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It Is Time to Assess Sexual Health in Women With Lung Cancer – The SHAWL Study

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The Lung Cancer Registry has launched a landmark new survey on the impact of lung treatments on women's sexual health. The aim is to explore the magnitude of the problem and give researchers and clinicians new insights to improve the quality of life for women lung cancer survivors. Sexual distress is an essential component of quality of life in lung cancer, but it is infrequently studied and discussed. Most of the data regarding sexual dysfunction in patients with lung cancer precede the approval of targeted therapies and immune checkpoint inhibitors, which are now the backbone of lung cancer treatment. We lack an understanding of how these new regimens that have significantly improved the survival of patients with lung cancer are affecting our patients' sex lives and intimacy. Sexual dysfunction symptoms are often not collected in the clinical trials that lead to regulatory approvals.

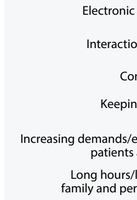
Sexual health in patients with lung cancer is under-reported and, therefore, understudied. Previous studies have reported that the impact on sexual function is distressing to most patients with lung cancer, and sexual concerns are related to both higher symptom distress and worse functional status in patients with lung cancer.

The SHAWL (Sexual Health Assessment in Women with Lung Cancer) study is the result of a multi-institutional collaboration between the University of Wisconsin Carbone Cancer Center and the GO2 Foundation for Lung Cancer. All women with lung cancer, independently of cancer stage, treatment type, and geographic location, can participate in the study, including women with a history of lung cancer or who are actively receiving treatment for the disease. The survey is located at lungcancerregistry.org; it takes 5 to 15 mins to complete and is strictly confidential. Participants will not be asked to provide identifiable information while completing the survey. Study participants will have access to the online questionnaire for 6 months.

The data collected through the SHAWL study will help researchers better understand the effect lung cancer therapies have on women's sex life and intimacy—and, ultimately, identify solutions to improve sexual dysfunction and improve our patients' quality of life.

Patients and clinicians can access the SHAWL Study at lungcancerregistry.org.

Recognizing the Contributors to Burnout Among Community Oncologists



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Data indicate that medical oncologists, irrespective of where they practice, appear to be at greater risk for burnout than other specialists. Although burnout has been widely studied in academic physicians, community oncologists have not been specifically included in these studies. With community oncologists facing distinct challenges from those of academic physicians and the lack of reports on the impact of electronic health records (EHRs) on this physician group, Ajeet Gajra, MD, FACP, and colleagues conducted a study to assess the issues of work-related stress specific to them, especially addressing the contribution of EHRs as a stressor.

Determining Common Stressors

For a study published in *JCO Oncology Practice*, Dr. Gajra and colleagues conducted web-based, paid surveys of US community oncologists/hematologists from September to November 2018. "Physicians were asked about frequency of burnout symptoms, drivers of work-related stress, and their perceptions on management of workload," explains Dr. Gajra. "We developed a set of questions to explore the common stressors in their work lives, as well as questions that would address individual symptoms of burnout. Through our survey design, we were able to circumvent the low response rates in voluntary surveys and essentially achieve a 100% response rate."

Among survey respondents, 16% felt a substantial amount of stress at work, with most feeling emotionally (85%) and physically (87%) exhausted. A majority also felt lethargic (67%), ineffective (64%), and/or detached (63%). "In a typical workweek, 93% of respondents stated they needed additional time, beyond time allocated to clinical care, to complete work responsibilities," adds Dr. Gajra. "Of these, 21% needed an extra 7-9 hours, and 17% required more than 10 hours of additional time. Notably, two-thirds attributed moderate to excessive stress to EHR responsibilities," with 79% working on EHRs outside of clinic hours. Approximately one-third identified changing reimbursement models (33%), interactions with payers (31%), and increasing patient and caregiver demands (31%) as sources of excessive stress. One-third of respondents also reported having considered retiring early or changing their career path to cope.

"It's important to note that, excluding the 'never' and 'occasionally' frequencies, the frequency of burnout symptoms was highest for emotional exhaustion (50%), followed by physical exhaustion (44%), cynicism (30%), feeling unaccomplished (27%), and lethargy (23%)," notes Dr. Gajra (Figure). "These rates are rather high and suggest underlying burnout irrespective of whether it is recognized as such by the oncologists." Physicians provided their perceived magnitude of stress caused by various factors that contributed to their burnout on Likert scales: no added stress, minimal stress added, moderate stress added, significant stress added, and excessive stress added. "Excluding the 'no stress' and 'minimal stress' categories, the major offenders were: EHR responsibilities (67%), changing reimbursement models (62%), interactions with payers (66%), and increasing demands of patients and caregivers (65%)," says Dr. Gajra. "Notably, keeping up with scientific data and managing complex patients were not perceived to be contributors of excessive stress."

Despite the frequency of burnout symptoms observed in the study, more than three-quarters of survey respondents stated that their stress was manageable, with 63% reporting an optimal or good workload. "However, the high rates of those who considered retiring early or changing their career path due to increasing demands are a concerning trend when there is already a projected shortage of oncologists," Dr. Gajra says.

