The Forgotten Team Member: Meeting the Needs of Oncology Support Staff

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Key Words. Patient care team • Cancer care unit • Burnout • Stress • Staff attitude • Job satisfaction

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LEARNING OBJECTIVES

After completing this course, the reader will be able to:

1. Assess the impact of oncology care on nonlicensed support staff.
2. Identify four areas that challenge support staff caring for oncology patients.
3. Evaluate the impact of burnout and job satisfaction on support staff caring for oncology patients.

ABSTRACT

Introduction. The impact of working in an oncology setting has been widely researched for physicians, nurses, social workers, and chaplains. The experiences of nonlicensed support staff in an oncology setting have rarely been acknowledged or addressed. Few studies have addressed support or education initiatives for support staff caring for oncology patients. The intent of this study was to understand the work experiences of oncology support staff. Emotional impact, patient relationships, and team relationships were addressed. These data would help shape the development of an oncology support staff program.

Methods. A qualitative and quantitative approach was used to explore the experiences of support staff. Seven focus groups and individual interviews were conducted addressing work life in a cancer center. The quantitative survey collected baseline data on job satisfaction, working relationships, patient relationships, burnout, and support programs.

Results. Four predominant themes emerged from the focus groups. These included: relationships with patients and families, coping with death and dying, value and recognition, and balancing function with emotion. The quantitative survey reported the highest satisfaction with patient relationships and the lowest satisfaction with job recognition and supervisor support. High personal accomplishment scores declined with duration of employment. Educational grand rounds were a high interest.

Discussion. This study provides insight into the im-

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INTRODUCTION

Cancer patients have complex medical and psychosocial needs. Caring for these patients may present both challenges and rewards for the entire oncology team. As traditionally configured, the team that serves the oncology patient includes professional staff: doctors, nurses, social workers, chaplains, and other allied health professionals. The Institute of Medicine (IOM) published a report in 2001 focusing on improving quality health care. That report encourages health professionals to also consider the patient and family as integral members of the health care team. Many researchers have addressed the six pillars of quality care—safe, effective, patient-centered, efficient, equitable, and timely—and the importance of teamwork as a crucial element of achieving success in these dimensions [1]. Rarely mentioned as part of the team, however, are nonlicensed personnel, or support staff. These personnel are frontline staff that are often the first link a patient has to the team of oncology professionals, providing a range of critical services that can shape the patient and professional experience of cancer care.

Although the impact of working in an oncology setting has been researched and described over the past 30 years for physicians, nurses, social workers, and chaplains, the experiences of nonlicensed or support staff who also work in the same oncology settings have not been addressed [2–4]. In fact, understanding the impact of caring for cancer patients and the impact of the daily work life of support staff has rarely been acknowledged, described, or researched in the literature.

The terms “support staff” and “nonlicensed staff” refer to a variety of roles that may include secretaries, front desk staff, medical assistants, nursing assistants, phlebotomists, office assistants, or telephone operators. Support staff are critical to making patient referrals, assuring timely appointments, scheduling admissions, procedures, tests, and treatments, greeting patients, answering phone calls, and assisting with financial and insurance issues. In assessing the performance of staff in these very task-oriented roles, supervisors and health professionals may have a tendency to focus on tasks accomplished, rather than on the nature of the staff members’ interactions with patients and families. Building relationships with patients is a valued component in oncology care. Many support staff develop ongoing relationships with patients and families during the course of treatment and care in the oncology setting. The nature of support staff’s work frequently brings them into direct contact with patients throughout their work day. Support staff’s interactions can positively impact a patient’s care. A welcoming smile, a painless blood draw, or listening to a patient’s fears and concerns adds value to quality care, which impacts the patient’s experience and satisfaction with his or her care. Patient satisfaction with services provided by support staff is frequently assessed in routine surveys of patient experience and satisfaction [5–8].

