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Care about care for healthcare professionals providing palliative care

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Peer Support Program for addressing work-related stress in healthcare professionals providing palliative care: A pilot study

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Submitted

ABSTRACT

Working as a healthcare professional (HCP) is demanding and can lead to work-related stress. Peer Support aims to support HCPs who are involved in an incident using conversations with a trained peer. Peer Support might also help HCPs who struggle with the impact of caring for patients with life-limiting diseases. This pilot study aimed to assess feasibility and acceptability of Peer Support to address work-related stress in HCPs providing palliative care in a single Dutch hospital. HCPs from three departments were invited to complete a questionnaire including the Burnout Assessment Tool, additional questions on work-related stress and an invitation to use Peer Support. After the intervention participants completed the questionnaire again, supplemented with evaluation questions. A total of 56 respondents completed the questionnaire (response rate 11%). One in seven respondents scored (very) high on various burnout subscales. On average, respondents engaged in almost four activities to manage their work-related stress, but 57% of all respondents still had needs in this regard. Respondents felt more attention should be paid to work-related stress and more support was needed from their supervisor and organisation. Four respondents participated in the Peer Support Program, they all experienced this as valuable. Although getting time to talk with colleagues about impactful events is desired by HCPs to cope with the emotional impact of their work, the approach used in this pilot study was not suitable to reach HCPs who experience high levels of burnout symptoms.

INTRODUCTION

Working as a healthcare professional is demanding and can lead to work-related stress. Known causes of work-related stress include high workload, long working days, night and weekend shifts, and administrative burden.[1,2] A study among healthcare professionals caring for patients with a life-limiting disease also found that repeated exposure to dying patients, difficulty in balancing between a personal or professional attitude towards patients and family, and disagreement about what care should be provided were stressors associated with providing palliative care.[3] Moreover, an interview study among healthcare professionals providing palliative care suggests that conversations about life-threatening illness and end-of-life care can lead to feelings of anxiety among healthcare professionals due to a lack of communication skills or anticipation of an emotionally charged response from the patient and family.[4]

Prolonged stress can lead to burnout.[5] The prevalence of burnout symptoms among healthcare professionals is considerable. A meta-analyses by Zhang and colleagues showed that almost two-thirds of nurses have symptoms of burnout, and a European study found similar numbers of burnout symptoms among young medical oncologists.[6,7] A systematic literature review among healthcare professionals who provide palliative care showed that, despite a wide range of burnout prevalence rates, most studies reported a prevalence of burnout of 18% or higher.[8] Several studies in this review showed that healthcare professionals working in general care settings such as hospitals had higher burnout rates compared to their colleagues working in dedicated palliative care settings such as hospices.

Previous research among healthcare professionals providing palliative care has shown that most healthcare professionals engage in various coping activities to lower their work-related stress, such as engaging in leisure activities or talking with colleagues.[9,10] However, almost a quarter of these healthcare professionals felt that this was not enough to deal with the emotional impact of their work and 55% felt that they needed more time to talk with colleagues about the impact of their work.[9] Brighton and colleagues also showed this importance, with all participants in their study mentioning the importance of reflecting on emotionally charged experiences in order to deal with their emotions, and having time to do so.[4] Barriers experienced in receiving social support from colleagues were fear of appearing vulnerable and not wanting to bother colleagues because they have their own emotional burdens.[10]

Research shows that physicians are more likely to seek help from a peer, a colleague physician, than they would access professional mental health support.[11] Peer Support as defined for the healthcare context is '*the provision of emotional, appraisal, and informational assistance by a created social network member who possesses experiential knowledge for a specific behaviour or stressor and similar characteristics as the target population, to address a health-related issue of a potentially or actually stressed focal person*'.[12] In Peer Support programs healthcare professionals who are involved in a predefined adverse event or critical incident are contacted and offered a number of conversations with a trained colleague (peer).[13] Over the years, Peer Support has evolved and now is used also as a way to promote the personal wellbeing of healthcare professionals in the work environment and help them cope with stress and anxiety.[14] Peer Support Programs are organised in diverse ways such as in one-to-one sessions, in group meetings or as online support groups.[12,14,15] Important components of Peer Support conversations are reaching out to a clinician who is involved in an emotionally stressful event, giving an opening to talk about the event, listening, reflecting, discussing the coping strategies and support system.[13] Studies on Peer Support interventions after an adverse patient event show that healthcare professionals experience it as to be helpful and feel that it leads to recognition, less stress and offers an opportunity to a culture in which healthcare professionals feel safe to share experiences.[14,16,17]

