Burnout and Self Care for Palliative Care Practitioners

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KEYWORDS

• Burnout • Palliative medicine • Self-care • Mindfulness • Exercise • Sleep
• Compassion • Empathy

KEY POINTS

- Burnout is common among physicians and other practitioners caring for patients with serious illness.
- Consequences of burnout include depression, substance use, suicide, leaving the profession, and poorer patient care.
- Risk factors for burnout include working on smaller teams, working longer hours, high workload, burdensome documentation, and regulatory issues.
- Mindfulness, exercise, sleep, and adequate time off can help buffer against burnout.
- Institutional and team factors can promote or protect against burnout.

INTRODUCTION

Caring for patients with serious illness involves frequent, intense interactions with patients and their families. Emotions run high as patients and families work through intense physical suffering, grief, existential distress, and all the other challenging experiences that may occur at the end life. It is the role of the physician to help guide people through this variable and complex psycho-socio-medico-spiritual context, which is a powerful and self-affirming exercise. However, the personal burden of this work is great. The emotional and physical toll can pile up over years and decades of practice. This accumulation of stress can gradually erode one's well-being and lead to feelings of depression, dissatisfaction, and depersonalization. This process is called burnout, and the purpose of this article is to define burnout and its associated terms; address the scope of the problem in medicine; discuss

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personal consequences of burnout; identify tools for burnout prevention and mitigation; and recognize team, institutional, and health system factors that can promote or protect against burnout.

RELEVANT DEFINITIONS

This section offers working definitions of the important terms used later in this article. This facilitates a larger discussion of these terms in the practice of physicians caring for patients with serious illness (which we shorten to provider for simplicity).

Burnout

A definition of burnout is central to further discussion in this article. The World Health Organization now includes the following definition of burnout in its International Classification of Diseases-11 document: "Burnout is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: (1) feelings of energy depletion or exhaustion, (2) increased mental distance from one's job, or feelings of negativism or cynicism related to one's job, and (3) reduced professional efficacy. Burnout refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life."[1]

The most commonly used tool for assessment of burnout is the Maslach Burnout Inventory.[2] The Maslach Burnout Inventory was first published in 1981, and it has now been revised multiple times. It assesses three domains of symptoms: (1) emotional exhaustion, (2) depersonalization, and (3) personal accomplishment.

Burnout is often accompanied by a loss of existential meaning in one's work.[3] Burnout has also been extensively discussed in the psychology literature as a specific syndrome with distinct phases. These phases include an insidious process by which well-intentioned individuals gradually succumb to a high-stress work environment that offers poor feedback and little reward. This sows discontent, leading to a pathologic coping response, which often manifests as cynicism. This response gradually evolves into the burnout syndrome and, if not intervened on, can result in severe personal and interpersonal dysfunction, such as substance abuse, depression, and suicide.[4]

Resilience

Resilience is the capacity of an individual to recover after exposure to stressful circumstances or events. The American Psychological Association believes that resilience is a learned behavior, which is strengthened through an individual's dedicated effort.[5] **Box 1** lists factors contributing to high resilience.

Mindfulness

Mindfulness is the act of existing in the present moment. It is a term originating from religious contemplative practice, and it draws from thousands of years of Buddhist scholarly work.[6] Buddhist teachings have now been adapted into a secular practice and applied to various personal and workplace contexts. Secular mindfulness teachings instruct individuals to release concerns for the past and future, instead isolating their attention on the present moment. This allows health care practitioners, specifically, to more fully engage with their patients during clinical encounters. Evidence for mindfulness in the prevention and treatment of burnout is discussed further later in this article.

Box 1
American Psychological Association core factors contributing to high resilience

- Ability to develop realistic plans
- A positive self-image
- Well-developed capacity for problem solving
- Strong communication skills
- Maintenance of supporting relationships inside and outside one's family
- Ability to manage strong emotions
- Control of impulsive thoughts and desires

From Maslach C, Schaufeli WB, Leiter MP. Job Burnout. Annu Rev Psychol 2001;52:397-422; with permission.

Sympathy

Within health care, sympathy is defined as an emotional reaction of a caregiver to the suffering of another individual. Sympathy acknowledges a patient's suffering without seeking to understand it or emotionally attune to the patient's suffering. In general, sympathetic statements involve pitying language that inherently identifies a patient's distressing circumstance as outside the realm of the caregiver's experience.

