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Burn-out in oncology professionals

Dr Franco: So, welcome everyone to diseases e-ESO session. This session is dedicated to burnout among oncology professional. I have the pleasure to have with me Professor Lorys Castelli, from the University of Turin, which will help me discussing this very urgent topic. So, let's start with a little bit of background. Human being can survive in a physical environment, if they can maintain their individual balance, which is called homeostasis. This balance is always challenged by stress factor which may comprise intrinsic and extrinsic causes. So, how people can respond to stress without syndrome, which is a stress syndrome, which doesn't have to be considered always as a negative factor. It's mostly physiological response, it is made up of three different phases: Alarm, Resistant, which are reactive to the stressor, and if the stressor becomes chronic, this syndrome may lead to exhaustion. The first two tend to be reactive-responses to an external stressor. So, individuals can maintain their own balance with coping strategies. Coping strategies are meant to try to change the situation, which is causing stress in trying to control the emotional response which most of the time is related only to the stressful agent. Whenever this coping strategy is not effective, or is not sufficiently effective, because maybe the emotional responses to tolerate, people may go into burnout, which is a persistent stress syndrome which might lead a person and individual to emotional exhaustion. So, the concept of burnout was introduced in the early 70s, when people start to observe the relationship at work and between like people working, in the same working environments and observing how this relationship might affect people life, and it's interesting because also fictional-nonfiction writer try to describe this extreme fatigue and loss of idealism in one's job. And you might want to take a chance, take a look at this nice book by Graham Greene, called A burnout case, which basically talks about an architect leaving his own life and his own job and like hiding in the jungle to get out of this stressful situation. So, at first he was observed by a fictional writer. The term burnout it has some kind of a marquee origin, thing that it comes from the illegal drug as seen, it represents work-burnout was for the physical effects of chronic drug-abuse and then the word kind of was shipped to the counselor and therapies, which were used to work with drug abuser, describing in the psychological deterioration and stress which was experienced during these relationships. But, the two psychologists that define the context of burnout were Herbert Freudenberger, a clinical psychologist, but particularly Cristina Masclach, a social psychologist who described, when she was interviewing workers in healthcare and human occupation, she described these psychological difficulties as "burnout". So, these interviewees tend to describe the situation as burnout and that's why the terms burnout pumps out in this type of situation. So, burnout is related to the domain of work, so, it's about Relations and about Work and it's something described in working environment where the workers are Caregiving or occupied in the Service Occupation. So, the core of burnout is the relationship between a provider and a recipient, so, it has to do with the interpersonal context of these relationships. So, it's not only a simple individual stress-response, but it has to do with the interaction in the work place between individuals who