Since most Peer Support Programs are thus focused on support after an incident or adverse event, it might also be beneficial for coping with emotional impact of providing palliative care, as this involves stressful and emotionally burdensome situations. A recent systematic literature review showed that, among nurses, good social support, such as support from the supervisor or peer, was associated with lower symptoms of burnout.[18] Therefore, we hypothesised that Peer Support Programs might be appropriate for healthcare professionals who struggle with work-related stress and their personal wellbeing as a result of providing palliative care. The aim of this study was to assess the applicability and feasibility of a Peer Support program to address personal wellbeing in healthcare professionals providing palliative care.

METHODS

Study design and setting

This pilot study aimed to assess feasibility and applicability of a Peer Support Program for addressing work-related stress and emotional wellbeing in healthcare professionals providing palliative care in the departments of Gynaecology/Obstetrics, Neurosurgery

and Radiotherapy of the LUMC. In the Netherlands, primary palliative care is provided by all healthcare professionals and is supported by palliative care specialists when necessary. The pilot study was conducted between October 2022 and December 2022. For reporting the CONSORT checklist was used.[19]

Participants and recruitment

All 490 healthcare professionals working in the departments Gynaecology/Obstetrics, Neurosurgery and Radiotherapy of the LUMC were invited to complete an online questionnaire and invited to participate in the Peer Support Program. In these departments healthcare professionals care for patients with life-limiting illnesses from various ages. Managers of the participating departments gave their consent to conduct the study and were asked to inform healthcare professionals in their department about the pilot study.

Intervention and data collection

A Peer support program has been installed in LUMC since 2017 and offers one-on-one conversations when serious events have been reported to the department of Quality and Patient Safety (DKP, acronym for Directoraat Kwaliteit en Patiëntveiligheid). The LUMC has circa 25 healthcare professionals that conduct these Peer Support conversations. The members of the Peer Support team are all trained in having these conversations. In 2021, Peer Support conversations after serious events have been formally offered to 67 healthcare professionals, of which 13 (19%) have accepted this offer.

In this pilot study, all healthcare professionals working at the participating departments received a personal e-mail with information about this pilot study and were invited to participate. In the email, a link to an online questionnaire on symptoms of burnout was provided. After two weeks a reminder was sent. The questionnaire consisted of the validated Burnout Assessment Tool (BAT) and additional questions on work-related stress and work characteristics and socio-demographics.[20] The BAT is a validated instrument using a 5-point Likert-scale measuring four core subscales of burnout: exhaustion, mental distance, emotional impairment and cognitive impairment. In addition, the BAT assesses secondary symptoms, divided in symptoms regarding psychological distress and psychosomatic complaints.[21]

At the end of the questionnaire, participants could indicate if they wanted to have three Peer support conversations. If so, they gave consent for the Peer Support team to contact them to schedule a first meeting. They were offered thee conversations with

a member of the Peer Support team of the LUMC to talk about work-related stress. Participants with high scores on the BAT subscales, and therefore seen as the intended target group for the Program, were also contacted by e-mail to offer them Peer Support. The match between the participant and Peer Support colleague was based as much as possible on similarity of function, but working in a different department. After completion of the Peer Support Program, participants again received the online questionnaire, supplemented with an evaluation form. Respondents who did not want to participate in the Peer Support program were asked about their reasons for not participating. Also the three Peer Supporters involved in these conversations received an evaluation questionnaire regarding their personal experiences of conducting Peer Support conversations in the context of this pilot study.

Data analysis

The results of participants who completed the Burnout Assessment Tool were included in the analysis. Descriptive analysis were used to describe sociodemographic characteristics, work characteristics, the prevalence of symptoms of burnout on the five constructs of the BAT and additional questions on work-related stress. Cut-off scores for low, median, high and very high scores on the BAT were used as provided in the manual [21]. All data were analysed using STATA (version 17.0, STATACorp LLC). Results of the evaluation questionnaires of the participants and Peer Supporters were discussed among researchers AD, LB and NR.

