






Evaluating Systemic Burnout in Medical Oncology Through a National Oncology Mentorship Program

Udit Nindra, MD^{1,2,3} ; Gowri Shivasabesan, MD¹; Rhiannon Mellor, MD^{4,5,6} ; Wei Chua, PhD^{1,2,3}; Weng Ng, PhD^{1,2,3}; Deme Karikios, PhD^{7,8} ; Bethan Richards, PhD^{9,10} ; and Jia Liu, PhD^{5,7,11} 

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ABSTRACT

PURPOSE Mentorship has a positive influence on trainee skills and well-being. A 2022 Pilot Mentorship Program in New South Wales involving 40 participants revealed high burnout rates in Medical Oncology trainees. As part of an Australia-wide inaugural National Oncology Mentorship Program in 2023 (NOMP23), a national survey was undertaken to assess the prevalence of burnout, anxiety, depression, professional fulfilment, and drivers of distress in the Australian medical oncology workforce.

METHODS NOMP23 is a 1-year prospective cohort study that recruited medical oncology trainees and consultants using e-mail correspondence between February and March 2023. Each participant completed a baseline survey which included the Maslach Burnout Index (MBI), Stanford Professional Fulfilment Index, and Patient Health Questionnaire-4 for anxiety and depression.

RESULTS One hundred and twelve participants (56 mentors, 56 mentees) were enrolled in NOMP23, of which 86 (77%) completed the baseline survey. MBI results at baseline demonstrated that 77% of consultants and 82% of trainees experienced burnout in the past 12 months. Professional fulfilment was noted to be <5% in our cohort. Screening rates of anxiety and depression in trainees were 32% and 16%, respectively, compared with 7% and 2% for consultants. When assessing reasons for workplace stress, two thirds stated that heavy patient load contributed to stress, while almost three quarters attributed a heavy administrative load. Lack of supervision was a key stressor for trainees (39%), as was lack of support from the training college (58%).

CONCLUSION Trainees and consultant medical oncologists demonstrate high rates of burnout and low professional fulfilment. The NOMP23 program has identified a number of key stress factors driving burnout and demonstrated concerning levels of anxiety and depression. Ongoing mentorship and other well-being initiatives are needed to address these issues.

ACCOMPANYING CONTENT

 [Data Supplement](#)

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HIGHLIGHTS

- Burnout rates in the Australian medical workforce are known to be concerning high.
- Factors driving this and interventions to improve the situation are lacking.
- To our knowledge, our study is the largest Australian study to evaluate the prevalence of burnout.
- Our study provides unique insights into the factors contributing to this.
- All specialties should screen for burnout and consider the implementation of formal strategies to tackle this.

INTRODUCTION

The increasing prevalence of burnout is well-recognized as a concerning issue within medicine. Occurring in all specialties and across all levels of training and experience, addressing the issue of burnout requires urgent attention to maintain the sustainability of the profession.¹ Burnout is a syndrome resulting from inappropriately managed chronic workplace stress leading to emotional exhaustion, depersonalization or cynicism, and a sense of professional ineffectiveness.² Burnout is linked to decreased job satisfaction, career regret,³ physician turnover,⁴ poor-quality care,⁵ and increased

CONTEXT

Key Objective

The National Oncology Mentorship Program (2023) was designed to use mentorship as a tool to tackle burnout. Using this program, we assessed for baseline levels of burnout and the stress factors that drove this in the Australian setting.

Knowledge Generated

We demonstrated that burnout rates in the oncology workforce are high and the reasons for this are multifactorial. We demonstrated that stress factors are different for trainees compared with consultants, highlighting the need for targeted interventions. We also demonstrated low levels of professional fulfillment and concerning levels of anxiety and depression in trainees.

Relevance

These data form the framework to implement interventions to tackle burnout. Using key strategies such as mentorship, we will assess the usefulness of national programs. The Medical Oncology Group of Australia National Well-being committee is committed to initiating interventions to tackle key stress factors to improve professional fulfillment and mental health for Australian oncologists and trainees.

medical errors.^{6,7} A recent systematic review and meta-analysis found that physician burnout was associated with two-fold increased patient safety incidents and increased patient dissatisfaction.³

Up to 50% of Australian cancer care workers have been reported to have high levels of emotional exhaustion.⁸ One of the primary contributors to burnout in medical oncology is the nature of the work itself. Medical oncologists frequently witness the suffering and mortality associated with cancer, leading to emotional strain and compassion fatigue.¹ Engaging in difficult conversations about prognosis, treatment options, and end-of-life care can take a substantial emotional toll, resulting in decreased empathy and emotional detachment. In addition, the ever-changing landscape of research means that there is a large breadth of information to be up to date on and can contribute to the stress experienced by oncologists.

