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Clinicians' perceptions of the emotional impact of providing palliative care: A qualitative interview study

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Abstract

Objectives. Many aspects of palliative care, such as managing (complicated) symptoms, conducting goals-of-care conversations, and repeated exposure to loss, can be stressful to clinicians. Previous research on the emotional impact of providing palliative care was mainly done in specialist settings. However, the majority of palliative care is provided by clinicians who are not specialized in palliative care, and can be supported by palliative care specialists only when needed. Therefore, this study aimed to gain insight into the emotional impact of providing palliative care on clinicians, both palliative care generalists and specialists.
Methods. A qualitative interview study among 21 clinicians (11 doctors and 10 nurses) working in hospitals, home care, or nursing homes in the Netherlands was conducted. Between February and June 2019, 13 palliative care generalists and 8 specialists were interviewed. Interviews were thematically analyzed by two researchers.
Results. All clinicians considered the emotional impact of providing palliative care to be substantial and experienced both positive and negative aspects of providing palliative care. Several aspects of providing palliative care can support or undermine emotional stability. These so-called facilitators and barriers, such as practicing self-care and complexity of palliative care, were found at three different levels: individual, team, and organization.
Significance of results. Although clinicians experience providing palliative care as meaningful and valuable, the emotional impact is considerable. Negative and positive aspects often coexist. Further insight into the dynamics and magnitude of the emotional impact of providing palliative care is needed in order to create a healthy working environment and develop adequate interventions.

Introduction

Clinicians providing palliative care are confronted with several impactful aspects such as complicated symptom management, complex and emotional conversations with patients and their family, and repeated exposure to death and dying (Dean, 1998; Payne, 2001; Kearney et al., 2009). These specific aspects of palliative care can attribute to work-related stress, which in turn may lead to burnout (Maslach et al., 2001; Bakker et al., 2004). Meanwhile, nurses and doctors are also confronted with a high workload (including administration and working long hours), greater staff shortages and treat more patients than ever before (and face increasing patient expectations) (United Nations, 2015; Demographic trends of workforce). In addition, there is a growing need for palliative care due to people getting older and having more co-morbidities (Etkind et al., 2017). In addition, unexpected developments can have a major impact on the emotional well-being of clinicians, as experienced with the outbreak of COVID-19. A meta-analysis of 65 studies on the psychological impact of COVID-19 on healthcare professionals all over the world showed a prevalence for clinical depression, PTSS, and burnout of, respectively, 31, 40, and 37% since the outbreak of the pandemic (Batra et al., 2020). The growing demand for palliative care, combined with an increasing shortage of healthcare professionals and high workload, means that drop-out of clinicians should be avoided. This calls for attention to the well-being of clinicians in order to retain them in the healthcare field.

Existing research on the emotional impact of providing palliative care is inconclusive. Firstly, most research focuses only on the specialized palliative care settings such as palliative care units and palliative care teams (Sanso et al., 2015; Pattison et al., 2020). Secondly, some studies suggest that healthcare professionals providing palliative care consciously choose to work in the field of palliative care, which is seen as a protective factor for work-related stress (Dougherty et al., 2009). However, providing palliative care might not be a deliberate choice for all clinicians, especially those providing generalist palliative care. In the Netherlands, palliative care generalists provide care during the whole disease trajectory including both curative and palliative care. These palliative care generalists often do not have any formal palliative care training (de Bruin et al., 2018).

Thirdly, there is unclarity about the impact of the confrontation with suffering and dying on a regular basis. Some studies state that there is a ceiling effect in the amount of dying patients a clinician can deal with (Müller et al., 2009). Other studies found no negative relation between level of exposure to death and burnout. They state that being able to help patients and their relatives in such an important part of their lives helps them cope with work-related stress (Samson and Shvartzman, 2018).

To our knowledge, limited studies have been conducted to assess the emotional impact of providing palliative care in both palliative care generalists and specialists. Therefore, this study aimed to gain insight into the emotional impact of providing palliative care on both types of clinicians.

Methods

Study design

A qualitative study using semi-structured interviews was performed. This study design allowed the examination of the perceptions of clinicians providing generalist and specialist palliative care in the Netherlands regarding the emotional impact of caring for patients in need of palliative care. For reporting the COnsolidated criteria for REporting Qualitative research (COREQ) checklist was used (Tong et al., 2007).