Ethical considerations

The Medical Ethical Committee (METC) of Leiden Medical Center (LUMC, N22.017) in the Netherlands reviewed the study protocol and has decided to exempt this pilot study from full ethical review. This was done in accordance with the Dutch Medical Research Involving Human Subjects Act (WMO). Data collection and analyses were done in accordance with the Dutch Personal Data Protection Act. Before the start of the questionnaire information was provided on the screen regarding the aim of the study, anonymity and the possibility to withdraw from the study at any time without any consequences. The contact details of the researcher were provided and informed consent was obtained through a statement declaring that by starting the questionnaire consent to participate in the study was given.

RESULTS

In total, 56 healthcare professionals completed the first questionnaire (11% response rate). Response rate differed per department: 24% for Radiotherapy, 7% for

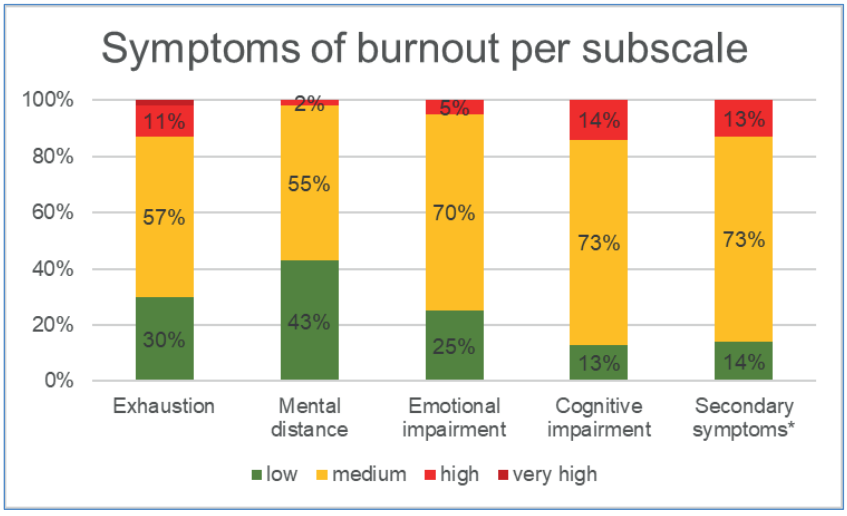
Gynaecology/Obstetrics and 5% for Neurosurgery. Most respondents were female (93%) and older than 40 year (58%) (Table 1). Of the 56 respondents, 31 worked at the department of Radiotherapy (55%), 23 at the department Gynaecology/Obstetrics (41%) and 2 worked at Neurosurgery (4%).

Slightly more than half of respondents (54%) regularly cared for patients who probably were in the last year of their life. All 10 healthcare professionals that indicated to see no patients in the last year of life work in the Gynaecology/Obstetrics department. Almost a quarter (23%) of respondents felt they have (completely) insufficient knowledge and experience to care for patients in their last phase of life. In this regard, 42% of respondents perceived themselves as (completely) sufficient.

Symptoms of burnout

Most healthcare professionals had medium levels on all subscales of the burnout inventory, namely exhaustion (57%), mental distance (55%), emotional impairment (70%), cognitive impairment (73%) and secondary symptoms (73%). Of all 56 respondents, 13% had a high or very high level of exhaustion, 14% had a high level of cognitive impairment and 13% a high level of secondary symptoms (Figure 1).

Figure 1 Symptom of burnout scores per subscale.



**Secondary symptoms includes psychological distress and psychosomatic complaints*

Table 1 Sociodemographic and work-related characteristics of healthcare professionals (n=56)

	% (n)
Gender	
Female	93 (52)
Age	
≤30	20 (11)
31-40	23 (13)
41-50	38 (21)
≥ 51	20 (11)
Department	
Gynaecology/Obstetrics	41 (23)
Neurosurgery	4 (2)
Radiotherapy	55 (31)
Profession	
Physician	36 (20)
Radiotherapy lab technician	23 (13)
Hospital midwife	13 (7)
Nurse specialist	9 (5)
Psychologist	4 (2)
Other	16 (9)
Years of working experience as healthcare professional	
1 – 5	18 (10)
6 – 10	16 (9)
11 – 20	29 (16)
>21	38 (21)
Number of serious situations last year (e.g. sudden death)	
0	29 (16)
1-2	27 (15)
3-5	25 (14)
>6	20 (11)
Percentage of patients you cared for who had a serious illness and are probably in the last year of their life?	
0%	18 (10)
1-10%	29 (16)
11-50%	43 (24)
>51%	11 (6)
To what extend do you have sufficient knowledge and experience to care for patients in their last phase of life?	
Completely insufficient	7 (4)
Insufficient	16 (9)
Neutral	36 (20)
Sufficient	29 (16)
Completely sufficient	13 (7)