In addition to this, quantifying burnout can be difficult because of variability in definition and assessment. Historically, most studies have used the Maslach Burnout Index (MBI), a 22-item survey which uses three subscale domains to evaluate burnout (emotional exhaustion, depersonalization, low personal accomplishment). Because of limitations in the MBI, in recent times, several other burnout outcome measurement tools have been developed.^{2,9}

The aim of the current study is to describe the prevalence of burnout, anxiety, and distress in a cohort of medical oncology trainees and consultants recruited to the inaugural Australian-wide National Oncology Mentorship Program (NOMP23) which commenced in February 2023. This program was based on the results of the 2022 New South Wales Pilot Program.¹⁰ It demonstrated that burnout rates were high among the 40 participants with 93% of trainees and

54% of consultants classified as experiencing burnout using the MBI. Through NOMP23, we examined rates of burnout, anxiety, depression, and factors contributing to these in medical oncology trainees and physicians across Australia. Secondary objectives including correlation between demographics and work factors with rates of burnout and depression were also assessed.

METHODS

In 2023, the Medical Oncology Group of Australia (MOGA) endorsed NOMP23, a single-arm multicenter longitudinal study whose primary aim was to implement the national mentorship program for medical oncology advanced trainees and to evaluate its impact on rates of burnout. The project was launched in February 2023 after ethics approval from the St Vincent's Hospital Human Research Ethics Committee (Approval: 2022/ETH02399). Inclusion criteria for mentees were that they needed to be incoming or current medical oncology advanced trainees in 2023 or junior fellows within 5 years of being awarded fellowship of the Royal Australasian College of Physicians (RACP). The inclusion criteria for mentors included current specialist employment in either a public or private setting.

Recruitment was completed through e-mail correspondence via MOGA, social media, and snowballing techniques. All participants completed a baseline survey, which detailed their demographics, state of practice and nature of employment, clinical and research interest, and their reasons for joining the program (Data Supplement, online only). After the initial match, a virtual orientation session was conducted to outline the program goals and an anonymous baseline burnout survey was completed (Table 1, Data Supplement). This survey incorporated the MBI, Stanford Professional Fulfillment Index (SPFI), Patient Health

TABLE 1. Baseline Characteristics

Characteristic	Mentee	Mentor	P
No.	56	56	
Survey completion, No. (%)	43 (77)	43 (77)	
Age, years (median)	33	42	<.01*
Sex, No. (%)			
Male	13 (30)	19 (44)	.32
Female	27 (63)	23 (54)	
Not disclosed	3 (7)	1 (2)	
Relationship status, No. (%)			
Single	7 (16)	4 (10)	.36
Partner/de-facto	36 (84)	39 (90)	
Regular general practitioner, No. (%)			
Yes	32 (74)	39 (90)	.14
No	11 (26)	4 (10)	
Last GP visit, No. (%)			
<6 months ago	26 (61)	23 (53)	.49
>6 months ago	17 (39)	20 (47)	
Full-time equivalent, No. (%)			
1.0	27 (63)	25 (58)	.01*
0.5-1.0	8 (18)	18 (42)	
<0.5	6 (14)	0 (0)	
Work hours/week, No. (%)			
>50	15 (34)	10 (23)	.26
40-50	17 (39)	21 (49)	
<40	11 (26)	12 (28)	
Annual leave taken in 2022, weeks, No. (%)			
≥4	14 (32)	15 (35)	.77
<4	29 (68)	28 (65)	
Lunches eaten per week, No. (%)			
≥4	30 (71)	29 (67)	.97
<4	13 (29)	14 (33)	
Hours slept each night, No. (%)			
≥8	18 (42)	17 (40)	.92
7-8	18 (42)	21 (49)	
<7	7 (16)	5 (11)	
Regret oncology subspecialization?, No. (%)			
Yes	17 (40)	9 (26)	.05*
No	26 (60)	32 (74)	
Regret medicine as a career?, No. (%)			
Yes	21 (49)	7 (16)	.05*
No	21 (49)	36 (84)	
Not answered	1 (2)	0 (0)	

NOTE. * indicates statistically significant.

Abbreviation: GP, general practitioner.

Questionnaire-4 (PHQ4 screening for anxiety and depression), and questions related to factors contributing to workplace stress. The MBI is a 22-item tool that assesses burnout on three domains—depersonalization, personal achievement, and emotional exhaustion. Either a score over 10 in depersonalization, a score <33 in personal achievement, or a score over 27 in emotional exhaustion classifies an individual as burnt out. A high score in any one of the three

domains is required for an individual to be classified with burnout.¹¹ The SPFI is a 16-item index that assesses both burnout and professional fulfillment.¹² The SPFI requires a score of >18 of a possible 24 to be classified as having high professional fulfillment. The PHQ4 tool uses two questions to screen for anxiety and two questions to screen for depression. A score of over two in each domain is required to be classified with either anxiety or depression. Comparison between mentor and mentee results was performed using chi-square analysis of median scores, whereas Student's *t*-test was used to assess between dichotomous and continuous variables. All statistical analyses were completed using R4.1.1. A schematic outline of the project is presented in [Figure 1](#).