In an oncology setting, all staff members work in the presence of patients and families dealing with a life-threatening disease every day. The emotional impact of this work on all staff must be recognized if institutions hope to minimize turnover, and maximize high-quality care to patients and families. While an extensive literature addresses the work experience of licensed health professionals, including the work environment, work relationships, and the prevalence of stress and burnout, only infrequently have these issues been addressed in the health or medical literature with reference to support staff [3, 9–11]. Similarly, few studies have addressed the development of training, support, and education initiatives targeted at improving the sense of community and degree of coping skills in this population [12, 13].

During the period 2004–2005, several events in our work environment highlighted the importance of addressing the experiences of support staff in our academic cancer center. Support staff were sharing many anecdotal stories about difficult interactions they had with patients and families. They were also seeking out help and guidance as to how to deal with these difficult situations. Existing programs in place in our center address the emotional needs of professional staff [14]. These professional rounds do not generally include support staff, yet nurse and clinical social work leadership identified staff with similar issues of grief and work stress. The present study reports on our experience in developing a training, education, and support program for support staff that care for and provide service to oncology patients in our cancer center in Boston, Massachusetts over the period from 2004 to the present. We describe a formal needs assessment, including informal personal discussions and focus groups, and a baseline survey of the support staff prior to the advent of our Support Staff Development Program. The intent of this study was to

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better understand the work experiences of the support staff, focusing on the emotional impact of their work and relationships with patients and other team members. We also sought to make a formal assessment of burnout in this population, and to gather data that would shape the development of programs for this population.

**METHODS**

We combined qualitative and quantitative approaches to explore and understand the experience of support staff working in the outpatient setting of a large, urban, academic, hospital-based cancer center. In 2004–2005, we conducted individual interviews and focus group discussions with support staff about work life in the cancer center. A quantitative survey was conducted to collect baseline data on job satisfaction and working relationships as well as to assess burnout among support staff members. Support staff included in both the qualitative and quantitative approach were medical assistants, phlebotomists, patient service coordinators or secretaries, telephone coordinators, front desk staff, and office assistants.

**2004–2005 Baseline Focus Groups**

For the baseline, seven focus groups in total were conducted over a 9-month period. Support staff were recruited through invitation by supervising practice managers. Participation was voluntary. Initially, five groups were conducted. Two additional groups were then held to extend the discussions among a smaller group of prior participants. In all, 53 support staff members participated in at least one group, 10 people within this group participated in a second group.

Groups were scheduled at a time and location that was convenient for staff, and staffing coverage was arranged to facilitate attendance. The groups were facilitated by an oncology social worker on our team who had 16 years of experience facilitating groups. Groups lasted for 75 minutes. The first 15 minutes consisted of casual conversation and a light breakfast. The formal discussion lasted 60 minutes. Ground rules were set for these discussions, asking participants to maintain confidentiality both within and after the group, be good listeners, and demonstrate mutual respect for each other.

The initial five discussion groups centered on four questions: (a) What are the positive aspects of your work? (b) What are the difficult aspects of your work? (c) What do you do to take care of yourself? and (d) What are your suggestions for a supportive work environment? The follow-up groups had additional questions: (e) Has attending the prior group had any impact? (f) What was it like to leave the last group and go back to work? and (g) What are the next steps to start a program? The discussion itself was open-ended, which allowed for a rich exploration of all these questions.

All groups were recorded with the consent of participants. Documentation of verbatim comments and quotations was accomplished by one researcher on the team who observed and took detailed notes at all seven focus groups. A content analysis of these comments provided a summary of the key issues and themes.

**2005 Baseline Survey of Cancer Center Support Staff**

A self-administered paper survey was distributed to support staff members in the cancer center in 2005 over a 1-month period from June 2, 2005 to June 30, 2005. No single job classification was sufficient in size for subgroup analysis and reporting. Of the 137 surveys that were distributed, 76 were received completed (55% response rate). The survey instrument was developed by the research team in consultation with staff, practice managers, clinicians, and employee assistance program professionals. The content was designed to correspond to the themes emerging from the focus groups. Survey questions included metrics of job satisfaction, including satisfaction with work relationships and interactions with patients. Measures of job satisfaction and work relationships were drawn from existing health worker surveys [15]. Also included were several items from the Maslach Burnout Inventory personal accomplishment and emotional exhaustion subscales [16] to assess stress and burnout among support staff members, shown in Table 1. The reliability of the personal accomplishment subscale is 0.74 and the reliability of the emotional exhaustion subscale is 0.89 [9]. Interest in staff support groups and in development programs was also assessed in the survey.