Participants and setting

We aimed at including a heterogeneous group of clinicians providing palliative care with a fair distribution regarding type of clinician (nurse and doctor, both palliative care generalists and specialists) and setting, using a matrix of setting and profession.

In the Netherlands, palliative care generalists, such as general practitioners, medical oncologists, home care nurses, and oncology nurses provide care during the whole disease trajectory including palliative care. They are supported by palliative care specialists if required. Palliative care specialists were defined as clinicians with additional education in palliative care and working as a palliative care consultant, either in the home care setting, or in a hospital palliative care consultation team.

Recruitment

Participants were recruited through convenience sampling. Colleagues of the Netherlands Comprehensive Cancer Organisation were asked to act as an intermediary to contact clinicians from their local network for this study. Those clinicians who gave permission to be contacted received an e-mail from the researcher (AD) inviting them to a face-to-face interview at their place of preference.

Data collection

All interviews were conducted between February 2019 and June 2019 by AD, a female PhD with a background in psychology. Interview duration ranged between 29 and 65 min. A semi-structured topic list was used to guide the interview, with some separate questions for palliative care specialists (Supplementary material I). Participants also completed a short self-administered questionnaire on socio-demographics. The semi-structured topic list was developed by AD and LB, based on previous research on burnout among clinicians (Maslach and Jackson, 1981; Kavalieratos et al., 2017; West et al., 2018). The topic list was approved by all authors and tested on a clinician. Two main themes were included: (1) experiences and views of the clinicians related to the emotional impact of providing palliative care and (2) activities undertaken by the clinician and their organization to maintain emotional stability. Aim of the study, the role of AD, and main themes of the interview were explained beforehand.

All interviews were audio-recorded and transcribed verbatim. Interviews were held until saturation per type of clinician was reached.

Data analysis

Interviews were analyzed according to the thematic analysis approach using Atlas.ti version 8.4.18. Data analysis started during data collection so new themes that emerged from the interviews could be added to the topic list. Two researchers (LB and AD) independently coded three randomly selected transcripts using an open coding procedure and results were compared. This procedure was repeated two times, with in total three new manuscripts, to confirm uniformity among researchers. Disagreements between the researchers over codes and categories were resolved via discussion. Based on the codes, categories were derived by two researchers (LB and AD) and clustered into themes and discussed with the research group.

Ethical consideration

In the Netherlands, according to the Central Committee on Research involving Human Subjects, this type of study is exempt from approval of an ethics committee due to the fact that there was no invasive intervention nor were there vulnerable patients involved (CCMO, 2020). The interviewer explained the purpose of the study and anonymity of participants was guaranteed. For all participants, written informed consent was obtained and participants were informed that they could withdraw from the study at any time.

Results

Participant characteristics

In total, 21 clinicians were interviewed, including 13 palliative care generalists and 8 palliative care specialists. Ten participants were nurses and 11 were doctors. The clinicians worked in hospitals ($n = 9$), home care ($n = 7$), and nursing homes ($n = 5$). Participants were mostly women (81%) and had a median age of 49 (26–67) (Table 1).

Emotional impact of providing palliative care

All clinicians considered the emotional impact of providing palliative care to be substantial. When elaborating on this impact, many participants mentioned both positive and negative aspects affecting their emotional stability. These positive and negative aspects of their work often coexist, as illustrated in the following quote:

Table 1. Healthcare professionals' socio-demographic characteristics

	Palliative care generalists ($n = 13$) N (%)[a]	Palliative care specialists[b] ($n = 8$) N (%)[a]
Gender		
Women	11 (85%)	6 (75%)
Men	2 (15%)	2 (25%)
Age (median, range)	48 (26–66)	49.5 (35–67)
<35	3 (23%)	0 (0%)
35–55	5 (38%)	6 (75%)
>55	5 (38%)	2 (25%)
Profession		
Doctor[c]	6 (46%)	5 (63%)
Nurse	7 (54%)	3 (37%)
Setting		
Home care	5 (38%)	2 (25%)
Nursing home	3 (23%)	2 (25%)
Hospital	5 (38%)	4 (50%)
Years of experience in health care in general		
<10 years	4 (31%)	0 (0%)
10–20 years	4 (31%)	4 (50%)
>20 years	5 (38%)	4 (50%)

[a] Due to rounding, the numbers do not always/necessarily add up to 100%.
[b] Having received a specific training in palliative care and working as a consultant or in a palliative care team.
[c] GP, medical oncologist, pulmonologist, and elderly care physician.