RESULTS

Participant Demographics

Among the 112 participants, 86 (43 mentees, 43 mentors) completed a voluntary baseline burnout survey. The median age of the mentors was 42 years (33-61 years) compared with 33 years (29-39 years) for the mentees. The majority of participants in both the mentee and mentor group identified as female (63% and 54%, respectively). A majority of trainees (*n* = 30, 54%) were in their second or more year of advanced training, with New South Wales and Victoria accounting for most of the trainees recruited (*n* = 21, 38% and *n* = 20, 36%, respectively). Similarly, a majority of mentors were also from either New South Wales or Victoria (*n* = 19, 33% and *n* = 20, 36%, respectively). Full baseline demographics are summarized in [Table 1](#).

Burnout Rates and Contributing Factors

The MBI results demonstrated that 77% of mentors and 82% of mentees had experienced burnout in the past 12 months. Mentees scored worse than mentors in each of the three domains. The median personal accomplishment score was 37 for mentees and 38 for mentors (*P* = .26), with a score of <33 suggesting high burnout. The median depersonalization score was 19 for mentees and 13 for mentors (*P* = .82), with a score of >10 indicative of high burnout. The median emotional exhaustion score was 19 for mentees and 14 for mentors (0.52), with a score >27 suggestive of burnout. Six of 43 (14%) mentees had high levels of burnout in all three domains of the MBI, compared with 1 of 43 (2%) mentors. Full MBI results are summarized in [Figure 2](#) and [Table 2](#). Age, hours worked per week, presence or interaction with a general practitioner, and hours of sleep did not independently statistically correlate with high rates of burnout.

Professional Fulfillment, Anxiety, and Depression

Using the SPFI, 0% of mentees had a high level of professional fulfillment compared with 5% of mentors. A score of 18 on the SPFI is classified as high professional fulfillment. The median score of mentees was 13 (5-17), and that of

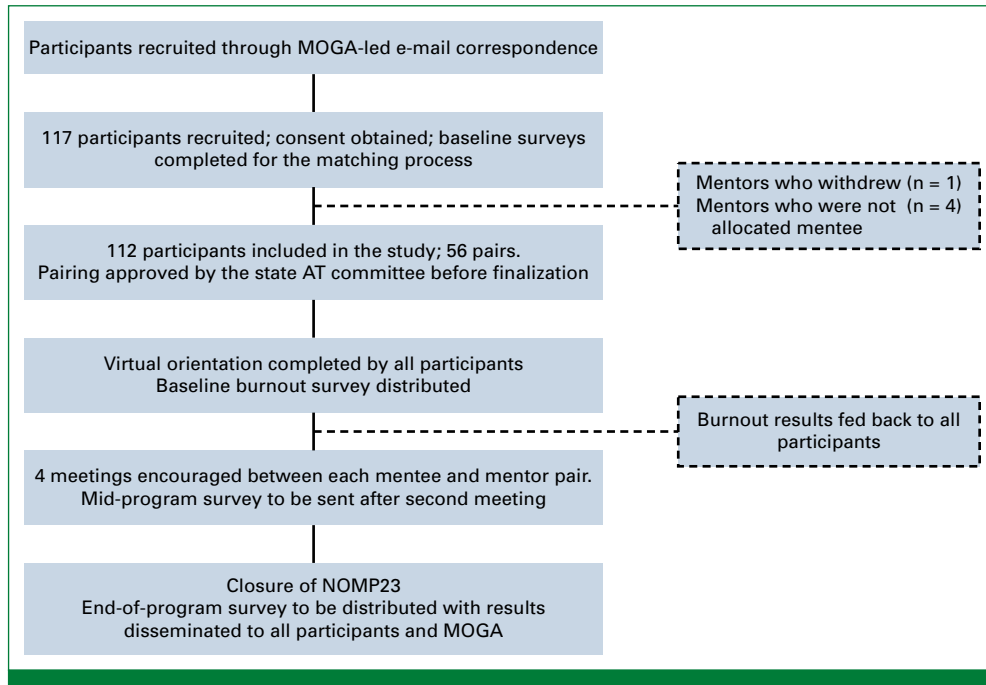


FIG 1. National oncology mentorship program schema. All participants completed the baseline surveys for the matching process. After the initial match, two pairs required rematching because of the direct line of supervision. One mentee withdrew from the program before the first meeting, whereas two mentees had to be reallocated mentors because of external factors. One mentor withdrew from the program before first meeting. Four mentors were unable to be allocated a mentee as part of the NOMP23 program. AT, advanced trainee; MOGA, Medical Oncology Group of Australia; NOMP23, National Oncology Mentorship Program in 2023.

mentors was 12 (6–18). Among mentees, 49% experienced regret with medicine as a career choice and 40% had regret toward choosing oncology subspecialization. These rates were lower in the mentor group, with 16% and 21% experiencing regret toward medicine and oncology subspecialization, respectively ($X^2 [6, n = 81] = 12.9, P = .05$).