Coping activities and support needs for work-related stress

The 56 healthcare professionals reported a mean of 3.7 activities that they do to remain balanced. The most commonly reported activities were seeking support from a partner or friends (80%), leisure activities such as sports, gardening and reading (80%), and seeking support from colleagues (79%) (Table 2). In total, 43% felt that these activities were enough to deal with work-related stress. Almost two third (57%) of respondents had one or more unmet needs, with a mean of 4 unmet needs, ranging from 1 to 13. These unmet needs included less work pressure (27%), more attention for work-related stress at work (25%), more support from their supervisor (25%), feeling safe within the team (23%) and more support from the organisation (21%) (Table 2). Half of all respondents (50%) stated they knew where to find help in dealing with work-related stress, but also almost a quarter (23%) reported they did not know where to find help.

Table 2 Work-related stress activities and needs

	Total (n=56)	Low/Medium score BO subscales (42)	High score on BO subscales (n=14)
	% (n)	**% (n)**	**% (n)**
Signed up for Peer Support	11 (6)	10 (4)	14 (2)
Secondary Symptoms	2.0 (.52)	1.9 (.45)	2.6 (.58)
Percentage of patients you cared for who had a serious illness and are probably in the last year of their life?	26	24	32
(Completely) Sufficient knowledge and experience to care for patients in their last phase of life	41	45	29
Mean number of Coping Activities	3.7	3.8	3.6
Activities			
I seek support from partner of friends	80 (45)	83 (35)	71 (10)
I spend time on my hobby (e.g. sports, hiking, reading, gardening)	80 (45)	81 (34)	79 (11)
I seek support from colleagues	79 (44)	81 (34)	71 (10)
I seek support from supervisor	30 (17)	29 (12)	35 (5)
I alternate my work activities	30 (17)	33 (14)	21 (4)
I get support from team meetings (sharing experiences)	23 (13)	29 (12)	7 (1)
I practice mindfulness/meditation	18 (10)	14 (6)	29 (4)
I make use of individual coaching/mentoring	16 (9)	12 (5)	29 (4)
I share my experiences in intervision meetings	11 (6)	14 (6)	0 (0)
I seek support from my employer/organisation	4 (2)	2 (1)	7 (1)
I am taking additional training/education	2 (1)	0 (0)	7 (1)
Not applicable	4 (2)	2 (1)	7 (1)
Mean number of needs	*4.0*	*3.6*	4.7

Needs			
Nothing, the current activities I undertake are sufficient	43 (24)	52 (22)	14 (2)
Less work pressure	29 (16)	21 (9)	50 (7)
More attention for work-related stress at work	25 (14)	19 (8)	43 (6)
Support from their supervisor/manager	25 (14)	21 (9)	36 (5)
Feeling safe within the team	23 (13)	12 (5)	57 (8)
Support from the organisation	21 (12)	19 (8)	29 (4)
Tools on how to deal with work-related stress	18 (10)	10 (4)	43 (6)
Time to talk to colleagues about event within work	18 (10)	17 (7)	21 (3)
Support from my team	14 (8)	14 (6)	14 (2)
Conversations with colleagues	11 (6)	10 (4)	14 (2)
Hobbies (e.g. exercising, walking, reading, gardening)	11 (6)	7 (3)	21 (3)
Individual coaching/mentoring	9 (5)	2 (1)	29 (4)
Alternate activities	7 (4)	7 (3)	7 (1)
Mindfulness or meditation	7 (4)	5 (2)	14 (2)
Conversations with partner or friends	5 (3)	2 (1)	14 (2)
Intervision	4 (2)	5 (2)	0 (0)
Training/education	2 (1)	0 (0)	7 (1)
I know where to find help in dealing with work-related stress			
Completely disagree	9 (5)	7 (3)	14 (2)
Disagree	14 (8)	12 (5)	21 (3)
Neutral	27 (15)	(24 (10)	36 (5)
Agree	32 (18)	33 (14)	29 (4)
Completely agree	18 (10)	24 (10)	0 (0)

