LETTER FROM THE EDITOR

When I am asked what I do at work, the response is a long and rambling one. I devote 50% of my week to direct patient care; 25% to clinical research; 20% to administration; 20% to teaching; 20% to writing, editing and lecturing; 10% to mentoring; 10% to serving on various committees; 8% to consulting; and 10% to various and sundry other activities (yes, I am aware that this adds up to 173%). It is this diversity that gives me career satisfaction, keeps me going, and protects me from the 2 blackest of threatening clouds: retirement and burnout. The former I will have to face sometime, I guess. To the latter, I say, "Stay away from my door!"

Addressing this issue of burnout was a recent article by Shanafelt and colleagues that was published in the *Journal of Clinical Oncology* on March 1. Their goal was to identify why oncologists experienced burnout, an occurrence associated with poor health and reduced quality of care provided. These investigators contacted almost 3000 oncologists from the American Society of Clinical Oncology membership list, of whom nearly half completed a survey that included 60 questions regarding personal and professional characteristics. These were derived from a standardized burnout questionnaire. As stated in the article, this questionnaire was designed to identify burnout through feelings of emotional exhaustion, depersonalization, and low personal accomplishment.

The respondents were middle-aged, with a median age of 52 years, and 33.8% were in academics, 43.2% were in private practice, and the remainder were in other areas. They worked an average of 57.6 hours a week, including 34 hours in direct patient care, seeing a mean of 52 outpatients. No wonder the burnout rate was 44.7%! Nevertheless, 82.5% replied that they were satisfied with their career choice, and 80.4% with their specialty. There were marked differences, however, between academics and those in private practice. Academics were a bit younger, had a greater proportion of women as patients, saw half the number of outpatients but spent as much time with them overall as physicians in private practice, and saw more inpatients. They also spent more time with physicians in training. They were less likely to be compensated on an incentive-based model and to have experienced a decline in compensation in the previous year. They also tended to be more satisfied with their chosen occupation. Nevertheless, the overall burnout rate was similar between the 2 populations.

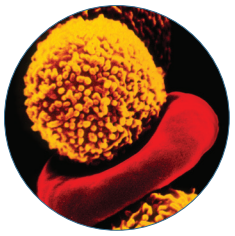
The major predictors of burnout—no surprise—were more time spent in direct patient care and more hours worked per week. However, what was troubling was that younger age also stood out. The authors offered no theories or explanations; however, it is possible that the more-rigorous training we geriatrics experienced prepared us better than our younger counterparts. (When we were their age . . . !) Also telling was the relationship between burnout rate and type of compensation: lowest for salary only, higher for salary plus bonus, and worst in an incentive-only compensation structure. This finding is particularly disconcerting given the increased tendency to compensation based on patient volume and relative value unit (RVU) generation.

Our bonus was recently restructured to be based not only on clinical RVUs, but also on those academically important, nonclinical RVU-generating activities: publications, presentations at meetings, protocol generation, accrual to clinical trials, committee membership, administrative responsibilities, and the like. Thus, I expect my bonus to increase as well. Are we now running the risk of creating a generation that only contributes to the system after asking the question, "How many RVUs will I get for doing this?"

Although Neil Young sang that "it's better to burn out than to fade away," I would prefer to avoid both in the near future.

Until next month . . .

Bruce D. Cheson, MD



On the cover: False-color scanning electron micrograph of white blood cells (yellow) and a red blood cell from a patient with chronic lymphocytic leukemia (CLL). The white cells are B lymphocytes, though in a minority of CLL cases they may be T lymphocytes. CLL cell surfaces have numerous microvilli, as seen here.

Credit: Professor Aaron Polliack / Science Source