**Analysis**

For each item from the Maslach Burnout Inventory, respondents were asked to rank how often they felt this way using the following scale: 0, never; 1, a few times a year; 2, once a month or less; 3, a few times a month; 4, once a week; 5, a few times a week; and 6, every day. The personal accomplishment and emotional exhaustion scores were calculated by summing the numbers assigned to the responses indicated for both the personal accomplishment and emotional exhaustion items. These calculated scores were then categorized into low (score, 0–5), medium (score, 6–15), and high (score ≥16) groups for both personal accomplishment and emotional exhaustion. Whereas a high score for the personal accomplishment items represents a positive outcome, a high emotional exhaustion score represents a greater amount of exhaustion, and therefore represents a negative outcome.
RESULTS

Focus Groups
Content analysis of the comments from the focus groups revealed the emergence of four predominant themes in discussions by support staff of the experiences of working with patients and patient families. These four themes included relationships with patients and families, coping with death and dying, value and recognition, and balancing role function with emotional impact of the job. Additional comments about self-care activities, emotional self-care, and ideas for creating a supportive workplace environment were also recorded and analyzed.

Theme 1: Relationships with Patients and Families
Support staff members clearly recognize the importance of their relationships with the patients of the cancer center and their families. Support staff in different roles described the importance and value of these relationships with patients, families, and other staff. Staff reported that they believe they are able to help patients cope with their illness and also to provide them with education and information. One staff member noted the value of these relationships when he said: “I’m not working with dying people . . . I’m working with living people who are coming for chemo treatments . . . what we do here matters, and you can see that . . . we matter to these people and that’s what I discovered . . . this job matters.” Another staff member said that “patients really appreciate what we do . . . they make us feel wonderful.” Support staff provide comfort and support to patients and families and some reported feeling like part of the patient’s extended family. As one staff member noted, “you feel like you’ve known them all your lives.”

While members of the support staff were clear that patients and families valued their help, they consistently reported that the professional staff did not acknowledge the importance of these relationships. One staff member shared that “the doctors and nurses need to understand that what we do is important . . . they need to know how they treat us.”

Theme 2: Coping with Death and Dying
Support staff acknowledged that conversations with patients and families about death and dying were very difficult for them. They expressed the difficulty in finding the “right” words to provide comfort and often wondered if there was something they “should” be saying. One comment from a staff member was: “I still have not learned how to answer those phones when the funeral home calls . . . I still don’t know how I should handle that . . . it makes me feel like I want to cry . . . I go ‘another one has died.’”

Support staff reported repeated experiences with lack of communication about a patient’s death, and a feeling of being “out of the loop” in communications between families and professional staff. Oftentimes, the professional team would be informed of a death, but this information would not reach support staff. Support staff also reported that, while professional staff often engage in follow-up with the family of deceased patients, they do not have the same opportunity. This lack of contact caused some support staff to feel that there is no sense of closure and sadness that they are left wondering about what happens to those families with whom they have forged relationships.

Theme 3: Value and Recognition from Professional Staff
The theme of needing to feel valued and recognized in the work environment was prevalent in all focus groups. Consistent with findings about relationships, support staff reported feeling undervalued by some professional staff, notably physicians and nurse practitioners. One staff member said that the “nurse practitioners beckon to her as they sit in their office.” Another staff member shared her thoughts about her position, “I am a nobody . . . I do realize that I use the word ‘below’ when talking about my role in the pecking order of positions.”