High symptoms of burnout score

Of all respondent (n=56), 25% had high scores on one or more of the four burnout subscales, which indicates a potential risk for burnout. These healthcare professionals were considered as high risk group and potential participants for the Peer Support Intervention. These healthcare professionals cared on average for a patient population of which 32% was in need of palliative care and engaged on average in 3.6 activities (Table 2). The most frequently mentioned activities in the high risk group were the same as those mentioned by all respondents. Respondents in the intended target group had an average of 4.7 needs. Similar to all 56 respondents, the most common needs in the high risk group were to feel safe in the team (57%), less pressure at work (50%) and more attention to work-related stress (43%). They also reported a need for tools on how to deal with work-related stress (43%) and about one in three respondents in this group had a need for support from the organisation (29%) and

individual coaching and mentoring (29%). Of the healthcare professionals with a high score on one of the subscales, 35% did not know where to find help in dealing with work-related stress.

Peer Support Program: Non participating respondents

Of the 56 respondents, 6 (11%) signed up for participation in the Peer Support Program and 50 did not (Figure 2). Of the latter group, 40% (n=20) reported their reason not to sign up for the Peer Support Program. They mainly stated that they did not experience any problems with the personal impact of their work (40%) or already talk to someone else about the personal impact of their work (20%). Other practical reasons for not signing up were that the timing of the pilot study (conversations were held in the two months following the questionnaire) (15%) or /and a too great time investment (15%) (Table 3).

Figure 2 Flowchart participants Peer Support Program

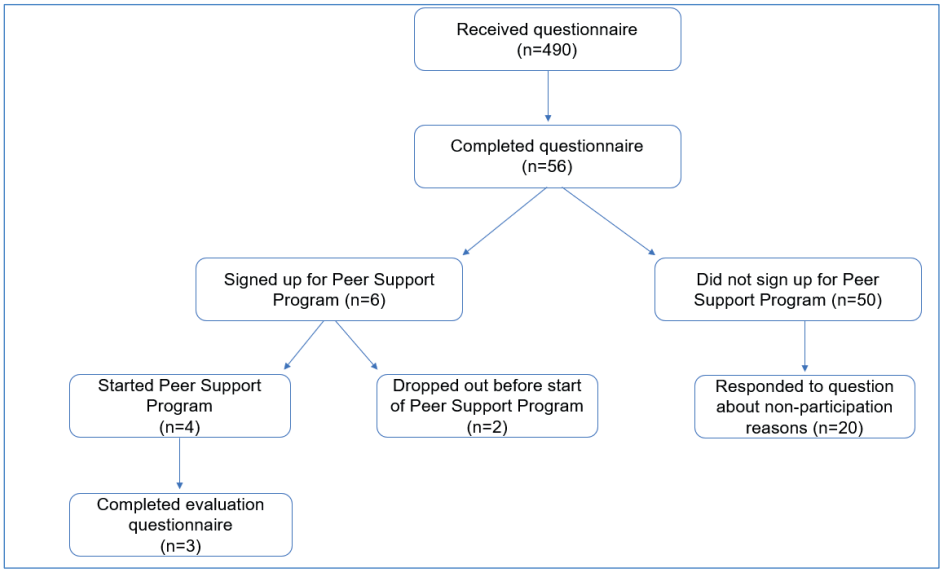


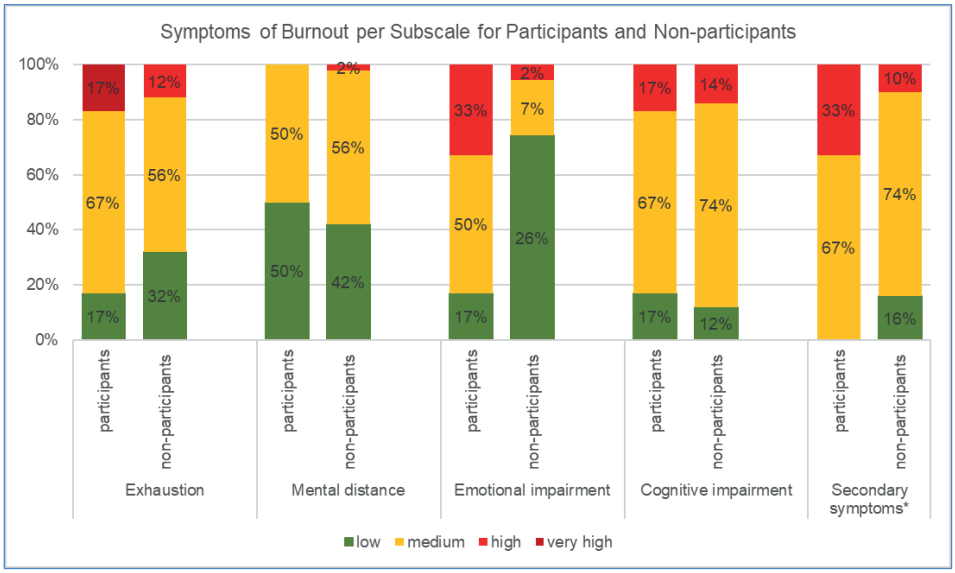
Table 3 Reasons for not signing up for Peer Support (n=20)