are working in that specific environment and it's interesting because also the most recent burnout definition by the World Health Organization, stresses this point. Burnout is not considered anymore as a pathological condition, it is more consider as a working-environment phenomenon, in an occupational phenomenon and it's a chronic workplace stress, which is not sufficiently and successfully managed. So, it shouldn't be considered as a pathological entity but more as a condition related to the working environment. And when the Freudenberger and Maslach's start to study these contents and this is an entity with qualitative research made of interviews, surveys and observations, they found similar patterns, which were quite common within all the interviewers, and those patterns were comprised with primacy of exhaustion. So, exhaustion was a very crucial point, then these negative effects shift in the response that one individual has in relation with the others, and the final step was negative self-assessment of his own, or her own, professional competence. So, three main domains had the same strategy of exhaustion which was described as an end-state caused by excessive demand on one's energy and resources which led to depersonalization. And depersonalization is a phenomenon where individuals tend to moderate the compassion for our recipients by holding an emotional distance between oneself and the other, and the final step was to assess assessment of the professional competences, which was like strongly affected by the absorption and depersonalization. So, three clusters of presentation for now, emotional exhaustion, depersonalization and the low sense of personal accomplishment. Burnout is a syndrome and is a syndrome that has physical symptoms. So, there are symptoms which belong to the physical cluster, and they are characterized by insomnia, lack of energy, back pain, loss of appetite, migraine, nausea, ulcer. There's also a psychological cluster which is more pertinent to the psychological aspects of the human being with changes in the emotional and cognitive aspects of psychology, with cynicism, irritability, denial of failures, loss of sense of humor, indifference, insecurity. So, a lot of physical and psychological repercussions from an individual point of view. So, burnout is a working syndrome, it is a stress-related syndromes, and then there are like specific environments which are most prone to generate stress and those are typical environment where burnout is more likely to happen: hospital or like environment where the work is made of care, are very prone to develop, for burnout to develop in oncology, clinical oncology in general, medical oncology, radiation oncology, surgical oncology which is a team effort. So, it's made of interpersonal relationship, in the working environment and with the recipient, normally the patient, our environments, which are very prone for the development of burnout. In a hospital environment, burnout is definitely relevant, because it can have like a strong impact on the staff, it can lead to impair cognitive function, and so, it can increase the potential to harm the patient. So, it's a phenomenon which is highly relevant in a work environment. In general, but particularly in healthcare working environments and in hospitals. So, it has consequences for the hospital staff, leading to illness, a higher rate for absenteeism, conflict within the staff, distrust of management and poor coping and substance abuse and it can also have clinical consequences, so, it can affect the performance of the service deliver to the patient, with medical errors, adverse events, poor prescribing habits, low patient satisfaction, and low adherence to guidelines and increased recommendation. So, the focus and on burnout in the ecological environment star to being raised in the early 90s, with surveys undertaken in the U.S. popularity and the prevalence of burnout in oncology professionals was high. It was estimated in first estimates as high as 50%. So, highly relevant in terms of prevalence, more recent surveys determining the prevalence, the point-prevalence of burnout as being around 30% and this is quite transversal to all the ecology professionals, meaning medical doctors, so medical oncologists, radiation oncologists, surgical oncologists have like prevalence rates tend to be around 30%, which is one out of three of professionals-volume-oncologists. So, highly relevant also in terms of prevalence. These are specific data in the field of radiation oncology, with the prevalence of emotional exhaustion, depersonalization, a low personnel accomplishment. Of course, there's a bit of heterogeneity in the current prevalence, but the numbers tend to be around 30% average, for all the three domains of the burnout-scale. So how to set burnout: We have like validated instruments, and the most typically used, in all the studies, investigating burnout is the month like burnout inventory, which is a psychometric-scale highly used to assess burnout. There are different versions of the Maslach Burnout Inventory scale. Some are declined more in general, as a general overview, some are dedicated to specific contexts like for example the

