals who have undergone MBSR training have identified, on whole brain analysis, increases in gray matter density in several areas of the brain, including the posterior cingulate cortex, the temporo-parietal junction, and the cerebellum, when compared with pre-intervention and controls.
Prevention and early detection are thought to be the best approaches to minimize the risk for serious consequences from burnout and compassion fatigue. A variety of lifestyle management techniques may help healthcare providers maintain balance in their lives and reduce the risk for burnout (Table 2).

### Table 2. Lifestyle Management Techniques

<table>
<thead>
<tr>
<th>Monitoring for and recognizing symptoms early</th>
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<tr>
<td>Maintaining good nutrition</td>
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<td>Maintaining spiritual life; meditating; spending time in nature</td>
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<td>Grieving losses effectively</td>
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<td>Reducing overtime work</td>
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<tr>
<td>Exercising: aerobics, yoga, qi gong, tai chi</td>
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<tr>
<td>Maintaining energy: Reiki, healing touch, therapeutic touch</td>
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</table>
Maintaining a sense of humor

Seeking consultation if symptoms are severe

Discussing work-related stresses with others who share the same problems; visiting counterparts in other institutions; looking for new solutions to problems

Meier and colleagues\(^{[45]}\) recently proposed an approach to physician awareness that involves identifying and working with emotions that can affect patient care. Although originally proposed with the physician in mind, the approach has applicability to other healthcare professionals. The approach involves looking at healthcare professional, situational, and patient risk factors that can influence provider emotions and patient care.\(^{[45]}\) The steps include:

1. Identify the factors that predispose to emotions that might affect patient care.
2. Monitor for signs (behavioral) and symptoms (feelings) of emotions.
3. Name and accept the emotion.
4. Identify possible sources of the emotion.
5. Respond constructively to the emotion.
6. Step back from the situation to gain perspective.
7. Identify behaviors resulting from the feeling.
8. Consider implications and consequences of behaviors.
9. Think through alternative outcomes for patients according to different behaviors.
10. Consult a trusted professional colleague.

More research needs to be done on organizational changes to reduce burnout. Hierarchical organizations that overemphasize standardization and efficiency, combined with increasing expectations of perfection (by patients, corporations, and colleagues) may promote burnout and reduce the quality of professional practice.\(^{[46]}\) The underlying theme in burnout and work engagement is that group and management processes have to promote more open futures in which employees are better able to deploy their gifts in meaningful ways and grow as human beings.

It may be essential to measure the moral climate, assess the culture of each workplace, and evaluate spiritual concerns of staff. The latter might include clarification and strengthening of meaning and purpose conducive to both personal vitality and that of the organization.

Interventions that combine changes in managerial practice with educational interventions, on the basis of the 6 areas of work life, may reduce burnout.\(^{[1]}\) People may be able to tolerate heavier workloads if they value the work and feel they are doing something important, or if they feel well-rewarded for their efforts. Interventions can target values and rewards. A study by Fallowfield and coworkers\(^{[47]}\) showed that improvements in communication skills of oncologists leads to more personally and professionally rewarding consultations, which can have a significant impact on clinical care and the well-being of both patients and physicians.

**Points to Remember**

Burnout is prevalent among cancer care providers and physicians. Women are more often affected by burnout than men. Age is an independent predictor of burnout, with a higher prevalence of burnout in people at earlier stages of their careers. To prevent -- or address -- burnout, monitor yourself for signs and symptoms of burnout and compassion fatigue. The lifestyle management techniques will help you maintain balance in life and reduce the risk for burnout. Changes in management strategies combined with educational interventions may further reduce burnout.

**Key Take-Home Points**
Key dimensions of burnout are exhaustion, cynicism, and a sense of personal ineffectiveness;
Burnout often presents as a feeling that you "don't care anymore;"
Burnout is related more to the situation than the individual;
Burnout is more prevalent in women than men and those in earlier stages of their careers;
Long work hours and work-home interference are strongly associated with burnout;
Burnout arises from chronic mismatches between people and their work settings;
Job engagement (energy, involvement, and efficacy) is conceptualized as the opposite of burnout;
Burnout, in contrast with depression, is specific to the work context;
Lifestyle management techniques (exercise, meditation, humor, etc.) can reduce vulnerability to burnout; and
Burnout can be prevented by changes in management combined with educational interventions and improved communication.

Pearls and Pitfalls of Burnout

- Burnout is common; expect it and prevent it;
- The working conditions, not the patients, are the most common cause of burnout; and
- Trying to simply "suck it up" does not work.

References

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