Reasons for not signing up for Peer Support	% (n)
I experience no problems with the personal impact of my work	40 (8)
I already talk to someone else about the personal impact of my work	20 (4)
The timing was not convenient, maybe at a later time	15 (3)
The time investment is too big	15 (3)
It does not feel safe to talk to a colleague about the personal impact of my work	10 (2)
Lack of time for such conversations	10 (2)
I prefer to solve it myself, outside of work	10 (2)
Three conversations seem too much to me, I prefer to start with one conversation and see what is needed	5 (1)
I don't want to do anything about the personal impact I experience from my work	5 (1)
Other, namely…	10 (2)

Feasibility of the Peer Support Program

The six respondents who did sign up for participation had on average median scores on symptoms of burnout. On both the subscales Exhaustion and Cognitive Impairment one participant scored (very) high, and on Emotional Impairment and on Secondary Symptoms two participants scored high (Figure 3).

Figure 3: Symptoms of burnout per subscale for participants and non-participants



**Secondary symptoms includes psychological distress and psychosomatic complaints*

These six healthcare professionals were contacted by the Peer Supporter that was matched to them. After this initial contact, two dropped out. One did not remember

signing up and had no interest and one did not respond, despite repeated attempts by the Peer Supporter, either by phone or e-mail, to make an appointment. Four participants participated in the Peer Support intervention of which three completed the evaluation questionnaire.

All three participants that completed the Peer Support Program would recommend it to their colleagues, because they felt it had added value, they learned about themselves and it was easy to participate. The length of the Peer Support Program (three conversations) was perceived as enough and as good but also as "too big a tool to put in place for everyone". It seems to depend on the situation and needs of the individual. One participant mentioned that the encouragement of the supervisor was an important support to participate. Another participant highlighted the added value of sharing the same working environment.

The Peer Supporters providing the Peer Support Program felt it was nice and pleasant to offer Peer Support. They also felt it was useful for the participant and that they were able to support their colleague. The Peer Supporters experienced barriers related to time (busy schedules), especially within working hours. One Peer Supporter mentioned that it is important to have clear expectations of the Peer Support Program.

DISCUSSION

This pilot study aimed to assess the feasibility and applicability of a Peer Support Program to address the personal wellbeing of healthcare professionals providing care for patients in the last year of life. This pilot study did not reach the intended target group. The response rate to the questionnaire was low (11%). One in seven respondents scored high or very high on the burnout subscales of exhaustion and cognitive impairment, but the step to participate in the Peer Support Program was only followed by four healthcare professionals. Respondents engaged on average in almost four activities to deal with work-related stress, but more than half of respondents still has (unfulfilled) needs in this regard. A quarter of respondents indicated that more attention should be paid to work-related stress and that they needed more support from their supervisor and from the organisation.

A quarter of the respondents had a high score on one or more of the four subscales. These respondents were considered as the intended target group for the Peer Support Program. Healthcare professionals who fell in this group had similar outcomes to the other respondents regarding activities they undertake and their needs. However,

respondents with a high score on one of the subscales had on average more unfulfilled needs. In addition to the needs mentioned above, they more often expressed a need for tools on how to deal with work-related stress and individual coaching.

Despite these expressed needs among respondents to the questionnaire, only six respondents signed up for the Peer Support Program (11%) and four actually started the program. Reasons for not signing up for the program included experiencing no problem with the personal impact of work, already receiving other support and practical issues including timing and time investment. The participants varied in their experiences with the Peer Support Program and this gave little insight into the applicability of the program. Due to the low response rate for the Peer Support Program, it cannot be concluded from this study if this intervention sufficiently fits the needs.