MBI Educator Survey. All the versions tend to focus on the three different domains, which are characteristics of burnout, the emotional exhaustion, depersonalization and the low personal accomplishment with specific sequence and questions for each of the three domains. There are other tools which can be used to assess burnout. Another interesting tool is the Professional Quality of Life Scale, which is a scale that has a Professional Quality of Life at work. So, the wellbeing in the working environment is made up of two domains - the competitor satisfaction domain which is a positive feeling a personal experience while working and the Compassion Fatigue, which are the negative feeling experience at work and the compassion fatigue is made-up of two sub-domains: the burnout, which is chronic stress and the secondary traumatic stress, which is more of an acute type of fatigue. Compared to the Maslach like inventory, the professional quality of life care is more of a comprehensive type of evaluation, investigating both the positive aspects and the negative aspects related to work. So, what are the causes of burnout? There's data out there and we know that there are risk factors. Some risk factors are related to the individual, for example, a young age is a typical risk-factor; some other are related more to the working environment. So, for example, the low appreciation by the colleague, by patient and by the supervisor can be a risk-factor. Sure, there's also cultural risk-factor, geography is a factor that is able to differentiate, distributes the rate and the intensity of burnout. In general, burnout is related to stress and stress syndrome that's what we say. Stress is not necessarily always negative, it's like a person an individual, that has a low-level of stress and can cope with the stress, it's the way somehow to improve his own performance at work. So, if it is an Eustress, an individual can reach an optimal performance, if the stress is too intense, if the stress is chronic, if this stress has or induces an ineffective coping strategies, in my lead to fatigue, it may lead to exhaustion and finally it may lead to burnout. So, burnout is not an abrupt type of content, it is a multi-step continuous concept, with a person starting for example being ambitious, want to prove yourself at work, then dedicated all is that for work, and neglect his own needs and denying basic needs with a tendency for withdrawal , I mean for lack of social contacts which may lead to behavioral changes, with panic, it would lead to depersonalization considering life as a mechanical event, with like a feeling of inner exhaustion, with finally a mental the physical collapse leading to the final syndrome of burnout. So, it doesn't come abruptly, it is a double-step process and each of the steps in this multi-step process can be dealt with, can be interrupted as it can be somehow healed if faced with proper timing. So, we say there are different causes and different factors influencing burnout and they are related to the individual, and they are related to lifestyle, they are related to the working environment and they are related to personalities. So, there's three different cycle factors that can influence likelihood to develop burnout and the intensity of burnout. So, the working environment is important the administrative fatigue, a person might experience at work is important, there will be the likelihood to develop burnout, professionals tend to face the requirements of increased productivity, they may face reduce autonomy, they may deal with increase it administers the regulations, they may have legal issues or these may lead to administrative fatigue which may be contributing factor to lead to burnout if the coping is not sufficiently effective. On a personal level, people might have personal distress, there might be coexisting situation and psychological situation or disease, I would say like depression, anxiety, emotional distress, which might be contributing factors for the development of a burn-out. One important aspect is coping. Coping-style is one of the most prominent factors we implant the likelihood to develop burnout. Coping may be different depending, depending on the person. There are different coping styles and the type of coping style a person has might influence the likelihood that he can, that this situation may lead to burnout. So, there's a more effective type of coping strategy and there are more ineffective type of coping strategy depending on the copy strategy, which is more characteristic of specific person. The likelihood to develop burnout is different. So, normally, a person can be stressed. So, there's a stressor, a person can acknowledge the situation of distress and he can adopt a coping strategy. So, if the company strategy is more effective, so it's more related to the emotion, it can be a little bit ineffective. If it's a more of a coping strategy, which is called problem-focused-coping-strategy, so, it's more pragmatical, cognitive, it might be a little bit more effective in dealing with burnout. In general, it's not 200%,100%, but in general emotions are a coping strategy less effective in dealing with burnout and maybe predisposing factors, impact to develop burnout. Task-oriented-coping-