Using the PHQ4, in mentees, rates of anxiety and depression were 32% and 16%, respectively, compared with 7% and 2% for mentors ($P < .01$). All participants who reported anxiety and/or depression also experienced burnout via the MBI. By contrast, participants who were classified as not experiencing burnout showed 0% rates of both anxiety and depression ($P < .01$). These results are summarized in [Table 2](#).

Factors Contributing to Stress in the Workplace

The baseline survey also explored factors contributing to stress and burnout ([Fig 3](#) and [Table 3](#)). For mentees, heavy administrative load (84%), lack of sleep (79%), low self-confidence (76%), and job security (74%) were the most commonly identified causes of stress. For mentors, bureaucratic processes (88%), heavy administrative load (72%), time spent in meetings (72%), and distressing patient cases caused the most stress (67%). Of note, lack of supervision was a key stressor for mentees, reported in 39%, as was lack of support from the college, reported in 58%.

Lack of time to exercise was also a key stress factor reported in 71% of mentees and 63% of mentors. Bullying and poor workplace interactions were low for both mentors and mentees, reported in approximately 10% of respondents.

Eighteen (16%) respondents reported that they made a mistake within the past 12 months that directly resulted in patient harm. Sixteen (89%) of these respondents scored as burnout using the MBI. Overall, 24% of burnt-out participants reported medical error that resulted in patient harm compared with 11% of participants who were not burnt out ($P = .21$). In addition, of the total cohort, 47 (42%) made at least one medication mistake, whereas 39 (35%) made at least one laboratory or imaging mistake in the past 12 months.

DISCUSSION

The NOMP23 baseline survey found high levels of burnout among Australian medical oncology trainees and consultants (82% and 77%, respectively). This rate is similar, if not higher, than what was reported in health care workers across Australia, with documented rates reaching 70% during the COVID-19 pandemic.¹³ Very few participants had a high level of professional fulfillment, with many regretting their choice of profession. This result is unsurprising given the correlation of burnout with job satisfaction.¹⁴ Our findings on

