Reluctant reflections

An oncologist’s take on how physician and patient burnout might be prevented

BY WILLIAM SHIMP, M.D.

I have never been a fan of dinner parties, galas or wine-tasting events, especially if word gets out I am a cancer specialist. Invariably, someone attempts to engage me in conversation about how depressing my work must be. Sometimes they are amazed that I can keep hanging in there amid such a steady diet of death and destruction. In response, I make no apology for my lot in life, and I do not try to explain what motivated me to make a career of cancer medicine in the first place. Usually, when people ask why I do what I do, I offer a few platitudes about what a privilege it is to bring solace to those who suffer, how it matters to provide comfort at the end of life and that it is possible to cure some of my patients. Then I act surprised to find that my wine glass is empty and excuse myself, hoping to regain anonymity and not be ambushed again.

But the unwelcome small talk with a stranger raises an important point. Some of my oncology colleagues do suffer from burnout and depression, and it is easy to see why.

Caring for cancer patients is hard work. Many of our “successes” often are seen as something other than that by friends and physician colleagues who do not understand what we do. Professional burnout is a stalker of oncologists everywhere, causing some to leave the field prematurely or, even worse, to disengage professionally and still stay on the job. After all, we are dealing with the saddest of circumstances, hoping for enough small victories along the way to sustain our zest for our profession.

We also witness another type of burnout that afflicts so many of our patients. They are fed up with an existence defined by doctor visits, IVs, scans and neuropathy. Because their life is not turning out the way they had planned, depression can become their constant companion. We are supposed to be tuned in to that, to inquire as to our patients’ psychological and spiritual health, to listen with compassion, to prescribe antidepressants as needed and to ask for help from other colleagues when we are in over our heads.

Lurking among our patients is a subset that is potentially suicidal. Although one can argue suicide becomes a more understandable choice when one has a terminal condition, we still are prone to regard a patient’s suicide—the ultimate expression of burnout with life—as a failure of our duty as physicians. We should have seen it coming. We should not have been so rushed that last day we saw them in the office. We should have spent less time talking about chemotherapy and more time asking about how they were doing and listening. The list of laments goes on and on.

Three of my patients have ended their ordeal with cancer by committing suicide. All were male, and all did so by gunshot. Each death rocked me to the core, caus-
traits had been in place long before their cancer. Remarkably, these families seemed to be more focused on ministering to me than to themselves. And so, immersed in my busy and demanding practice, I found the simple passage of time my best ally in making peace with what had happened.

The first two patients were elderly loners, rather stoic and inscrutable, and new to my practice. Their suicides surprised me because their cancers were responding nicely to treatment (one had limited-stage small-cell lung cancer and the other non-Hodgkin lymphoma); I was optimistic they would do well for a time. Although they were mildly symptomatic from their chemotherapy, the men were having few symptoms from their disease. With hindsight, I see that their view of things was different from my own. I wonder if I hadn’t stressed enough of the positives of their situations; did I come off as too negative? Since they asked few questions and didn’t seem to demand much by way of communication, their office visits seemed easy. I worry that I scurried off too soon to see the next patient.

Interestingly, their families were not surprised by their suicides. Concerned by my expressions of remorse, they told me I was not to blame and that I should not take it personally: “They were going to do what they were going to do. You couldn’t have stopped them. Even psychiatrists lose some patients to suicide.” The message was clear: Their suicidal personality traits had been in place long before their cancer. Remarkably, these families seemed to be more focused on ministering to me than to themselves. And so, immersed in my busy and demanding practice, I found the simple passage of time my best ally in making peace with what had happened.

The third suicide was more difficult, however. I had known this patient for many years. His chronic lymphocytic leukemia was under good control with periodic treatment with chlorambucil and prednisone. Most of his office visits were routine, consisting of an inquiry about symptoms, a blood count and lymph node palpation. I would describe him as quiet and at times taciturn, but always pleasant and at no time showing signs of depression. His adult daughter accompanied him to most of his office visits. Sometimes she did his talking for him. Although I can’t be sure, perhaps this dynamic prevented me from appreciating his reaction to his disease, and from knowing the depth of his despair.