strategies are very cognitive, very practical, very pragmatic, and are associated with a decreased risk of burnout. And this is clearly shown here. This is a nice study made on professional working in emergency departments, those have an emotional oriented coping strategy, they are more likely to develop burnout, those having task-oriented-coping-strategies where definitely less likely to develop burnout. So, we say individual factors are very important, environmental factor is very important copying strategy is very important, but also personality plays an important role in the likelihood to develop burnout. So, what is personality? Personality is a complex trait. It is the union, basically, a set of behavior. is a comprises cognition. It comprises emotional factors. So, the way you are which is made up of behaviors, cognition and affection, so, emotional pattern. So, personality is the type of person that you are, shown by the way you behave, the way you feel and the way you think, so, it's a very ontological, is an ontological perspective on the individual. Since with the -- Personality can be very important in the likelihood to develop burnout. We try to investigate which personality-traits might be potentially correlated to burnout. And I just want to point out a study that we did amongst oncology professionals, particularly radiation and clinical oncology, investigating personality-traits potentially leading to the likelihood to develop burnout, and which personality traits we chose to investigate. We chose investigate Alexithymia. Alexithymia is an interesting personality trait which is able to interfere with the normal emotional regulation ability of an individual. The term Alexithymia comes from the Greek, it stands for lack, lexis stands for a word and thymos for mood. So, person and in Alexithymia has a cognitive and affective disorder which will impair their capability to regulate emotions and consequently interact with other human beings. So, people and persons having Alexithymia might have difficulties in identifying and distinguishing emotions from bodily sensations, they have difficulty describing and verbalizing emotion, they have a poverty of fantasy-life, as they tend to have an externally oriented thinking side. So Alexithymia is a personality trait and potentially might be linked to burnout. This is the hypothesis that you may want to test, so, we measure Alexithymia in the study that we are showing you very soon. We did a validated questionnaire with Toronto Alexithymia scale, which is able to core the level of Alexithymia of a person by evaluating the difficulty in identifying feelings, the difficulty describing feelings and the intensity of external oriented thinking style. Another personality trait which is relevant and it's particularly relevant for the medical profession, for professional that has to deal with patients, with suffering persons is Empathy. Empathy is the process of understanding a personal, subjective experience by sharing the same experience, but maintaining a distance as an observer, at the same time. And empathy is very, very important because it's like one of the mean by which a good physician a good doctor can profitably and efficiently relate to the patient or to the recipient of the service in general. Also, empathy can be assessed with the Interpersonal Reactivity Index, which is a measurement tool for the mood. Emotional assessment of empathy is made up of four top cases: perspective taking, empathic concern, the personal distress and the fantasy. So, it's a major, in general, of empathy evaluating like for specific sub-domain. So, the aim of our study evaluating burnout in oncology professionals was to evaluate the connection between personality traits, Alexithymia-Empathy in some professional and personal characteristics to the professional quality of life, in general and in particular, to burnout. So, we surveyed more than 2000 members of The European Society of Therapeutic Radiation Oncology, ninety-four countries and all continents were involved, with like almost 1000 answers and up to 800 corresponded to the whole questionnaire. It was interesting because we found data which were quite well tuned with a detector up to 30% of responded as in the general population this is the mostly observed point prevalence between 10 and 30%. So, we assume clinical oncology can be similar to the general population. So, that makes a lot of sense. What is interesting is that these 30% rate up again, so, around one out of three of the profession scored high in the burnout-score. So, it is in burnout basically which is highly prevalent, and it's compared and then this finding come first in defining, which is present in the literature. So, what are the predisposing factors? So, the risk factors or the protective factors, are the factors that may increase or decrease the likelihood to develop burnout? Age for sure it is a protective factor, being valued by colleagues, by the supervisor, by the caregivers, by the patient, is for sure, protective factor and being more empathic, so, be scoring high in empathic concern or perspective taking is generally effective to a burnout. Alexithymia is definitely a risk factor, people that score high in the Alexithymia score tend to have a higher