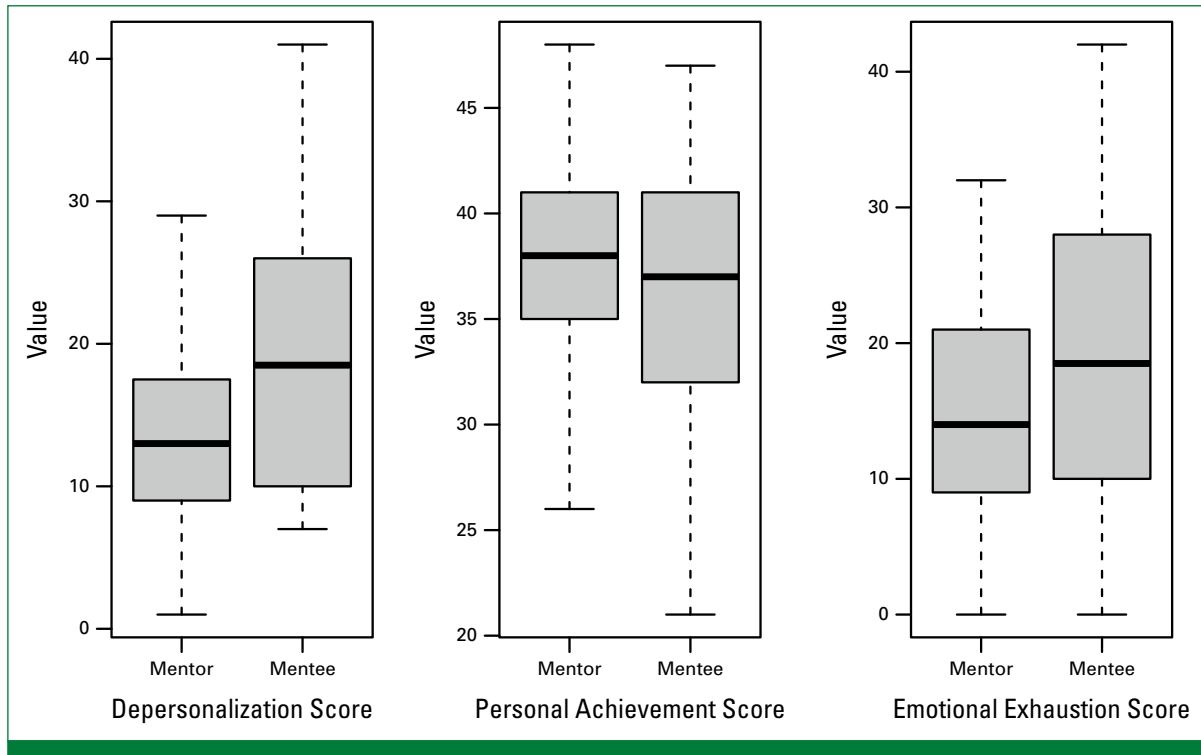


FIG 2. MBI scores. MBI is a 22-item assessment encompassing three domains of depersonalization, personal accomplishment, and emotional exhaustion. Burnout is classified if a participant scores high in any of the three subdomains. Depersonalization scores over 10 indicate high burnout, with median scores in mentees being 19 versus 13 in mentors ($P = .82$). Personal achievement scores under 33 indicate high burnout, with median scores in mentees being 37 versus 38 in mentors ($P = .26$). Emotional exhaustion scores over 27 indicate high burnout, with median scores in mentees being 19 versus 14 in mentors ($P = .52$). Overall, 82% of mentees and 77% of mentors experienced burnout with the MBI assessment. MBI, Maslach Burnout Index.

the prevalence of burnout in medical oncologists in Australia echo data from various countries.¹⁵⁻¹⁷ ASCO found that 44.7% of American Oncologists display at least one symptom of

burnout,⁶ and the European Society for Medical Oncology (ESMO) Young Oncologists Committee found that 71% of those surveyed responded similarly.¹⁸

TABLE 2. Baseline Burnout Results

Parameter	Mentee	Mentor	<i>P</i>
No.	56	56	
Survey completion, No. (%)	43 (77)	43 (77)	
Maslach Burnout Index			
Median personal accomplishment score	37	38	.26
Median depersonalization score	19	13	.82
Median emotional exhaustion score	19	14	.52
Overall burnout identification rate, No. (%)	35 (82)	33 (77)	.99
Stanford Professional Fulfillment Index			
Median fulfillment score	13	12	.82
Overall high professional fulfillment rate, No. (%)	0 (0)	2 (5)	.64
PHQ4			
Median total PHQ4 score	2	3	.62
Overall anxiety identification rate, No. (%)	14 (32%)	3 (7%)	<.01*
Overall depression identification rate, No. (%)	7 (16)	1 (2)	<.01*

NOTE. * indicates statistically significant.

Abbreviation: PHQ4, Patient Health Questionnaire-4.

Notably, the measurement of burnout can be variable in individual studies despite widespread use of the MBI. For example, Shanafelt et al used a definition of burnout that was limited to high scores on the emotional exhaustion and depersonalization subscales only. Personal accomplishment was reported but not included in the definition of the overall rate of burnout.⁶ Kust et al and Banerjee et al, however, used a burnout definition that included all three domains of the MBI and interestingly showed similar rates of burnout to our study.^{11,17}

Burnout is dangerous for doctors as it is associated with high rates of suicide and increased risk of medical comorbidities that reduce life expectancy. Furthermore, it can be dangerous for patients as well. A recent systematic review found that doctors with burnout were twice likely to provide unsafe care and doubled the odds of major medical errors.¹⁹ Our data also reflect this concern as well where 24% of respondents who classified as burnt out reported that they had made a mistake in the past 12 months that directly led to patient harm compared with 11% of those who were not burnt out. Reducing burnout by even a single point has been associated