> "As a nurse, I think it is almost like you torment yourself a little, […] because it is beautiful, it brings you a lot, but it comes at a higher expense. And I think it is important that you keep a balance in that." Palliative care generalist (hospital nurse)

Reported positive aspects were (1) having a fulfilling and rewarding job and (2) experiencing personal growth as a result of providing palliative care. Several clinicians said that, although providing palliative care can be difficult and burdensome, they felt strongly motivated in their work by being able to help patients during this difficult part of their life:

> "It [providing palliative care] concerns not only medical technical and pharmacological matters, but, above all, also the phenomenon that people end up in an existential crisis […]. Yes, that can keep you awake at night, but it also gives you a lot of satisfaction." Palliative care specialist (elderly care physician)

Personal growth was described in relation to learning valuable personal lessons as a result of providing palliative care. It made clinicians aware of what is really important in life and helped them realize that every person has different viewpoints and backgrounds. This resulted in becoming more open minded:

> "It turns out that life is not so malleable. It [providing palliative care] has taught me to live in the moment. […] I used to be very forward-looking and almost always just yearned for what was yet to come, while I forgot to enjoy the present. And that has very much changed." Palliative care specialist (hospital nurse)

Feelings of powerlessness were mentioned as having a negative emotional impact. Clinicians found situations in which helping a patient was beyond their control such as relatives getting upset due to a patient's death rattle, to be emotionally burdensome. One participant described a situation in which she was unable to relieve a patient's pain:

> "I think mainly the sense of powerlessness. We are of course focused on helping [patients], on supporting them, on solving something. And in these situations you often can't do much anymore. Yes, you can be there, and often that is enough. But I think the powerlessness, the feeling of powerlessness… […] When the family looks at us like 'what can you do to make this easier or more pleasant?' And you do not always have a solution." Palliative care generalist (home care nurse)

Facilitators and barriers of providing palliative care regarding emotional stability

Several aspects of providing palliative care can support or undermine emotional stability; they function as so-called facilitators and barriers. These facilitators and barriers for emotional stability of the individual clinician were found at three different levels: individual, team, and organization (Table 2).

Individual level

Aspects of providing palliative care at the individual level included elements that are associated with personal attitudes, coping and actions of clinicians. Two facilitators of emotional stability on the individual level were mentioned: (1) attitude toward the inevitability of death as part of life and (2) practicing self-care. Also, three barriers of emotional stability in relation to providing palliative care were mentioned: (1) patient-related aspects, (2) conflicting personal values between the patient and the clinician, and (3) lack of experience with loss and dying.

Some clinicians mentioned that it was helpful to realize illness and death are an inevitable part of life and that you cannot prevent this from happening. They mainly focused on their potential contribution to providing high quality of care for patients in their last phase of life. Some clinicians said that recognizing the difference between what they can and cannot change about the patients' situation can prevent feelings of frustration and powerlessness:

> "I also notice awareness of what you do have, and what you can do for someone and what you cannot change. This may also have a protective effect. It's like a circle of influence: on what aspects can I exert influence and how do I do that, and which aspect cannot be changed?" Palliative care specialist (General practitioner)

Engaging in self-care activities or rituals was also mentioned to be a helpful coping mechanism. These took place during the workday (after contact with a patient, or after death of a patient), or at the end of the day. Examples were taking a deep breath after having seen a patient, going for a run, never working from home after working hours or consciously distancing themselves from work after a workday. Some clinicians became aware of this during the interview and engaged in these activities unconsciously. Others were already aware of needing activities to maintain emotional stability.

Table 2. Facilitators and barriers of providing palliative care regarding emotional stability

Level	Facilitator	Description	Barrier	Description
Individual	Attitude toward the inevitability of death as part of life	*Realizing illness and death are part of life* *being aware of what you can and cannot change about the patients' situation*	Patient-related aspects	*Young patients* *involvement of young children* *a long-lasting therapeutic relationship*
	Practicing self-care	*Taking a deep breath after having seen a patient* *going for a run* *consciously distancing yourself from work after a workday*	Conflicting personal values	*Different perspectives on the best possible care* *having to choose between attend to patient wishes or sticking to one's own values and personal boundaries*
			Lack of experience with loss and dying	*Having little experience in witnessing loss and dying increases the emotional impact*
Team	Supportive team culture	*Receiving support from colleagues* *feeling safe within the team to be open and honest about the impact*	Colleagues not experienced in palliative care[a]	*Experiencing stress as a result of colleagues not recognizing what is needed to provide adequate palliative care*
	Having role models in self-care	*Having experienced clinicians to set the right example how to practice self-care* *observing different types of self-care activities helps less experienced clinicians develop their own coping strategies*		
Organization	Opportunity to reflect on (impact of) care	*Structurally discuss impactful situations among colleagues*	Care as usual is under pressure	*Experiencing a high workload* *not having the extra time that is needed to provide good palliative care*
			Complexity of palliative care	*Providing four-dimensional care is mentally and emotionally demanding*

[a] Only experienced by palliative care specialists.