likelihood to develop burnout. So, it's definitely a risk-factor and this was confirmed in the multivariate that we found. Empathy was highly correlated to a higher satisfaction at work. Alexithymia was more linked to secondary form of stress and burnout for what definitely they're expected to develop burnout. So, personality and particularly Alexithymia is definitely a risk factor. So, it can be also a valid tool to screen people and professionals at a higher risk of developing burnout. So, how to intervene on burnout? There is potential intervention approaches out there that can be used and employed to increase the likelihood or decrease the intensity or the direction of a burn out syndrome for the professionals. So, there's intervention, which are directed to the organizational, so, are more of a structural type of approach to the organization direct intervention are aimed at removing the county's stress and working on procedure. So, there are organizations with direct intervention which are focused on task restructuring, work evaluation of working processes on the supervision of the working processes. And they tend to lead to long-term changes, which may potentially decrease the job demand, they can increase the job-control and, in the end, increase the level of participation of specific professionals in the decision-making process. So. with organizational direct intervention decisions, which are involved in these intervention, normally, it has less a lesser degree of emotional exhaustion and are more satisfied and more the quality of the job, the quality of the service delivery, doesn't necessarily increases, but for sure the quality of life, the wellbeing of the professional workers usually affected can be improved. For sure, this is a nice study, which improves employs organizational approach, the underlying psychology theme where the intervention was made up of participatory action research, with interviews MIDI counseling focusing on organizational factor and on decreasing the environmental factors of stress and without a witnessing intervention, the professional were found to have significant reduced level of emotional exhaustion and depersonalization of two of the domains of burnout. They were significantly improved by these interventions. Communication is also important, it is at the organizational level and so, every initiative that tries to improve the communication skills within a specific working environment might lead to a better quality of life, in general, and a decreased likelihood of burnout and this was done in Australia. Counseling is important with days or weeks dedicated to the reflection on personal situation, personal needs, organization, counseling is also an organized directed intervention which may potentially reduce the absorption of professional and improve the professional wellbeing. So organizational directed intervention, but there's all three prevention that can be addressed to the individual level. And those are more of a reactive approach, so they can be employed for people that are already experiencing burnout. They don't prevent burnout. They just, it's the next level when burnout is already present in those individual directed interventions are focused in enhance the job competencies, and have the copies skills in improving resilience or implemented trainee program aimed at managing the negative emotion a person can perceive and feel in the work in an environment. So, some of the approaches, individual directed approaches, are basically cognitive behavioral approaches which are effective in treating stress related disorders to provide basically stress-relief, so, they are targeted to the management of stress and this reminds of study done in pediatrics, pediatric medicine, pediatric doctors, and pediatric medicine residents, where self-managing was able to significantly reduce the emotional exhaustion domain of burnout. Anther nice approach done in earlier study, they are using a creative art therapy, using a different type of technique based on art therapy and cognitive behavioral therapy, using for example, psychodrama techniques to promote communicative change or relaxation techniques in order to reduce anxiety and negative symptoms were able to significantly reduce the level of burnout. So, there are intervention out there which can be implemented in order to reduce the likelihood of burnout and to improve the quality of life in the working environment. Some are directed at their organizational level, some other are more on an individual-level and there are based on a cognitive behavioral approach. So, this led us to the conclusion about burnout so, for sure burnout is a relevant issue in general in the medical profession and it affects all the medical professionals, Doctors, technicians, nurses, practitioners and medical students. It is very important for professionals and workers in the field of oncology, so, medical oncologists, surgical oncologists, radiation oncologists any it can have consequences for the patients and for the professional itself. Burnout has slightly different causes and it is for sure influenced by the lifestyle, so, individual-level; by the working

environment and by the inner-self, by the personality. Coping is very important, so, the type of coping strategy substantially influences the likelihood to develop or not to develop burnout. Personality is very important. Type A personality for example, it's more connected to burnout and we've shown how Alexithymia and Empathy may be able to influence the rate of burnout. So, since we know those personality traits that may predispose individuals to develop burnout, we can implement preventive screening strategy to try to identify properly the people at risk and try to come-up with different strategies to reduce the exposure to threats. Burnout can be tackled somehow with intervention. The intervention can account for all the causes and to incorporate a variety of different tools. Reducing stress for sure is important, because burnout is a stress-related syndrome, but may not be the only way to deal with burnout. There are different techniques, different strategies, different approaches available. Training and coping strategy is one approach for sure, training interpersonal skills in order to enhance social support is another approach, improving communication and improving communicational skills within the working environment, environment with the VPN to observe the patient or the relative of the patient is also important. It is always very important to discuss the specific high-stress situation. So, whenever a high stressful situation is present at working environment, it's better to tackle it in advance. So, early, not late. Relaxation techniques are also very important and can be used in order to decrease the stress in general and the likelihood of different depersonalization and emotional exhaustion. The intervention should be at both individual and institutional level; So personal like level and the organizational level. There is always a balance between the service responsibility and the personal life. So, the inner balance is always very important. It's also interesting to notice that all the prevention strategies, which are made at an individual level, they should intercept the position at the early stage of their career, in order to be able to develop it, and the skills which might be pulled in the future to properly manage the stressful situation. So, as soon as the problems are faced, as soon as a specific professional is interceptive and is given the chance to improve his own skills to manage stress that will in the future be very helpful to be able to manage stress and to decrease the likelihood to develop burnout and all these tools. All these intervention approaches should be synthesized into a more comprehensive and holistic approach, directed to the person and directed to the working environment where the person works. So, person-directed intervention and organizations-directly intervention. And I think this is the last slide and with this I thank you for your attention. And I think we can start a little bit of a discussion with Professor Castelli.

