

Correspondance

The effects of stress on oncology staff

The recent article by Eva Grunfeld and colleagues contributes further information on stress and its effects on oncology staff.¹ The amount of published evidence indicates that stress is a substantial problem.^{2,3} What Grunfeld and colleagues did not address is the source of stress and what might be done about the problem.

Models of work-related stress, work disengagement and burnout have been presented and reviewed by Vachon² and Maslach and colleagues,^{4,5} among others. Gifted, intelligent and empathic workers are more likely to experience distress;³ personality types² and personal values⁴ are also relevant. However, Maslach and colleagues strongly argue that the main determinants of worker impoverishment and burnout are corporate rather than individual and that due attention to such factors may promote work engagement and job satisfaction.⁴ Attention is now being paid to contexts of work, particularly the quality of any organization, including its values,^{4,5} culture, moral climate and institutional ethics.⁶ Hierarchical organizations with overemphasis on standardization and efficiencies, combined with increasing expectations of perfection (by patients, corporations and the college) may promote burnout and reduce the quality of professional practice.

The underlying theme in research in burnout and work engagement seems to be that group and management processes have to promote more open futures in which professionals are able to deploy their gifts in meaningful ways, and in which they are able to grow as human beings. To better understand the present problem and to apply appropriate corrective measures, it may be essential to measure moral climate,⁶ assess the culture of each workplace^{3,4} and evaluate spiritual concerns of staff. The latter might include clarification and strengthening of meaning and purpose conducive to

both personal vitality and agility of the organization.

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Uncertainty and equipoise

In his recent article,¹ David Sackett confuses the constructs of clinical equipoise and theoretical equipoise. Clinical equipoise, unlike uncertainty, can never be “possessed” by individual trialists. It is a collective concept. Instead, individual trialists must ask themselves, after diligent examination of the accumulated evidence, whether clinical equipoise is present. As to whether

equipoise is possessed by ethics committees, we would argue that a great number of ethics committees “practise” clinical equipoise. It is their duty and responsibility to ask for and weigh the evidence surrounding the proposed treatment alternatives. By doing so, they are implicitly invoking the requirement for clinical equipoise.

As Benjamin Freedman wrote, theoretical equipoise is “conceptually odd and ethically irrelevant.”² He therefore suggested an alternative: clinical equipoise, a concept that, in our opinion, brilliantly allows the requirement for genuine uncertainty at the level of the medical community to coexist with the possibility of uncertainty at the individual level.

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[Editor's note:]

David Sackett's response to this letter and to a related commentary can be found on page 835.