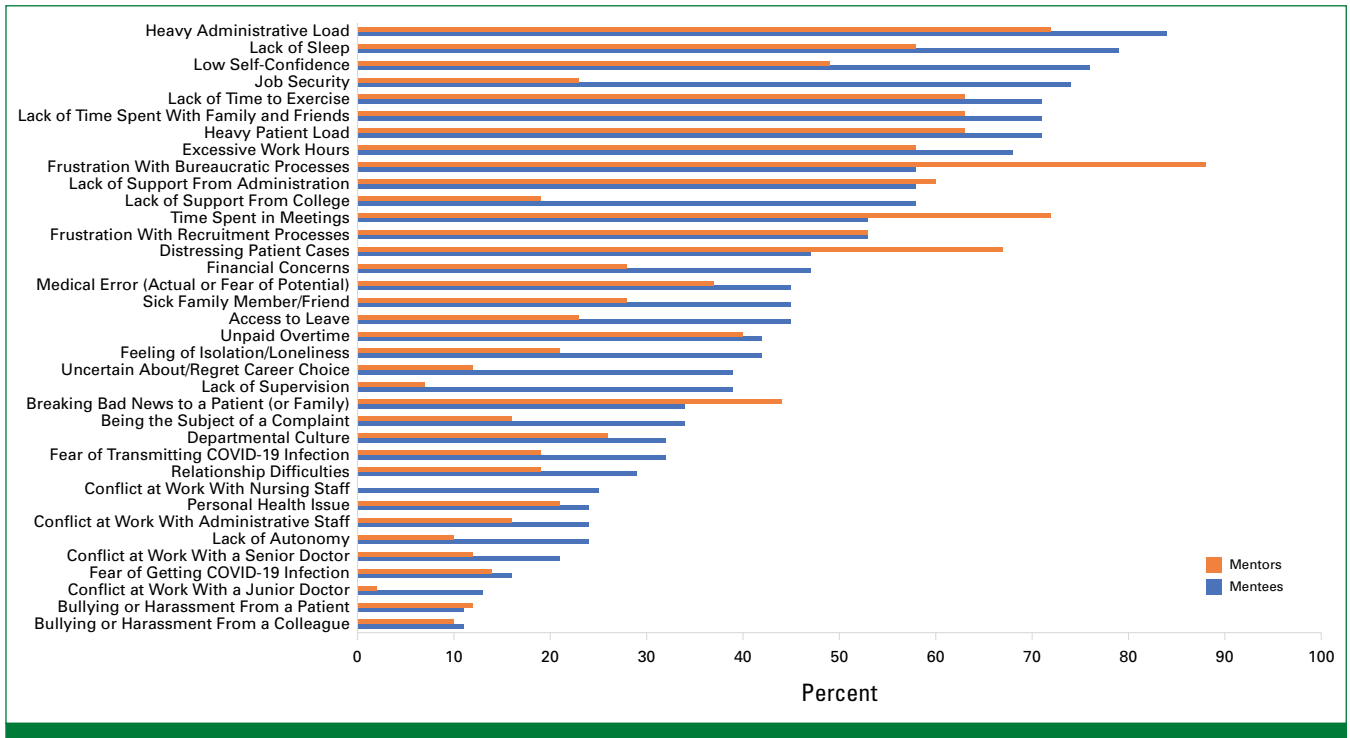


FIG 3. Identification of recent stress factors leading to burnout.

with a reduction in adverse patient outcomes.⁷ Furthermore, there is a clear association between burnout, anxiety, and depression. Whether anxiety and depression drive burnout or are a result of it is unclear. Further assistance and systems approach to provide services and help for those who are suffering as a result of their mental health are crucial to addressing burnout.

The most cited stressors identified by NOMP23 participants were heavy patient and administrative loads (Fig 2). This is consistent with many other studies which have identified inefficient work processes, clerical burden, and heavy work hours as key drivers of burnout.⁷ Both individual-specific challenges (self-confidence, distressing cases) and system-wide issues (administrative load, patient load) caused high levels of stress. Furthermore, it is likely that the subsequent time paucity led to a reduction in protective measures (sleep, exercise, recreational time with support network) exacerbating burnout. Trainees also specifically identified job security and future professional endeavors as other stressors, as well as a perceived lack of supervision and support from training colleges. From the MBI results, depersonalization appears to be the major driver for burnout, which may reflect the unique nature of the oncology workforce. Other burnout reviews have not demonstrated such high rates of depersonalization, with emotional exhaustion being a key driver.^{6,9,16} Our data may reflect the need for an individualized approach to burnout in oncology, where the workforce may be more prone to depersonalization perhaps as a result of distressing patient cases and the nature of the

subspecialization itself. Resilience training, debriefing, systemic interventions to tackle this at local institutional, and recognition of this from state and national bodies are essential to ensure that trainees feel that they are working safely in their clinical settings.

Various interventions have shown effectiveness in reducing burnout, with most focusing on individual rather than structural or organizational changes, presumably because of the relative ease in implementing such programs. On an individual-focused level, counseling, mindfulness-based programs, and small support groups have been shown to improve rates of burnout in physicians.^{7,20} Of note, this effect is even seen with fairly short interventions with a Norwegian study showing that attending a 1-day counseling session (with a psychiatrist or occupational health specialist) significantly reduced emotional exhaustion at 1 year.²¹ Interestingly, during the COVID-19 pandemic, it was found that even a perception of organizational support could reduce the risk of burnout, emphasizing the importance of top-lead ventures, for example, by specialty bodies and training colleges, in helping alleviate burnout.²² This concept forms the basis of the NOMP23 program given its formal endorsement by the MOGA. It serves a top-led structural initiative that focuses on communication and collegiality as a way to affect burnout rates. This is especially important, given that structural interventions have shown more effectiveness than individual-focused strategies in reducing overall burnout. In addition to supportive interventions, other measures have included staffing changes and

