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Cancer Providers and Health Care Delivery Systems are Downstream Benefactors of
Psychosocial Support of Cancer Patients

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Running Head: Benefits of psycho-oncology extend beyond just the patient

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Five Key Points

1. Breast cancer is associated with significant emotional distress, from the time of diagnosis through survivorship.
2. Patient distress may impact the early diagnostic period where major treatment decisions must be made, resulting in both overtreatment and undertreatment.
3. The implications of patient distress on providers and healthcare delivery are not routinely considered.
4. Impact of chronic exposure to patient distress may impact long-term professional performance of cancer physicians
5. Psychosocial consultation or coaching may benefit providers and reduce burnout, benefitting both patients and the healthcare system.

Emotional distress following a diagnosis of breast cancer has been described across the disease course, often lasting decades after completion of treatment. Emotional distress has a significant impact on patients and on upfront decision-making about treatment, but may also have an impact on healthcare providers and the healthcare delivery system. While much of the literature on distress and breast cancer decision-making has focused on patient-centered outcomes, such as decisional regret, the broader impact of distress on providers and overall quality of health care delivery is often not considered.

The early emotional response following a breast cancer diagnosis is often characterized by fear and anxiety. Emotional distress in the early diagnostic period is important not only because of the psychosocial impairment itself, but because of the potential impact on crucial diagnostic and treatment decisions that must be made by a patient and their healthcare team during that time. Initial decision-making in breast cancer is largely centered around surgical decision-making, including the decision to remove part or all of the breast, some or all of the axillary lymph nodes and the decision to remove the unaffected breast, or contralateral prophylactic mastectomy (CPM). The fear and anxiety experienced during this early emotional response has been documented as a driver of treatment decision-making, often resulting in higher intensity treatment preferences such as CPM.¹

Physicians at the front line of treating breast cancer include surgeons, medical oncologists and radiation oncologists. In modern treatment paradigms, surgeons are often the first providers to establish a relationship with a patient with newly diagnosed breast cancer. Owing to the relatively time-sensitive nature of the diagnosis, patients and providers are put in the position to make decisions quickly and the long-term impact of these decisions are often difficult to consider or even imagine for patients. At the same time, there is rising awareness of the over-treatment of breast cancer. One of the natural tensions confronted in the discussion of over-treatment is the tension between patient-centered or patient-directed care and high value, cost-efficient care. For oncologists, the tension between over-treatment and patient autonomy is pervasive and is a source of significant conflict as we want to both take care of patients in a way that is sensitive to their preferences and be a responsible steward of healthcare resources in the face of growing scrutiny. In this regard, further understanding the impact of patients' emotional response on treatment decision-making and the way this may have both short and long-term

impact on providers' professional performance or on the health care system as a larger whole must be considered. Ultimately, the 'best decision' may require offering both the best psychosocial care as well as the oncologic care.

It is well-established that much of medical and surgical training does not adequately prepare physicians to respond to social, emotional or psychological domains of health for our patients. Furthermore, the surgical workforce caring for breast cancer patients is diverse, from general surgeons to fellowship trained surgical oncologists and breast surgical oncologists. They may care exclusively for patients with breast cancer, a wide variety of cancer patients or, in some cases, the entire spectrum of general surgery. Certainly, the priority through surgical training is to develop critical thinking skills and technical skills with only minimal attention paid to non-operative, non-technical skills. Although most providers receive little to no training in social or emotional skills or communication, recent work out of the University of Wisconsin has documented that in patients diagnosed with thyroid cancer, emotionally supportive language on the part of the provider improves patient-reported quality of decision-making.² Confronted regularly with patients who have high psychological and social needs, surgeons in particular may feel a dissonance between the technical skills that were central to their training and the demands of meeting complex psychological and emotional needs of their patients. While support from the fields of psycho-oncology, social work and nursing may lighten this burden to some degree, access to such supportive services in the early diagnostic period is variable. Patient specific factors, including degree of distress, and recommendations from treating oncologists have both been shown to influence the use of psychosocial support networks.^{3,4}

Burnout, or elements thereof, is estimated to affect 40% or more of American surgeons, with reported rates somewhat variable owing to the variability in measurement.⁵ The symptoms of burnout among physicians are described as a triad of depersonalization, physical and emotional exhaustion and a decreased sense personal accomplishment.⁶ The burnout literature has explored causes of burnout with good evidence to support that lower job satisfaction predicted higher burnout scores. Among surgical oncologists, higher clinical volume and younger age are associated with higher burnout scores.⁷ In another survey of surgical subspecialists, the perception of not fulfilling patient expectations was a significant factor in reported burnout. In fact, failure to meet patient needs was found to contribute to provider burnout with at

least the same impact as administrative and EMR related stressors in this population.⁸ The consequences of burnout are devastating, for patients, providers and our health care delivery system. Physician burnout is associated with decreased patient satisfaction, lower quality of care, higher rates of medical error and malpractice claims, high rates of physician attrition and turnover and physician depression, substance abuse and suicide.⁶

Potential strategies to support providers in their support of distress patients could improve both patient and provider-specific outcomes. Training of surgeons in basic emotional support strategies has been proposed but not widely implemented. This may include training of surgeons and other oncologists in non-technical communication skills that would help them to support patients through the decision-making process and training in how to identify patients who would benefit from referral for additional services. Additionally, expansion of and integration of psychosocial support teams into initial patient evaluation and treatment decisions may help normalize this support as an important part of the decision-making experience for both patients and providers. Although integration into oncology teams has been studied and is recommended as a standard part of whole-person care, implementation is variable. The role of provider personality on a wide range of personal and professional skills is often overlooked by both researchers and providers themselves. Understanding a wide variety of personality styles and how these influence work and personal behavior has long been a focus of psychiatrists with an interest in personality and personality disorders.⁹ While professional coaching has been suggested and may be utilized to correct problem behaviors among surgeons and physicians, its use is in its infancy as a response and treatment approach to burnout. One pilot study which evaluated coaching to 88 physicians identified improvements in overall burnout scores, life satisfaction scales and emotional exhaustion, although changes in other important domains of burnout were not significant.¹⁰ The use of highly personalized coaching or specialized mentorship to guide providers through how their own personality style influences their stress response distress may help providers develop skills and mental adjustments to cope and, ultimately, positively influence their sense of job satisfaction and mitigate the emotional fatigue described in burnout.

Addressing the mismatch between training and real-world demands may have further implications than just improved quality of care and decision-making. Supporting front-line

oncology providers may improve the extent to which we feel we are meeting the needs of our patients, which may in turn temper the development of burnout and overall improve the health and well-being of this valuable group of health care providers.

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