Empathy

Empathy is a response to another's suffering in which the caregiver acknowledges the suffering and experiences a visceral, affective response. Empathy is divided into cognitive empathy, which includes acknowledgment of suffering and an effort to objectively understand suffering, and affective empathy, which involves the evocation of a patient-centered emotional response within a caregiver. Empathy is a process by which caregivers can attune to the patient's experience of suffering, thus gaining enhanced understanding of the patient.

Compassion

Compassion occurs when caregivers are empathetic, while also demonstrating a sincere desire to reduce the patient's suffering. Compassion combines an understanding of suffering (either one's own or another's) with the intention for enhanced wellness.[7] Compassion arises from altruism, allowing insight that occurs during emotional engagement to be transformed into effective action. Given that loss of meaning is a hallmark consequence of burnout, one can see immediately that the ability to work compassionately is a central pillar of prevention and amelioration of burnout (discussed later in this article).

The terms sympathy, empathy, and compassion are often used interchangeably, and therefore incorrectly, in medicine. The relationship between these three concepts is depicted in **Fig. 1**. In fact, the isolation of these different modes of interactions allows providers deeper understanding of their relationships with patients. This is especially important for providers who care for the seriously ill, given the high intensity of the clinical encounters, which often have life and death consequences for patients. In the book *Standing at the Edge: Finding Freedom Where Fear and Courage Meet*, Joan Halifax[8] discusses five "edge states," related to an individual's personal demonstration of altruism, empathy, integrity, respect, and engagement.

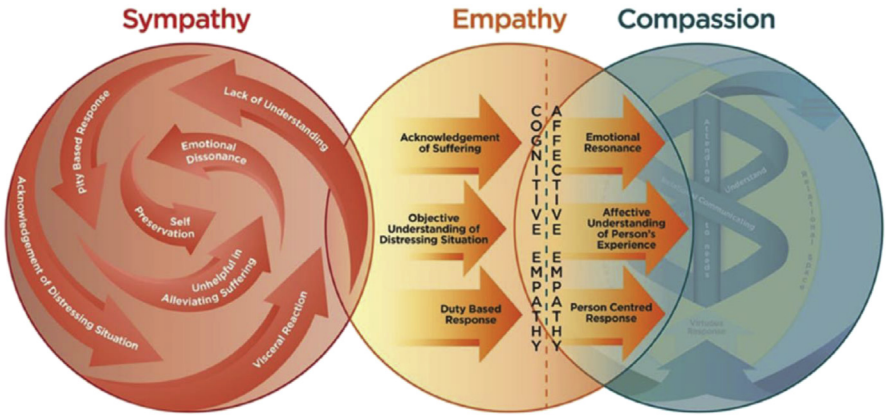

Fig. 1. The interplay among sympathy, empathy, and compassion. (*From* Sinclair S, Beamer K, Hack TF, et al. Sympathy, empathy, and compassion: A grounded theory study of palliative care patients' understandings, experiences, and preferences. Palliat Med 2017;31(5):441; with permission.)

These five qualities each facilitate meaningful and therapeutic connections with patients. However, each quality can also be taken too far, resulting in negative consequences. In the book, these are described as pathologic altruism, empathic distress, moral suffering, disrespect, and burnout, respectively. This is just one example of a mental construct that can be learned and applied to medical practice to better understand one's role in patient care. Overall, it is through the combination of reflective practice and the accurate, definitive use of language that inner life is delineated. With clear purpose and insight, one can increase resilience and become less susceptible to negative forces in the health care environment that might otherwise lead to burnout.[8]

MAGNITUDE OF THE PROBLEM IN THE HEALTH CARE SYSTEM

Physician, nurse, and other health care provider burnout is common, morbid, expensive, and increasingly recognized as a serious health care challenge. To highlight the magnitude of the problem, some experts now refer to the triple aim as the quadruple aim, adding the goal of improving the work-life of health care providers to the original aims of enhancing patient experience, improving population health, and reducing costs as the guideposts to optimize health system performance.[9] The prevalence of burnout varies between studies, in part because of differences in diagnosis and measurement, but rates near or exceeding 50% are reported in many studies.[10,11] A 2019 study estimated that approximately $4.6 billion in costs related to physician turnover and reduced clinical hours are attributable to burnout each year in the United States. At an organizational level, the annual economic cost associated with burnout related to turnover and reduced clinical hours is approximately $7600 per employed physician each year.[12]

Several risk factors for burnout have been identified, including poor control over workload, inefficient teamwork, insufficient documentation time, having a hectic-chaotic work atmosphere, lack of value-alignment with leadership, and excessive electronic medical record time at home. Younger, female physicians seem to be at particularly high risk.[10]