Another staff member shared her thoughts about her position, “I am a nobody . . . I do realize that I use the word ‘below’ when talking about my role in the pecking order of positions.” Staff often expressed feelings that professional colleagues minimized the importance of relationships among patients, family members, and staff. On the other hand, they felt that patients and families did value their roles and their assistance and underscored the importance of these relationships. One staff member recalled: “[I] had a patient call [my supervi-
The four themes described here provide a sense of the challenging work environment for cancer center staff. Groups also addressed strategies for coping with these challenges and tried to elicit from participants ideas for further programs and training. Additional areas of discussion in these focus groups included their self-care activities as well as ideas for creating a supportive workplace environment. Support staff identified having self-care activities as being essential to their overall well-being. Talking with others, including coworkers and family, doing physical activities, such as going to the gym, and participating in spiritual activities, such as going to the hospital chapel, were all examples of how staff take care of themselves. They also spoke about developing other strategies in order to protect their emotional well-being. Examples included learning to establish boundaries so as not to feel “overinvolved” or finding ways to not bring the emotional burden of their work home with them at the end of the day.

In addition to ideas for self-care, ideas for creating a supportive environment at work were discussed. All participants were in agreement that a more supportive workplace needed to be developed. They presented numerous suggestions and recommendations for enhancement. These included weekly staff meetings with a focus on enhancing collaboration and communication, memorial services for patients known by staff members, complementary therapies with a focus on wellness and stress reduction for staff, support groups, educational programs, and appreciation events.

Survey Results
The quantitative survey of the staff was conducted after completion of the discussion groups and formulation of a program activity plan. The survey was designed to probe the thematic areas uncovered in the needs assessment and to test interest in programs that were being launched for support staff.

Respondent characteristics are shown in Table 2. The initial section of the questionnaire measured several aspects of work life and job satisfaction in domains that were to be addressed by program objectives. Specifically, we measured staff responses to items on overall job satisfaction, recognition for a job well done, interactions with patients, opportunities to learn new skills, and supervisor support. Responses were on a four-point scale—very satisfied, somewhat satisfied, somewhat dissatisfied, and very dissatisfied. Overall, as measured in the highest category of “very satisfied,” support staff expressed the highest satisfaction with patient relationships (66%) and the lowest satisfaction with job recognition (28%) and supervisor support (38%) (Fig. 1). Findings in the survey addressing support staff relationships provided a somewhat different picture than did the focus groups. A majority of the support staff reported very high satisfaction with work relationships with physi-
of employment, with high accomplishment scores declining with increasing duration of employment, from 55% (<2 years) to 32% (>5 years).

Support staff were asked to rate their interest in three development programs about to be introduced by the cancer center, including support groups, educational grand rounds, and brown bag lunches with the cancer center leadership. Overall, 92% of respondents were very or somewhat interested in at least one of the three proposed programs. The most interest expressed was for grand rounds (88% very or somewhat interested), followed by lunches with leadership (75%) and support groups (66%).

**DISCUSSION**

The data from the cancer center support staff reveal the complex nature of work in the oncology setting. Our staff reported high levels of job satisfaction and mostly positive working relationships, and took particular satisfaction from patient interactions. It should be noted that only one in four staff members reported being very satisfied with job recognition and only 38% reported being very satisfied with support from supervisors. While findings related to staff feelings of inadequate recognition from physicians, nurse practitioners, and supervisors emerged in the focus groups, the positive survey findings about working relationships were not as evident in group discussions. Focus group participants were a smaller subset of the staff, responding in a group dynamic format that is quite different from an anonymous survey.

Discussion from the focus groups primarily addressed the issue of staff feeling that their work is undervalued by the professional staff and that there is little acknowledgment of the importance of their relationships with patients and families. This is shown in the example of support staff “being kept out of the loop” in the communications among the professional team when a patient dies. The survey asked about their working relationship with the professional staff. The support staff may feel that they have a good working relationship in the day-to-day work but that the professional staff do not recognize or understand the importance of their relational work with patients and families.