TABLE 3. Identification of Recent Stress Factors Leading to Burnout

Parameter	Mentee (n = 56), No. (%)	Mentor (n = 56), No. (%)	P
Survey completion	43 (77)	43 (77)	
Heavy patient load	31 (72)	27 (63)	.58
Heavy administrative load	36 (84)	31 (72)	.19
Excessive work hours	29 (67)	25 (58)	.37
Time spent in meetings	23 (53)	31 (72)	.11
Distressing patient cases	20 (47)	29 (67)	.11
Fear of getting COVID-19 infection	7 (16)	6 (14)	.99
Fear of transmitting COVID-19 infection	14 (33)	8 (19)	.28
Breaking bad news to a patient (or family)	15 (35)	19 (44)	.49
Medical error (actual or fear of potential)	19 (44)	16 (37)	.64
Being the subject of a complaint	15 (35)	7 (16)	.11
Lack of supervision	17 (40)	3 (7)	<.01*
Lack of support from administration	25 (58)	26 (60)	.99
Lack of support from the college	25 (58)	8 (19)	<.01*
Lack of autonomy	10 (23)	4 (10)	.14
Departmental culture	14 (33)	11 (26)	.72
Unpaid overtime	18 (42)	17 (40)	.99
Frustration with bureaucratic processes	25 (58)	38 (88)	<.01*
Frustration with recruitment processes	23 (53)	23 (53)	.99
Uncertain about/regret career choice	17 (40)	5 (12)	<.01*
Job security	32 (74)	10 (23)	<.01*
Bullying or harassment from a colleague	5 (12)	4 (10)	.99
Bullying or harassment from a patient	5 (12)	5 (12)	.99
Conflict at work with a senior doctor	9 (21)	5 (12)	.40
Conflict at work with a junior doctor	6 (14)	1 (2)	.15
Conflict at work with nursing staff	6 (14)	0 (0)	.04*
Conflict at work with administrative staff	11 (26)	7 (16)	.58
Lack of sleep	34 (79)	25 (58)	.07
Lack of time spent with family and friends	31 (72)	27 (63)	.58
Lack of time to exercise	31 (72)	27 (63)	.58
Access to leave	19 (44)	10 (23)	.07
Feeling of isolation/loneliness	18 (42)	9 (21)	.08
Low self-confidence	33 (77)	21 (49)	.02*
Financial concerns	20 (47)	12 (28)	.11
Personal health issue	10 (23)	9 (21)	.99
Sick family member/friend	19 (44)	12 (28)	.56
Relationship difficulties	12 (28)	8 (19)	.21

NOTE. * indicates statistically significant.

modifications to clinical work processes.^{7,20} Unfortunately, many studies have small sample sizes and cover diverse populations, which can make generalizable conclusions difficult with studies not always demonstrating consistent results.²⁰ It is likely that interventions have different efficacies in different subsets of populations. Given this, our survey has also been able to demonstrate key drivers for burnout, as discussed previously. These data are unique in the Australian context and provide the framework for key stakeholders at local, state, and national levels to reflect on

practices and interventions that can be used to improve burnout and professional fulfillment as this is integral to the long-term sustainability of the workforce.

In oncology, a recent scoping review showed that psychosocial education training and conducive working environments led to a decreased risk of depersonalization, which was a major driver for burnout in the current study.¹⁴ Emotional exhaustion has been shown to be reduced by structured education and meetings.²³ Strategies such as

cultivating positive relationships, providing institutional wellness resources, and mindfulness practices have also been recommended. Recognizing the impact of burnout, ASCO and ESMO have recently made several recommendations for addressing burnout in oncology including broadening clinical education resources, regularly assessing burnout in oncology practices, and promoting evidence development.¹⁸ ESMO, in particular, has also launched the Resilience Task Force¹⁸ to help understand risk factors and potential interventions and to develop solutions that support the welfare of the oncology community.