For providers, the most serious personal consequences of burnout include depression, suicidal ideation, family strain and divorce, substance abuse, motor vehicle crashes, and other dysfunctional behaviors.[10] According to a 2004 study, female physicians have a suicide rate 130% higher than the general population; for male physicians it is 40% higher.[13]

Burnout has an impact on patients and patient care.[14,15] Patients of practitioners who are experiencing burnout may feel a lack of compassion and human connection with their provider, which can lead to worse adherence and poor outcomes. Physicians who report higher levels of burnout have lower patient satisfaction scores, are more likely to be named in a malpractice suit, and perceive that they provide lower quality patient care and commit more medical errors.[16,17]

BURNOUT AMONG PROVIDERS CARING FOR PATIENTS WITH SERIOUS ILLNESS

Many factors contribute to burnout among providers who care for the seriously ill. Seriously ill patients are often frail; elderly; vulnerable; complex; and dealing with loss, grief, and intense emotions. Distress and conflict among seriously ill patients and their families is common, and providers sometimes become targets for the frustrations of families dealing with serious illness and a system that often does a poor job of supporting them. Many providers feel distressed when they cannot establish meaningful relationships with patients and their families or fully control symptoms of pain or existential despair. Providers often do not feel adequately trained to have conversations about prognosis, goals of care, grief, loss, or suffering or to manage refractory symptoms. Conflict may exist between different consulting teams with different ideas about prognosis or plans of care. Providers may feel the frustration of working in a system in which they care for patients who are uninsured, homeless, or lacking in resources and coverage for caregivers. Not all providers find meaning in the work of caring for patients with serious illness; some may see death as “failure” and think that there is “nothing they can do” if a patient cannot be cured. This lack of meaning may be a particular risk factor for burnout.

A 2016 study of burnout among hospice and palliative care clinicians in the United States reported an overall burnout rate of 62%, significantly higher than the average reported clinician burnout rates.[18] Nonphysician palliative care and hospice clinicians and home-based palliative care clinicians have particularly high burnout rates, which might be partly related to isolation. Other factors associated with burnout in hospice and palliative care include working in smaller organizations, working longer hours, being younger than 50 years, and working weekends. Other sources of burnout include increasing workload, tensions between nonspecialists and palliative care specialists, and regulatory issues.[18,19] Although not all providers who care for the seriously ill experience all the same set of stressors that hospice and palliative medicine practitioners do, there is likely to be some overlap.

PREVENTION AND MANAGEMENT OF BURNOUT

Burnout is a multifactorial process. It involves a complex interplay of individual characteristics with environmental effects. **Fig. 2**, based in part by a construct by Cotton and Hart,[20] demonstrates this schematically.

MINDFULNESS

In brief, mindfulness is the act of focusing on the present moment. This simple concept, when applied, can yield profound effects. Mindfulness can be practiced

Fig. 2. Schematic demonstration of burnout as a multifactorial process. (*Adapted from* Cotton P, Hart PM. Occupational wellbeing and performance: A review of organizational health research. Australian Psychologist 2003;38(2):118–127; with permission.)

anywhere and at any time. It can be performed before, during, and after patient care. There is a growing body of evidence that suggests mindfulness practice can improve burnout in health care professionals. **Table 1** details a selection of individual studies and their relevant outcomes. A systematic review from 2016 that includes eight studies concludes that there is strong evidence that mindfulness reduces burnout in health care professionals and teachers.[21]

Many of these studies use a program called mindfulness-based stress reduction (MBSR). This program was developed by John Kabat-Zinn, who founded the MBSR clinic in 1979 at the University of Massachusetts Medical Center. MBSR is coordinated by trained facilitators. It occurs over 8 weeks, including weekly, 2-hour meetings and a single, 7-hour retreat. MBSR focuses on teaching a combination of yoga, meditation, and body awareness techniques. This approach has been subsequently modified by multiple groups to fit the parameters of different studies and populations. The Center for Mindfulness in Medicine, Health Care, and Society at UMass Medical School outlines this program in further detail, which can be explored on their Web site (https://www.umassmed.edu/cfm).

On an individual basis, there are many ways to begin learning and practicing mindfulness. There are innumerable books on the topic. Two introductions to the topic include *Wherever You Go, There You Are: Mindfulness Meditation in Everyday Life* by Jon Kabat-Zinn[22] and *The Miracle of Mindfulness: An Introduction to the Practice of Meditation* by Thich Nhat Hanh.[23] There are also multiple smart phone applications that offer guided meditation audio and video resources. Two notable applications include Insight Timer (www.insighttimer.com) and Headspace (www.headspace.com). These applications offer resources for first-time meditators and experienced mindfulness practitioners.