> "I have been practicing mindfulness for years and it has brought me a lot. And by applying mindfulness in my daily life as a doctor, I actually build in moments of recovery all the time: When I walk to the waiting room I use that walk to get out of my head and focus my attention on my legs and feet. This way I get close to myself for a moment. I find these moments promote my recovery, they give me energy." Palliative care generalist (General practitioner)

Several patient-related characteristics or situations were frequently mentioned as emotionally undermining aspects of palliative care, including caring for a young patient, involvement of young children and having had a therapeutic relationship with the patient for many years.

> "It really depends on what kind of patient I have in front of me and probably also a bit on my own identification with the patient. For example age, what kind of disease, their family and how the relationship with family members is." Palliative care generalist (hospital nurse)

Another barrier was conflicting personal values between the patient, their family, and the clinician, resulting in different perspectives on the best possible care. Conflicting values can lead to difficult situations for clinicians as they must choose between letting go of their personal values to meet the needs and wishes of the patient. Or protecting their personal boundaries and telling the patient that they cannot comply to their wishes.

Furthermore, some participants said that their lack of experience in witnessing loss and dying increased the emotional impact. With time and experience they found a way to deal with it and the impact declined. This was also observed by a palliative care specialist among her colleagues from other departments:

> "In departments where they are not so used to dealing with [dying patients], I notice that the impact is substantial. People almost drown in the feeling that the appropriate care should be delivered, immediately, because the patient is dying. […] and the impact in those departments seems to be greater than in a department in which it is more common for people to die." Palliative care specialist (hospital nurse)

On the contrary, it was also mentioned that witnessing many patients die may have a cumulative effect, in which case the clinician appears to reach some sort of limit:

> "Well, I think you can reach a saturation level in terms of grief. And for some that level may be different than for others, but overall I think that after a certain period you have to say 'life is more than just this'. So it's self-protection…" Palliative care specialist (elderly care physician)

Team level

On the team level, two facilitators supporting emotional stability of the individual clinician arose: (1) supportive team culture and (2) having role models in self-care. Having colleagues who are not experienced in providing palliative care was experienced as a barrier undermining emotional stability. The team level included those colleagues with whom a clinician works together in the care for patients.

Many participants reported receiving support from colleagues and feeling safe within the team to be open about the impact of providing palliative care to be an important facilitator in dealing with the impact of providing palliative care. Respondents also found other collaborative practices, such as sharing the care for patients when a colleague had a heavy patient load to be supportive:

> "What I find very important is that you and your team are very collegiate. So you have to be flexible if you have terminal clients in care. And palliative care is of course much broader, but especially that last part, that dying phase, you have to be very flexible among each other. So if someone works in the evening shift, they must be able to call a colleague and ask 'hey, extra care is needed, can you go or do you want to take over my work?'." Palliative care generalist (home care nurse)

Furthermore, having role models in self-care was mentioned as an important facilitator. Experienced clinicians should set the right example so that less experienced colleagues can observe different types of self-care and coping. This way less experienced colleagues can learn what self-care activities fit their personality and develop their own coping strategies.

> "You learn by watching how others do it [self-care activities]. And then by doing it yourself and when you gain experience, you will learn: this may also work for me. You also experience: this does not suit me, I shouldn't do that. […] And just a good division between that the beginners are in a good surrounding, that they have enough examples where they can compare themselves to and can pick from what suits them. And be able to not use what does not suit them." Palliative care specialist (medical specialist)

Having colleagues who are not sufficiently educated in providing palliative care was mentioned as a barrier regarding the impact of providing palliative care. This was solely mentioned by palliative care specialists working in a team with mainly palliative care generalists. The palliative care specialists mentioned it can be emotionally stressful when your colleagues do not always recognize what is needed to provide adequate palliative care:

> "They give the care that is needed and then they leave again. And the next care-visit they come again and think: what needs to be done this time? But they are not looking ahead: the weekend is coming up, shouldn't we already discuss what pain medication should be available? Suppose something happens, what should we do? And then you feel very responsible." Palliative care specialist (home care nurse)

Organizational level

One facilitator of emotional stability on the organizational level was mentioned, namely peer support. Also, two barriers of emotional stability in relation to providing palliative care were mentioned: (1) care as usual is under pressure and (2) the complexity of providing palliative care.