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**Table 2. Respondent characteristics**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>% of total (n = 76)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>&lt;30</td>
<td>28</td>
</tr>
<tr>
<td>30–44</td>
<td>41</td>
</tr>
<tr>
<td>≥45</td>
<td>29</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>93</td>
</tr>
<tr>
<td>Male</td>
<td>5</td>
</tr>
<tr>
<td>Not reported</td>
<td>2</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td></td>
</tr>
<tr>
<td>White, non-Hispanic</td>
<td>62</td>
</tr>
<tr>
<td>Black</td>
<td>12</td>
</tr>
<tr>
<td>Hispanic/Latina</td>
<td>12</td>
</tr>
<tr>
<td>Not reported</td>
<td>14</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>High school, GED</td>
<td>25</td>
</tr>
<tr>
<td>Some college</td>
<td>27</td>
</tr>
<tr>
<td>College and higher</td>
<td>28</td>
</tr>
<tr>
<td>Not reported</td>
<td>20</td>
</tr>
<tr>
<td>Time at MGH Cancer Center</td>
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</tr>
<tr>
<td>&lt;2 yrs</td>
<td>25</td>
</tr>
<tr>
<td>2–5 yrs</td>
<td>53</td>
</tr>
<tr>
<td>&gt;5 yrs</td>
<td>22</td>
</tr>
<tr>
<td>Not reported</td>
<td>0</td>
</tr>
<tr>
<td>Hours worked per week</td>
<td></td>
</tr>
<tr>
<td>FT (≥40)</td>
<td>86</td>
</tr>
<tr>
<td>PT (&lt;40)</td>
<td>7</td>
</tr>
<tr>
<td>Not reported</td>
<td>7</td>
</tr>
</tbody>
</table>

Items may not total 100% because of rounding.

**Table 3. Maslach personal accomplishment and emotional exhaustion scales**

<table>
<thead>
<tr>
<th>Personal accomplishment (n = 69)</th>
<th>Emotional exhaustion (n = 72)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (≥16)</td>
<td>48%</td>
</tr>
<tr>
<td>Medium (6–15)</td>
<td>44%</td>
</tr>
<tr>
<td>Low (0–5)</td>
<td>9%</td>
</tr>
</tbody>
</table>

Items may not total 100% because of rounding.

Abbreviations: FT, full time; GED, General Educational Development; MGH, Massachusetts General Hospital; PT, part time.
As mentioned in the IOM report [1], effective teamwork in a health care setting is a critical element in providing patient-centered care. Including all team members, professional staff and support staff, is important for providing quality patient care. These findings of inadequate recognition and value in the focus groups and survey suggest that support staff are not included nor recognized as a member of the team. Even though the findings show that support staff feel their work is important, being included as a member of the team is not evident in the findings.

The complex interactions among staff, clinicians, and supervisors in a busy clinical environment make it difficult to tease out more detailed information about relationships that may include a range of peer, supervisor, practice management, clinical professional, administration, or other leadership. The anonymous nature of the survey response and concerns about confidentiality in both the focus group and survey data collection in a work environment may also have impacted the response.

Detailed discussion in the focus groups revealed both the joy and sadness of the relationships in an environment where bad news, declining health, and death are commonplace. Support staff are touched by these events in their relationships and may need support and guidance to cope.

The prevalence of burnout and stress in the oncology health care setting has been well described in the medical and nursing literature. Burnout is the result of high levels of stress in the workplace. Maslach and Jackson described burnout as a syndrome of emotional exhaustion, depersonalization, and low personal accomplishment that can occur

**Figure 1.** Support staff satisfaction in current job.

**Figure 2.** Support staff relationships in current job, 2005 ($n = 76$).
among individuals who work with people on a daily basis [9]. We did not use the depersonalization scale for this research. Burnout is the caregiver’s response to the chronic emotional strain of working with people who are suffering. Maslach and Leiter describe burnout as a malady that spreads gradually and continually over time, putting people into a downward spiral from which it is hard to recover [17]. The term “burnout” was originally used in the 1970s to describe a phenomenon seen in caregiving occupations [18], and the scales have been validated in many populations of professional and informal family caregiving relationships. Indeed, one study has shown considerable correlation between a single item of the emotional exhaustion scale, “I feel burned out,” and the summary score of all items in all subscales.