EXERCISE

There is a broad evidence base regarding the benefit of exercise in managing stress and maintaining good mental health. The Department of Health and Human Services

Table 1
Evidence for mindfulness in burnout reduction

Reference	Subjects	Intervention	Outcome
Happier Healers: randomized controlled trial of mobile mindfulness for stress management[2]	88 medical students	Randomized to control or cell phone–based mindfulness application	Improvement in well-being and reduction in perceived stress
A mindfulness course decreases burnout and improves well-being among healthcare providers[3]	93 health care providers from multiple disciplines	Continuing education course based on mindfulness-based stress reduction that met 2.5 h a week for 8 wk plus a 7-h retreat	Improvement in emotional exhaustion, depersonalization, and personal accomplishment per Maslach Burnout Inventory tool Improvement in mental well-being as measured by the SF12v2 tool
Mindfulness training for stress management: a randomized controlled study of medical and psychology students[4]	288 medical and psychology students	6 weekly sessions of 1.5 h each, a 6-h session in Week 7, and 30 min of daily home mindfulness practice based on a mindfulness-based stress reduction program	Significant improvements in mental distress, perceived stress, and subjective well-being
The effects of mindfulness-based stress reduction on nurse stress and burnout: a qualitative and quantitative study, part II[5]	27 individuals, including nurses, pastoral care, respiratory therapy, and social workers	8-wk-long intervention modeled after mindfulness-based stress reduction curricula	Improved in emotional exhaustion and personal achievement, as measured by the Maslach Burnout Inventory Improvement in emotional exhaustion at 3-mo follow-up

recommends that adults do at least 150 minutes of moderate-intensity exercise or 75 minutes of vigorous-intensity aerobic exercise per week. They recommend that this occur in episodes greater than 10 minutes and be spread throughout the week. They advise that some activity is far better than no activity.[24]

Studies have directly addressed the role of exercise in the management of burnout. Weight and colleagues[25] conducted an incentivized, team-based exercise program for residents and fellows. They found a statistically significant improvement in quality of life in the group that participated in the exercise program compared with residents and fellows who did not participate. Another study of medical students at the University of Pittsburgh School of Medicine found an association between lower exercise and lower professional efficacy.[26]

Psychiatric studies have also evaluated the role of exercise in generally improving mental health. A Cochrane systematic review published in 2013 included 39 trials with 2326 participants. They concluded that exercise was moderately more effective than controls in treating the symptoms of depression.[27] Another systematic review evaluated 12 randomized controlled trials examining the effect of exercise on anxiety. Although most studies included in the meta-analysis were methodologically limited, they suggest that exercise is more effective than placebo in reducing anxiety.[28] Overall, the link between physical activity and personal wellness is clear. Healthy exercise habits are a strong step toward resilience.

SLEEP

Maintaining high-quality sleep promotes resilience. In one study, individuals with high burnout had significantly greater sleep latency, greater daytime dysfunction, poorer sleep quality, and poorer sleep duration. Overall, this study found that high burnout predicted poor sleep.[29] No data examine the effect of sleep interventions to improve burnout; however, sleep and burnout seem to be intimately related, and the implementation of sleep hygiene techniques can only be beneficial in preventing burnout. Basic sleep hygiene tips are detailed in **Box 2**.

SUBSTANCE USE

Substance abuse is a significant public health problem with many deleterious mental and physical health effects. In one study, completed surveys from 7288 physicians regarding substance use found that 12.9% of male physicians and 21.4% of female physicians had use patterns consistent with the Diagnostic and Statistical Manual-IV definitions of alcohol abuse or dependence.[30] The use of other illicit substances was rare in this study, with 1.3% of physicians reporting opioid abuse and 2.7% reporting cannabis use. This study also found that individuals with alcohol abuse and dependence were much more likely to have burnout, depression, suicidal ideation, and lower quality of life. It is unclear whether substance use and abuse lead to distress or arise as a consequence of distress. However, it is clear that substance abuse suggests underlying pathology, and is likely to worsen or prolong distress. It is therefore recommended that clinicians with emerging or established substance abuse seek treatment of mental health problems, substance dependence, or both.[31]