Many participants mentioned the possibility of structurally reflecting on the impact of palliative care and especially impactful situations as beneficial for emotional stability. An often mentioned example was peer coaching sessions. Several clinicians mentioned that such peer coaching sessions should be guided by a trained professional to make sure feelings are being addressed adequately and prevent the conversation from remaining superficial:

> "Good peer coach sessions with a good supervisor once every two months. I don't even think every month is necessary. But you must attend them and share your experiences. I think, that way, things will come out sooner rather than when it is actually already too late." Palliative care generalist (medical specialist)

An aspect that undermines the emotional stability is that clinicians felt the whole healthcare system is under pressure due to a high workload. Some participants mentioned that they feel it is impossible to take some extra time that is needed to provide good palliative care.

> "That the formation of care is not sufficient, that there are people who do not look carefully at what is happening, that they call you in too late so that someone, in your opinion, suffers unnecessarily. […] You know, all those things that I, as a simple doctor, can't influence. Or at least to a limited degree, in my experience. And that also costs energy, because it is precisely the things that you have no influence on, that cause the most frustration and by now I learned that frustration is a killer." Palliative care generalist (elderly care physician)

Furthermore, the complexity of palliative care was also mentioned as an important barrier. When providing palliative care, clinicians address not only physical care, which can sometimes be complex, but also pay attention to the psychological, social, and spiritual dimensions of palliative care. This not only requires time, but is also perceived as mentally and emotionally demanding as the following quote demonstrates:

> " It just makes an appeal to you as a doctor, because at that point everything comes together. You are dealing with people who are in a very intensive period of their lives, who are vulnerable, yet can also be very strong because of it. There are so many emotions involved and the four pillars of palliative care […] yes in every area it is just pulling all the stops and that is intense. Yes, that does something to you as a doctor." Palliative care specialist (general practitioner)

Overall, in the above-mentioned results, there were no substantial differences in the perceived facilitators and barriers between doctors and nurses and both palliative care generalists and specialists experience needs on the individual, team, and organizational level. Only having colleagues who are not sufficiently educated in providing palliative care was mentioned solely by palliative care specialists. It means that they feel they cannot rely on the quality of the care their colleagues provide, and are hesitant to go on holiday.

> "Well you know how hectic the care in the end-of-life can be. So I already arranged a lot of things and everything was well put in order because I knew I was going on holiday, now I have to hand it over to the team, with all palliative care generalists so to speak. Is that going well? And then I felt that responsibility very strongly. Are things going well? Are they handling this well now? Can I leave this to my team?" Palliative care specialist (home care nurse)

Discussion

Main findings

This interview study shows that both palliative care generalists and specialists experience substantial emotional impact of providing palliative care and that providing this care can simultaneously positively and negatively affect their emotional stability. This coinciding positive and negative impact can be attributed to facilitators and barriers on the individual, team, and organizational level. Facilitators include practicing self-care, having role models in self-care and having the opportunity to reflect on the impact of providing palliative care. Barriers include conflicting personal values, palliative care not being integrated in care as usual, the complexity of providing four-dimensional palliative care, and repeated exposure to death and dying.

Some findings deserve attention. Firstly, aspects of palliative care that undermine or support emotional stability occur simultaneously. It seems these factors do not balance out as a scale but coexist regardless of the degree of presence of the opposite factor. This was also seen in an Italian interview study among nurses and doctors who worked in a palliative care unit (Maffoni et al., 2020). The authors concluded that some factors, such as work experience, may be supporting emotional stability in one clinician, but undermine stability in another. Likewise, in our study, we found different views among the 21 clinicians about repeated exposure to dying. If a person perceives certain work aspects as stressful and how they respond to this stress can be explained by many factors, for example working conditions, not working in a team, personality, or age (Maslach et al., 2001; Perez-Fuentes et al., 2019; Gómez-Urquiza et al., 2020; Horn and Johnston, 2020).