Mentorship is known to be a key driver of physician well-being and is regarded as an integral part of medical training.²⁴ Mentoring provides an opportunity for the sharing experiences from senior colleagues toward trainees. Therein, trainees are able to absorb real-world experience anecdotally while also learning from the mentor's skill and knowledge.²⁴ Mentors are role models who also act as guides for trainee's personal and professional development. Importantly, mentors can enhance implicit knowledge about the hidden curriculum of professionalism, ethics, values, and the art of medicine not learned from texts. In many cases, mentors also provide emotional support and encouragement.²⁵ Mentorship is also known to benefit mentors as well through greater productivity, career satisfaction, and personal gratification.^{25,26} Given the importance of mentorship, ASCO has inbuilt multiple mentorship programs as part of its core structure. As of 2023, four subdomains of mentorship opportunities have been included: global mentoring, virtual mentoring, diversity mentoring, and topical mentoring. Using this knowledge and the high rates of burnout and low rates of professional fulfillment, the NOMP23 program is aimed to tackle burnout using mentorship as a key intervention. Through the NOMP23 program, not only will the direct impact of mentorship be assessed on burnout, but qualitative data regarding strengths and weaknesses will also be determined to help top-led institutional interventions for overall well-

being programs. The identified stressors from our baseline data will be actively reviewed throughout the mentorship program with end-of-program qualitative and quantitative surveys to assess how the program assists in addressing contributors to burnout and tailoring the program to the needs of the participants in 2024 and beyond. This will be published in a subsequent end-of-program study.

To our knowledge, our NOMP23 program survey is the largest performed in the Australian Medical Oncology cohort assessing burnout, professional fulfillment, and key stressors that are affecting the workforce. It has continued to demonstrate the high prevalence of poor professional fulfillment and its negative impact on patient care. It has also demonstrated that burnout is correlated with anxiety, depression, and medical error. A key limitation in our study is the selection bias as part of participant recruitment. It is likely that those who have signed up to the program are increasingly motivated to seek mentorship and thus may not reflect the true workforce. Hence, our study likely underestimates the true prevalence severity of burnout and distress. A quality improvement for NOMP 2024 will be to aim recruit all incoming first-year trainees to the program and reach out to more senior trainees as well, encouraging their participation by demonstrating the success of the inaugural national pilot.

In conclusion, the results of the NOMP23 survey confirm burnout as a significant issue for Australian Medical Oncology. Many studies have investigated the impact of burnout, and the NOMP23 program aims to tackle this issue at a national level. A multifaceted and holistic approach is required to target systemic burnout, with mentorship being one intervention that can make a difference. Through mentorship, the NOMP23 program is hoping to foster communication between trainees and senior colleagues. Our program will form part of multiple MOGA-sponsored well-being initiatives in the future.

AFFILIATIONS

¹Department of Medical Oncology, Liverpool Hospital, Liverpool, Australia

²School of Medicine, Western Sydney University, Sydney, Australia

³Ingham Institute for Applied Medical Research, Liverpool, Australia

⁴Department of Medical Oncology, Chris O'Brien Lifehouse, Sydney, Australia

⁵Garvan Institute of Applied Medical Research, Sydney, Australia

⁶School of Medicine and Health, University of New South Wales, Sydney, Australia

⁷School of Medicine, University of Sydney, Sydney, Australia

⁸Department of Medical Oncology, Nepean Hospital, Sydney, Australia

⁹Department of Rheumatology, Royal Prince Alfred Hospital, Sydney, Australia

¹⁰Institute of Musculoskeletal Health, Sydney Local Health District, Sydney, Australia

¹¹The Kinghorn Cancer Centre, St Vincent's Hospital, Sydney Australia

CORRESPONDING AUTHOR

Udit Nindra, MD, Liverpool Hospital Cancer Therapy Centre, Cnr Elizabeth & Goulburn St, Liverpool, NSW 2170, Australia; e-mail: udit.nindra@health.nsw.gov.au.

AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

Disclosures provided by the authors are available with this article at DOI <https://doi.org/10.1200/OP.23.00469>.

DATA SHARING STATEMENT

The data sets for this manuscript are not publicly available, but requests to access the data sets should be directed to Udit Nindra (udit.nindra@health.nsw.gov.au).

AUTHOR CONTRIBUTIONS

Conception and design: All authors

Provision of study materials or patients: Jia Liu

Collection and assembly of data: Udit Nindra, Jia Liu

Data analysis and interpretation: Udit Nindra, Gowri Shivasabesan, Wei

Chua, Weng Ng, Deme Karikios, Bethan Richards, Jia Liu

Manuscript writing: All authors

Final approval of manuscript: All authors

Accountable for all aspects of the work: All authors

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AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

Evaluating Systemic Burnout in Medical Oncology Through a National Oncology Mentorship Program

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Open Payments is a public database containing information reported by companies about payments made to US-licensed physicians ([Open Payments](#)).

Rhiannon Mellor

Travel, Accommodations, Expenses: MSD

Deme Karikios

Honoraria: MSD, MSD, Amgen, AbbVie

Consulting or Advisory Role: MSD

Travel, Accommodations, Expenses: MSD

Jia Liu

Honoraria: MSD, Specialised Therapeutics

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