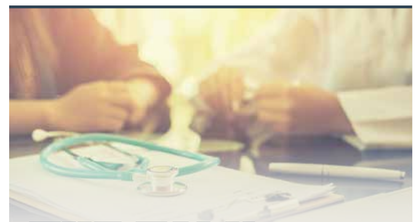
Recognize & Address

Oncologists need to recognize this syndrome in themselves and within their peers, according to Dr. Gajra. "And, if present, we hope they do not try to deny these symptoms given the stigma that has been associated with burnout in the past," he adds. "Physician burnout is an occupational syndrome that can lead to lower productivity and higher healthcare costs, as well as increased rates of patient and physician dissatisfaction. If not recognized and addressed by healthcare systems and practices, burnout among oncologists will lead to additional attrition in a stretched workforce by early retirement or change in career path. With timely and unprejudiced recognition, community oncologists can initiate processes to mitigate the factors that are the greatest stressors for them."

Table Burnout Symptom & Work-Related, Stress-Associated Factor Frequencies

A: The frequency of the common factors respondents associated with work-related stress
B: The frequency of burnout symptoms reported by survey respondents.

Source: Adapted from: Gajra A, et al. *JCO Oncol Pract.* 2020;16(4):e357-e365.



THE TALK: It's Time to Move from Curative to Palliative Care

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During the 2019 Liver Meeting, the Blue Faery Liver Cancer Assoc team had the opportunity to discuss hepatocellular carcinoma (HCC) care approaches with many physicians, nurses, researchers, and patient advocates. Several physicians reported that they had not typically explained the difference between curative and palliative plans to their patients, and in many cases, had not discussed end-of-life planning.

For some clinicians, there may be significant reluctance to specifically articulate a dismal prognosis to terminal patients. While the sentiment to protect a patient from alarm or despair may have benign roots, the lack of counseling about palliative options and lack of clarity as to prognosis can lead to ineffective end-of-life planning and worse patient outcomes.

A lack of effective and comprehensive end-of-life planning often results in unnecessary pain and discomfort, as well as unrealistic expectations that are detrimental to a patient's quality of life. Patients who are kept on curative plans that have no significant likelihood of success often have a lower quality of life due to painful, expensive, and intrusive tests, as well as the effects of surgery, radiology, or drug regimens that can result in missed opportunities to be with family and friends and to enjoy what finite time they have left.

Likewise, patients who are terminal but unaware of their prognosis may fail to wrap up their affairs and may not execute legal documentation. As a result, there may be confusion about their intentions, and the patient or their family members may agree to expensive, painful, and disruptive medical interventions that are futile. When adult patients don't leave clear care preferences in legally executable instructions, other adults—often their children—may disagree on what to do, resulting in worse quality of life for the patient.

Futile curative care robs the patient and their family and friends of quality of life that palliative care may have afforded or enhanced. Physicians should make end-of-life planning and clear articulation of the options for palliative care part of their standard operating procedures for patients who are terminal.

Using Teams to Address Burnout Among Oncologists

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Burnout is costly: evidence shows it takes a toll on mental health, leads to medical errors, and contributes to provider suicide. In interviews my colleagues and I conducted with oncology professionals, the issues that one might imagine cause burnout (eg, the emotional burden of caring for cancer patients) were often considered a source of meaning and purpose—what they signed up to do. On the other hand, burnout was often attributed to interprofessional issues, a sense of isolation while providing care, and not having someone else who truly understands what they're going through. This spoke to the need for a team-based approach to addressing burnout.

Our solution was an initiative to enhance teamwork using two organizational science concepts: 1) open, supportive communication and 2) psychological safety—a sense that one can express themselves authentically within a group without fear of negative consequences. As leaders drive many aspects of teamwork, oncology unit leaders were invited to participate in a developmental program that taught the skills of self-awareness, candid expression of thoughts and emotions, active listening, and approaches to cultivating a supportive climate within their teams.

As a healthcare organizational science team, we wanted to determine whether oncology leaders would bring these practices to their teams and whether it would affect teamwork and burnout. We analyzed assessments of the team-based initiative, teamwork, and burnout across 2 years of oncology unit employee survey data (409 employees across 30 units). Our results, published in *JCO Oncology Practice*, suggest that oncology burnout can be reduced by enhancing teamwork. Specifically, when units reported that their leaders implemented the team-based initiative, employees were more likely to feel positively about their teams and report lower burnout scores 1 year later.

Our study provides support for team-based initiatives designed to reduce burnout in oncology. It reinforces the idea that, to some extent, burnout is a disease of occupational loneliness; oncology professionals who come together as part of a supportive, interdisciplinary team are most likely to be resilient. It is a promising start, but important questions remain. For instance, we don't yet know which aspects of teamwork are most important across different stages of burnout. Future research should examine whether there are strategies more suited for teams that are already experiencing burnout as opposed to strategies to prevent newer teams from developing it in the first place.