Dr Castelli: Okay, thank you first for coming and congratulations for your very clear and insightful presentation. So, I would like to start the discussion with a comment and also a question on Alexithymia. There is now stronger evidence about the negative impact of Alexithymia on psychological aspects, as well as depression and hypertension are the two-key example of this issue. For instance, a recent study carried out by an Italian team, defining Alexithymia as a facet of uncontrolled hypertension, highlighting that Alexithymia is not only associated with hypertension, but these are issues that are present to a higher degree station in hypertension person that cannot maintain control of the blood pressure, despite following the operated specifics pharmacological treatment, so Alexithymia can be considered a risk factor for hypertension. Coming back to your study, you pointed out that Alexithymia has a strong relation with burnout. So, can we say that, if you are Alexithymic if you have these personality traits, you do not have an important emotional instrument to manage to face the suffering of patients? What's your opinion about this hypothesis?

Dr Franco: Thank you, it's really, it's for sure a good point. So, it's interesting that burnout is very linked to the working environment and the working environment is made of relationship, meaning relationship within the working *equipe*. So, with all your colleagues, relationship with the recipient of service or relationship with the patient, but not only with the patient but for example with the caregivers of the patient, and this is true for general medicine. So, every situation in medicine, and this is very, very true in the field of oncology, where patients have a trauma, so knowing that you have a tumor is for sure traumatic. So, the knowledge of diagnoses of being sick basically is a trauma and so, people are for sure suffering and with the patient, also

the relatives and caregiver, all the people that are surrounding that specific individual are suffering. And it's of course, very, very important for a physician, and for an ecologist, in specific, to be able to tune up with the feelings of the patient and with the feeling of the caregiver and the relatives. If a physician, if a professional has the emotional ability to enter in a connection with the person and with the relatives, of course, the patient-physician relationship will be better for sure. And then the perception also of the physician will be easing even the intervention of his work will be better. So, for sure, Alexithymia can be considered a risk factor because if professionals and doctors, oncologists, is not very skillfully dealing with his own emotion is probably not able to deal with a suffering patient, emotion, and it will be harder to establish a proactive and useful relationship. So, for sure the interactions will be worse. And of course, the perception of the position will be of this relationship will be worse itself. So, in general the interaction will be not very practice in the health school interaction and so, both the physician and the patient will be unhappy for relationship. So, if a professional is able to balance his emotions and uses empathy and communicate his emotion and tune at the same emotional level with the patient that of course will be very helpful. But of course, if a professional physician is Alexithymic so, cannot deal properly with his or her emotions, then the relationship with the patient will be for sure more complicated to establish and to be fruitful.

Dr Castelli: Yeah, I totally agree with you, I also feel that the Alexithymia causes less empathy and the difficulty in managing their relation to the suffering passion. So, especially when you have to get in touch with suffering person, suffering patient Alexithymia can be relevant problem. I have another question. What about if the condition of burnout would be considered categorized as a psychiatric as medical condition? I just would like to know in your opinion, which would be the advantages and disadvantages of this option? Move-or now to the importance that it deserves, or this would be a useless impact for the patient with that a condition?