Our findings for the support staff population appear somewhat lower than the distribution of scores in other health worker populations. Grunfeld et al. [10] measured the prevalence of burnout and psychological distress in oncology physicians, allied health professionals, and support staff. Their results support the concern that oncology care workers are experiencing burnout and stress. The prevalence of emotional exhaustion in support staff was 30.5% and the prevalence of low personal accomplishment was 31.4%.

The experiences of nonlicensed support staff in an oncology setting were also examined in 2003 by Mack et al. [19]. The aim of that study was to gain an understanding of the experience of working in a cancer center. The study focused on staff perception and understanding of cancer, the environment in which they work, and perceived training and support needs in the cancer setting. The results revealed that the workers had a limited understanding of cancer, they valued their interactions with patients, and they also felt that their contribution to patient care was not valued by their professional colleagues. Our finding of relatively low satisfaction with formal recognition may reflect similar feelings, and we documented ample opportunities for improvement in working relationships within the care team.

**CONCLUSIONS**

Recognizing the importance of the health care team and its impact on patient-centered care is essential for quality care. Rarely mentioned as part of the team, support staff or nonlicensed staff are often the first encounter a patient or family member has with the team. Although support staff care for patients and families, little research relates to their roles with oncology patients. Most studies focus on professional staff and rarely address support staff. Addressing the challenges inherent in the oncology environment is essential to supporting a successful oncology practice for both the licensed and nonlicensed support staff of the oncology team.

There is clear evidence that burnout can be costly, not only to oncology clinicians but also to support staff. High levels of staff turnover, decreased job performance, increased absenteeism, and decreased work productivity may be evident as a result of burnout. An emerging literature on compassion fatigue suggests that burnout may not be the sole domain in which to consider the response of support staff in the health care environment [20]. We do not measure compassion fatigue in this work, but may consider the role of those measures in future research. The cost of caring can affect the oncology clinician and support staff physically, emotionally, and psychologically. Understanding the prevalence of burnout can empower staff to use preventive measures to promote self-care and enhance productivity. Ultimately, a support staff that has better training and education, better work relationships with the team, and better support has the potential to improve patient outcomes, and notably patient satisfaction.

In our center, we have taken these data and moved ahead to develop a three-pronged program that includes support staff education and training, peer support, and interaction with senior leadership. This program is designed to fill information or educational gaps, improve working relationships within the team, and increase recognition of the challenges that support staff face. Results from the evaluation of those efforts are forthcoming.

As health care becomes more complex, coordination of health care services is essential to the quality of patient care. Patients are increasingly asked to assess their experience of access to and coordination of care. As health professionals need to continue their professional education, so too do the support staff that support them. Programs that build a mutual understanding of the challenges that are faced by all members of the health care team can only help to improve key working relationships, foster mutual respect, and ultimately provide quality patient care.

**AUTHOR CONTRIBUTIONS**

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Conception/design: Barbara J. Cashavelly, Karen Donelan, Kathryn D. Binda, Katherine A. Clair-Hayes, Peter Maramaldi

Provision of study materials or patients: Barbara J. Cashavelly, Kathryn D. Binda

Collection/assembly of data: Barbara J. Cashavelly, Karen Donelan, Kathryn D. Binda, Johanna R. Mailhot, Katherine A. Clair-Hayes, Peter Maramaldi

Data analysis and interpretation: Barbara J. Cashavelly, Karen Donelan, Kathryn D. Binda, Johanna R. Mailhot, Katherine A. Clair-Hayes, Peter Maramaldi

Manuscript writing: Barbara J. Cashavelly, Karen Donelan, Kathryn D. Binda, Johanna R. Mailhot, Peter Maramaldi

Final approval of manuscript: Barbara J. Cashavelly, Karen Donelan, Kathryn D. Binda

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