Secondly, our study showed that repeated exposure to dying patients can have different effects on the emotional stability of clinicians, whereby having some experience of patients in the dying phase and witnessing death seems to help in coping. Whereas frequent exposure to death and suffering can have a cumulative negative effect on emotional stability. Similar findings have been described in an Israeli study by Granek and colleagues (Granek et al., 2017). In their study, 53% of the oncologists indicated that exposure to patients' death had normalized death and dying for them. While other participants indicated that exposure to a patient's death had made death more frightening (24%) and/or sadder (28%) for them.

Furthermore, apart from individual aspects undermining and supporting emotional stability, our results also revealed important elements on the team and organizational level. Similar results were found in a systematic literature review on moral distress experienced by healthcare professionals providing palliative care (Maffoni et al., 2019). This review identified four main areas: (1) personal, (2) patients and caregivers, (3) colleagues and superiors, and (4) environment/organization. The authors state that these factors may both support or undermine the emotional stability of clinicians and remark that moral distress is a multidimensional phenomenon and a complex process. They suggest that not only training and education is necessary to empower clinicians, but also preventive and supportive organizational interventions. Although the reaction to stress is different in every individual, increased attention is being paid to the need for a system approach to properly address work-stress and burnout among healthcare professionals. This system approach advocates a shift from a focus on individual-oriented interventions toward a combined approach in which attention is also paid to interventions at the team and organizational level (Gillman et al., 2015; Harrison et al., 2017) This is in line with our findings in which clinicians plea for group interventions such as peer coaching.

Strengths and limitations

A limitation of the study is that the participants were almost all woman with a Dutch cultural background. Therefore, this study does not provide insight into sex and cultural differences in dealing with the impact of providing palliative care. Also, it is plausible that there has been some degree of self-selection when recruiting the participants, whereby participants with interest in the emotional impact of their work were more likely to participate in this study. This may have led to a restricted impression of the experienced impact of providing palliative care. This study also has strengths to be mentioned. Firstly, by including both palliative care generalists and specialists, we aimed to broaden the research on the impact of providing palliative care, unrelated to work setting, or level of palliative care education. Secondly, the interviews might have worked as an intervention in itself, the so-called therapeutic effects of qualitative research (Shamai, 2003). During the interviews, it became apparent that many clinicians, especially palliative care generalists, were not used to talking about the emotional impact of their work. The interview itself might have helped them become aware of the importance of addressing this topic, both personally as within the team and organization.

Implications for practice and policies

This study shows that clinicians experience the emotional impact of providing palliative care as substantial. Its impact related to providing palliative care, on top of the general work-stressors experienced by clinicians, requires attention, in light of the call of the World Health Organization for equal access to palliative care and to integrate palliative care into existing health services (World Health Organization, 2014). With both the expected increase of need for palliative care in the near future, and in light of unforeseen situations such as the outbreak of a pandemic, more clinicians will be involved providing care for patients in their last phase of life. This would not only make the case to train clinicians in palliative care skills, as advocated in the context of the integration of palliative care, but also to pay specific attention to learning to reflect on the personal emotional impact of providing palliative care to maintain emotional balanced (Gómez-Batiste et al., 2019).

Furthermore, this study shows the importance of addressing the emotional impact of providing palliative care on clinicians at both the individual, team, and organizational level. However, most interventions aimed at reducing burnout are on the individual level (Dijxhoorn et al., 2020). This implies that the impact of providing palliative care is only an individual problem, while there are also important aspects regarding the team and organizational level (Harrison et al., 2017). Addressing these aspects are often beyond the personal influence of clinicians. Therefore, it is important that healthcare organizations support solutions such as peer coaching and provide the opportunity, both in time and in addressing the work culture related to this topic, to maintain and improve emotional stability for both palliative care generalists and specialists.

Conclusion

Providing palliative care has a substantial emotional impact on clinicians, both for palliative care generalists as palliative care specialists. Clinicians simultaneously experienced positive and negative impacts on their emotional stability. The impact of providing palliative care can be mitigated by facilitators and barriers on the individual, team, and organizational level. Structured attention toward dealing with this impact on all these levels should be implemented. More knowledge on adequate interventions to maintain emotional stability is needed to enable clinicians to provide excellent palliative care for a growing population.

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Author contributions.
All authors participated in the design of the topic list. AD conducted the interviews. AD and LB and NR were involved in the analysis of the interviews. Interpretation of the data was discussed among all authors. AD drafted the manuscript. All authors were involved in the critical revision of the manuscript and approved the final version of the manuscript.

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