Dr Franco: Yeah, thank you. This is interesting question for sure. Yeah, it's true if you take a look at the new definition in ICD-11 definition of the World Health Organization, burnout is not considered as a pathological condition is more of the condition, is considered as a stress-syndrome related to work, is a working syndrome. This implies that -- actually I was kind of surprised when I read it, because, I mean, in my opinion, in my mind, I would think of burnout as a pathology, as a disease, that you were mentioned. So maybe the WHO considers it a working related syndrome because maybe it deals with a working environment, so, if that specific individual which cannot cope with a working environment in which is working, so, probably if like the same individual would have the chance to work in a different working environment he might not suffer from burnout. So, it's not specific to the individual, but more connected and referred to the interaction between the individual and the environment. So, it has some parts due to individual, but it has most of the parts are due to the ineffective interaction with the working environment. So that's my guess, for the reason why the WHO did not consider as a medical condition. Probably if there's the risk, it is not considered as a medical condition to look down to it and not consider it as a prominent issue, as it is, as in a working environment. On the other side it is considered as a medical condition, it means the individual to be considered sick. So, whenever you're sick, then there's also there's a lot of medical or legal implications, which might be of course, complicated to manage, but it's true probably considered as a medical condition it would have more-- it would be more considered as something prominent and a clinical issue to be dealt with. I don't know. What is your opinion about that?

Dr Castelli: Yes, I agree with you, I think it's not an easy issue, there's not an easy solution because there are both advantages and disadvantages. For sure, if we all will consider it a medical condition, psychiatric condition. I think it can have the important that it deserves, because the people with the burnout, experience lots of suffering, otherwise, like you say, it's a condition strictly led to the working environment and so, maybe, it's also fine to consider it not as a medical, psychiatric condition.

Dr Franco: Yeah, there are pros and cons for both. There are two definitions and two declinations.

Dr Castelli: Okay. Yes. I would like to ask you one more question about emotional dysregulation, emotional coping. I think that emotional coping can be a useful instrument to get in touch with the patient, with the relation to the patient, with the suffering of the patient, but many studies, as you pointed out earlier in your presentation, highlight that emotional coping is not a good way to cope with the stress. So, I would like to know if in your opinion emotional coping is the only way to cope or there is also a good side of emotional coping?

Dr Franco: Now this is interesting, yeah. So, the two studies I showed, one was I think, was made in Hong Kong and it had a population of nurses and the other one was like professional working in an Emergency Department. And both studies demonstrated that emotional-oriented coping was a risk factor for burnout and task-oriented-coping were like protective factor. This is of course interesting. So, I would say that emotional coping is not necessarily negative. Emotional coping somehow has something to do with empathy. So, it has to do with the affective and emotional part of being human. So, it's very natural and it's also a way to connect with the others and to establish profitable relationships between people. So, it's not 100% negative. The point is that the emotional approaches is too rigid, is like completely emotional is like, we could define it as hysteric, I would say, then it may lead to ineffective coping strategy. So, it may be negative. But if the emotional coping is somehow has a cognitive dimension, so, if decline also pragmatically, with a strategy, with a behavioral strategy with a cognitive dimension, then it might be somehow also task-oriented, but also the emotional part can be also a way to connect with the others and so also a way to better cope with the stress. So, I agree with you the studies show that the emotional copying can be a risk factor but non necessary, I would say, so, cognitive, the cognitive part can be connected to the emotional part and it may also be somehow positive and it may also be linked to empathy, that is my feeling.

Dr Castelli: I agree, I also think that if emotional coping is properly offset by appropriate cognitive coping strategies, like you said, then emotional can be a good way to get in touch with the patient, because, if you deny the emotional side of the relation it can resolve and it can turn in bad relation, in a tense relation with the patient that is no good, nor for the patient, neither for the physician.

Dr Franco: Yeah, fine that was a nice discussion Lorys. Thank you, thank you for your great work, its grate. So, I think if there's no more pending or urgent question, I think we can like finish the session, so, it was nice. So, thank you, Lorys for the very nice discussion. It was very interesting, the topic is interesting the topic is very, very important. And it was nice like being with you and sharing our experience with all the audience. So, thank you, everyone.

Dr Castelli: Thank you again for inviting me, and for your very nice presentation. Thank you and bye everyone.

Dr Franco: Bye-bye.