Box 2
Tips for improved sleep hygiene

- Caffeine use close to bedtime disrupts sleep
- Nicotine use acutely and chronically disrupts sleep
- Alcohol may reduce sleep-onset latency, but it leads to sleep disturbance later in the night
- Regular exercise improves sleep
- Regular bedtime and waketime promotes improved sleep
- Bedroom noise reduction improves sleep by eliminating nighttime arousals
- Bedtime use of media devices (ie, smart phones, television) reduces sleep quality[12,13]

THE PURSUIT OF HAPPINESS

The sacrifice of personal life for work achievement occurs early in medical training. For trainees, incredible time and effort are necessarily devoted to the development of technical excellence. This often involves neglecting relationships and avocations. Once training ends, the subjugation of ineffable pursuits to medical practice has become habitual, and many physicians find themselves in a position of social isolation, where life has become a series of tasks designed to promote productivity. This type of behavior, sometimes described as a personal philosophy of "total work," is fertile ground for burnout and dissatisfaction.[30]

The solution to "total work" is the pursuit of activities that enhance meaning. What these include is highly individualized. Recreation may include spiritual pursuits, reading for pleasure, spending time with family, or any other venture that engages contemplation for its own ends. Moreover, work distractions during these ventures negate the experience. Setting clear boundaries between work and personal life is essential, which often includes eliminating work email, projects, or telephone calls during recreation. The importance of dedicated play cannot be overstated.

TEAM, INSTITUTIONAL, AND HEALTH CARE SYSTEM FACTORS CONTRIBUTING TO BURNOUT

Several team and institutional practices may be protective against burnout. The following discussion is based on interviews with dozens of palliative care practitioners and experts in the field in addition to published evidence.

According to one study, physicians who work in team-based settings where they feel better able to meet patient needs are less likely to report burnout. In that study, working with a social worker or pharmacist was protective against symptoms of burnout.[32] Other evidence supports that physician isolation contributes to burnout.[10] It is reasonable to assume that isolation is particularly difficult for physicians who care for patients with serious illness. There is a reason why palliative care and hospice are provided by teams; providers in isolation are lacking the important team "buffer" effect that hospice and palliative physicians rely on for support.

Approaches to the challenges of isolation are not always easy but may include creating virtual teams with other closely collaborating services, forming support groups (eg, several physicians who share similar practices coming together regularly to provide support). For providers who work in isolation or on small teams, it is particularly important to try to set clear limits about working nights, weekends, and taking clear time off with no work interruptions.

Highly emotional patient and family meetings can often be a source of stress, particularly if a practitioner experiences conflict personally or as a personal failing. Developing competence in conducting these difficult discussions empathically and competently can help providers feel less stress and find enhanced meaning. Such programs as VitalTalk (www.vitaltalk.org), the Serious Illness Communication Program through Ariadne Labs (https://www.ariadnelabs.org/areas-of-work/serious-illness-care/), is invaluable in improving communication and competence. The authors have found that family meetings conducted by two people (eg, physician and social worker or case manager) are often less stressful and can provide an opportunity to debrief, learn from one another, and reframe conflict so that it is less likely to be taken personally.

There is a growing sense within the medical community that the electronic health record (EHR) is driving professional dissatisfaction and burnout, some of which may be related to the burdensome documentation requirements to maximize

reimbursement.[32,33] Many EHRs are cumbersome and add unnecessary time and complexity to the clinician's workload. In many instances, using time-based billing codes and using advance care planning codes can make documentation less burdensome for providers caring for patients with serious illness. All physicians need to advocate at the institutional and national level for EHRs that support quality patient care and making clinician's lives easier, not more difficult.

The hard work of caring for patients with serious illness and their families, including conducting lengthy meetings and goals of care discussions, tends to be incompletely captured by relative value units. Physicians who work in purely incentive- or performance-based income models report higher burnout rates than those in salaried positions,[34,35] and thus providers are likely to be particularly stressed in those settings. Moving away from fee-for-service and toward value-based organizations with salaried physicians is likely to make caring for patients with serious illness less burdensome.

Probably, the most important element to protect providers is finding deep meaning in caring for patients with serious illness[36] and feeling valued by colleagues and institutions for their role in the health care system. When physicians see the work of alleviating the suffering associated with serious illness and the dying process as important, meaningful, and valuable, they will feel the satisfaction that helps them remain resilient throughout a long career.

SUMMARY

Burnout is a growing problem in medicine and seems to be especially common in physicians who care for patients with serious illness. Solving this problem requires approaches at the individual, team, institutional, and policy levels. Providers who care for patients with serious illness need to find meaning in their work and practice self-care if they are to remain vibrant, present, and resilient through a full career.

DISCLOSURE

The authors have nothing to disclose.

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