We still are prone to regard a patient’s suicide—the ultimate expression of burnout with life—as a failure of our duty as physicians.
One evening he simply walked outdoors and shot himself with his deer rifle. Along with the rest of his family, we in the clinic were shocked by this act seemingly so at odds with his personality and his good quality of life. Unfortunately, he lingered for a few days in the intensive care unit before he died. During that time, his family and I were able to grieve over what had happened. We consoled each other by saying something had been lurking beneath the surface—something none of us had seen. But I have never been able to get over thinking I had to have missed an important clue. Most of all, I wished I had gotten to know him better.

None of these patients fit the conventional definition of “end stage,” where the debate rages about physician-assisted suicide. Each would have lived for months to years with ongoing therapy. With symptom palliation and prolonged survival being the goal, we were well on our way to accomplishing that. I felt they had been cheated out of a longer and a reasonably comfortable life, and I had been cheated out of a chance to be a better doctor. The days I learned of their deaths were some of the most mind-numbing of my oncology career.

Friends and colleagues offer consolation by underscoring the difficult task of living with cancer. “If I were in their situation,” they say, “I might have done the same thing.” Some muse that I probably have prevented more suicides than I’ll ever know, and that there is a surprisingly low number of such deaths. Others propose that the cancers may have been only a part of the reason for the suicides.

In reply, sometimes I have to parse a nuance distinguishing incurable-but-treatable cancer from end-stage disease. I explain that my patients were in the former category, not the latter, and that is why their deaths seemed particularly harsh. Nobody likes painful surprises, and in these cases, death came sooner—and from a different direction—than I expected. This reality makes it particularly difficult for me to find much consolation.

In talking with other physicians who have had similar experiences, I find that remorse is a common response. From there, it seems easy to gravitate to a place where some degree of self-flagellation becomes inevitable. But there has to be some learning in there somewhere, something that helps us “bullet proof” ourselves and our patients against future tragedies.

There has to be something that helps us “bullet proof” ourselves and our patients against future tragedies.

Since these patients’ suicides, I have tried to be more intentional about understanding the mental and spiritual state of my patients. I have worked to better integrate into my practice the strategies of palliative care specialists, for whom probing and conversations with patients and their families are central to their work. Sometimes this boils down to asking some difficult and uncomfortable questions in the exam room, causing everyone to squirm a bit. But I think it is worth it. Thankfully, a growing drumbeat in our oncology literature is making this point and encouraging us all to move in that direction.¹

So, how am I to keep myself and my patients from burning out? Perhaps I can attend to my own burnout risk by attending to theirs because our risks are interconnected. Perhaps I can work to find greater satisfaction by entering their world more with words than with drugs. Approaching care with a more balanced mix of science and compassion, and being content with achievements smaller than chemotherapy success, may go a long way toward sustaining my satisfaction in my work. Being able to discourage lung cancer patients from opting for increasingly difficult and likely futile third- or fourth-line chemotherapy, as an example, might be a surrogate measure of how I understand and define the true nature of my job as an oncologist, and how I continue to feel good about what I do.

Given the time constraints in the clinic and hospital and the reality that talking with patients consumes more time than writing chemotherapy orders, the challenges are great. But direct conversation is the only way to get inside patients’ heads and to truly understand where they are in their psychological adjustment to their illness. If there are surprises to be had, I would rather they erupt as unexpected admissions from confiding patients and not as another midnight call from the county coroner.

I think the guy at the cocktail party could have been coaxed to understand this as well as anyone, but it would have taken too long to explain, and mercifully my wine glass was empty. MM

William Shimp is a medical oncologist who has practiced in Minnesota for more than 30 years.

REFERENCE