# Burnout among Oncologists in India: Challenges in Outpatient Department Practice and the Way Forward

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Running a cancer outpatient department (OPD) in India poses significant challenges for oncologists. The rising incidence of cancer, coupled with an inadequate oncologist-to-patient ratio and the concentration of oncology centers in urban areas, results in long working hours for oncologists. This situation is particularly prevalent in government or trust-run cancer hospitals, where a large proportion of cancer patients seek treatment due to financial constraints, since many Indians lack insurance coverage. It is not uncommon for a single oncologist to attend upwards of 50 patients in a single OPD session, extending working hours well beyond the standard 8-hour day, sometimes late into the evening. Considering these challenges, it is crucial to address the emotional toll and decision-making fatigue experienced by oncologists in India as they navigate the complexities of managing cancer patients.

## Understanding Burnout in Oncology

Burnout is defined by the World Health Organization as a syndrome resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: feelings of energy depletion or exhaustion, increased mental distance from one's job, and reduced professional efficacy. Oncologists in high-volume OPD settings, particularly in India, are especially vulnerable.[1,2] The demanding workload, emotional toll of cancer care, and systemic constraints often contribute to persistent stress, placing these professionals at significant risk. These issues, along with the way forward to address them, are discussed below.

The oncologist-to-patient ratio in India is 1:2,000. Each oncologist is consulted by 475 new patients per year.[3,4] This statistic shows the extent of scarcity of oncologists. Approximately 95% of referral cancer centers in India are located in urban areas, creating a significant geographic disparity in access to oncology services. This urban-centric distribution forces patients from rural and semi-urban regions, where nearly 70% of the population resides, to travel long distances for cancer diagnosis and treatment.[5] As a result, the OPD of specialized cancer centers in urban areas experience a disproportionately high caseload, often exceeding their operational capacity. This leads to overcrowding, extended waiting times, and increased pressure on oncologists, contributing to professional burnout and potentially compromising the quality of care delivered.

## Tales That Take a Toll on Mental Health

As I type this article sitting inside my consultation room, I remember the story of a triple-negative breast cancer patient who developed a distant recurrence within 3 months post completion of adjuvant therapy. Her husband told me that their wedding happened just a year before she was diagnosed with cancer, as they were planning pregnancy and that they had to drop the plans because of the diagnosis. Coincidentally, his wedding happened in the same city and on the same day as mine, which I came to know from him through our conversation in one of the consultations. Neither of us were aware then that destiny would bring us together in my consultation room. His mother was taking treatment for advanced esophageal cancer at the same time. Neither his wife nor his mother had health insurance coverage. Listening to his story, my eyes turned teary, which I could somehow hold back. Another woman in mid-30s, who lost her husband to a road traffic accident just 1 year before, came to me with a

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diagnosis of advanced pancreatic cancer. She had already lost both her parents and has two school-going children. Her office colleagues who were helping with treatment expenditure accompanied her into my consultation room. They felt she is emotionally fragile and would give up if made aware of the adverse prognosis and signaled to me not to reveal the stage. Being kept in the dark regarding stage and prognosis, she innocently enquired about the diet she must take besides treatment to get cured of the disease. That moment I felt a lump in my throat. A series of such patients encountered in a day can take a toll on the mental health of an oncologist.

## Managing Elderly Cancer Patients

Another challenge that many oncologists find is discussing treatment options with an elderly cancer patient. It becomes important to consider their physical fitness, comorbidities, logistics, and their goals of treatment. In India, most of the elderly cancer patients are dependent on their children for health care, which makes the job even more complicated because often the treatment goals of children do not match with those of the patient. Many elderly patients do not cope with their dependency on children for treatment, either financial or physical, fearing they might become an additional burden. Whereas, children feel it is their responsibility to take care of them no matter what. Such complex dynamics arise from the strong emotional attachments present in most Indian families. In some cases, their children are the sole bread earners of the family, who cannot accompany the patient leaving his/her job frequently. Time toxicity factor forces the physician to avoid weekly chemotherapy regimens or the regimens warranting admission for multiple days. Other factors like the patient's residence being situated at a far-off rural place without proper access to a hospital in case of need for supportive care or travel expenses also impact the type of treatment offered to the patient. Multiple such considerations in planning the treatment of every elderly cancer patient result in emotional drain. Comprehensive geriatric assessment (CGA), though recommended in various guidelines, is often challenging due to manpower and financial constraints in India. Additionally, delayed presentation to an oncologist warrants quick initiation of treatment precluding further assessment. This places the entire onus of evaluating an elderly cancer patient for treatment fitness on the treating consultant, contributing to burnout. It becomes all the more challenging when a majority of the patients encountered at OPD are of geriatric age group.

## Pressure of Not Being Able to Offer the Standard of Care

As pointed out earlier in this discussion, the financial status of the patient plays a very key role in decision making in most of the patients in India. Drugs like immune checkpoint inhibitors, antibody drug conjugates, and some of the targeted oral drugs are not accessible to most of the cancer patients. This is true even if generic or biosimilar forms of such drugs are available. The best example is biosimilar of Trastuzumab emtansine, which continues to remain beyond the reach of many patients. No matter how practical an oncologist tries to be, at some stage, he/she would feel the pressure of not being able to offer the standard of care to most patients encountered in practice. The vast amount of detailed documentation and paperwork, given the expenditure and toxicities associated with anticancer drugs, adds to this burden. This eventually leads to burn out and mental health issues in oncologists, affecting their own personal and social life.[6,7]

## How Can We Improve upon This?

Improving the workflow and well-being of individual oncologists is crucial for providing optimal care to cancer patients. Here are some practical solutions that can enhance the efficiency and mental health of oncologists:

- Utilizing trained physician assistants (PAs): implementing the concept of having trained PAs in every oncology OPD can significantly reduce the administrative burden on oncologists. While common in the Western world, this practice is under-utilized in India due to the lack of a structured training system for PAs. Developing a training program and providing adequate financial incentives can help bridge this gap effectively.
- Establishing a medical social worker (MSW) department: having a dedicated MSW department attached to each oncology OPD can assist in addressing the financial concerns of cancer patients. By collaborating with the oncologist to devise optimal financial solutions after treatment planning, the burden on the oncologist can be lessened, allowing them to focus primarily on medical and scientific aspects of patient care.
- Leveraging technology for medical record keeping: incorporating user-friendly applications and software specifically designed for oncology record documentation can streamline the documentation process for oncologists. It also helps in easy retrieval of data for clinical audits and research. By adopting technology that is easy to use and cost-effective, even government and trust-run hospitals can benefit from improved efficiency in record-keeping tasks.
- Short geriatric assessment in elderly: using online screening tools for frailty, prediction of toxicity, noncancer life expectancy, timed up and go test, etc., to guide treatment decisions in elderly cancer patients, if CGA is not feasible.
- Prioritizing self-care and mental health: recognizing the importance of self-care, oncologists should incorporate regular breaks into their schedules to prevent burnout. Taking a lunch break with colleagues, enjoying a brief coffee time, and listening to good music help recharging oneself to resume patient care and to maintain mental well-being.

To conclude, mental fatigue and burnout among oncologists in India are not just prevalent but deeply entrenched, particularly in OPD settings. Addressing this requires systemic reforms and personal self-care practices. Streamlining

OPD workflow, leveraging technology, involving trained personnel, and prioritizing oncologist mental health are essential steps toward sustainable oncology practice. Ultimately, caring for oneself is central to caring for the patient.

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The manuscript has been written in accordance with the Declaration of Helsinki.

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Conflict of Interest
None declared.

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