Overall, a considerable part of healthcare professionals participating in the questionnaire of this pilot study experience symptoms of burnout and have a need for more support. However, very few healthcare professionals with a high score on burnout symptoms were willing to participate in the Peer Support Programs. The reported needs ask for interventions to support healthcare professionals in dealing with the emotional impact of their work. Among all questionnaire respondents, 43% reported having no unmet needs. When looking at healthcare professionals with a high score on one or more burnout subscales, 86% reported having one or more needs. Apart from less workload (50%), most reported needs in this group were feeling safe within the team (57%), more attention for work-related stress at work (43%) and tools on how to deal with work-related stress (43%). These needs are mostly beyond the control of individual healthcare professionals and thus require organisation induced interventions.

The low response rate to this pilot study is likely to be multifactorial. It is known that healthcare professionals experience very high work pressure and this pressure on healthcare professionals is increased due to COVID-19.[22,23] The timing of the first questionnaire may therefore have contributed to a low response rate. In the autumn of 2022 healthcare professionals were cautious for a possible new increase in number of COVID-19 patients. Another possible reason for the low response rate is that the approach for this Peer Support Program may have been perceived as too much top-down. Previous studies have shown that healthcare professionals reported a need for support from their supervisors and organisation when it comes to talking about the emotional impact of their work.[9,24] Therefore, in this study supervisors of the

participating departments were asked to send an e-mail to all healthcare professionals in their department to encourage them to sign up for the Peer Support Program. Yet, this approach might have been too much a top-down approach. A study in the U.S. on the needs of physicians in coping with emotional stressors showed that barriers for seeking support were perceived lack of time (89%), concerns about lack of confidentiality (68%), stigma of mental health care (62%) and not knowing who to go to (61%).[11] Also, in this current study respondents felt at that moment they did not have time to take part in the Peer Support Program or the time investment was too big. However, a Dutch study on a coaching intervention among paediatric medical residents and specialists was able to include 57 healthcare professionals in the intervention.[25] The intervention consisted of six individual coaching sessions with a professional, external, coach. Like in this current pilot study, participation was voluntary and there were limited regulations for the coaching process. The study by Solms and colleagues did differ in the method of approaching potential participants. Besides sending an e-mail, informative presentations were held in the participating departments, and it was not necessary to complete a questionnaire prior to signing up. Also, participants could choose from a selection of professional coaches, rather than being assigned to a trained colleague (Peer).

Strengths and limitations

A major limitation of this study is the way the potential participants for the Peer Support Program were approached. By approaching healthcare professionals by e-mail through a questionnaire, we may not have been able to reach the target group properly. Filling in the questionnaire may have been perceived as a barrier, as this requires an additional time investment prior to participation in the Peer Support Program and may also have distracted from the exact goal in the communication about the Peer Support Program. A more direct approach, for example through a presentation in the participating departments or asking team leaders to share the information about the possibility to participate in the Peer Support Program in an existing team meeting might have contributed to a higher response. Furthermore, the way healthcare professionals were approached in this pilot study was too one-sided. By only sending an email, too little attention was paid to the cultural and social barriers that healthcare professionals may face in discussing the personal impact of their work. Second, selection bias may have occurred. Healthcare professionals who did fill in the questionnaire might have more affinity with the theme than their colleagues who chose not to participate in this pilot study. This may have led to an overestimation of burnout symptoms in this study. On the other hand, healthcare professionals who experience (very) high burnout symptoms are unlikely to make time for a

questionnaire. Therefore, it is difficult to state if the respondents are representative for the entire population in the partaking departments.

Implications for practice and future research

The limited number of people who were willing to participate in this pilot study combined with the expressed need for support in dealing with the impact of their work, suggests that further insight is needed into how to tailor the intervention to the needs of healthcare professionals, how to ensure that healthcare professionals have the time and space to participate in the interventions offered, and how these factors might interact. Furthermore, to increase the preparedness to participate in such interventions at the individual level, simultaneously interventions to the address the (team) culture should be addressed. Feeling save within the team; mutual trust to talk about impactful events but also a general consensus that addressing the personal impact of providing care is needed, can not only work as a protective, valuable factor in dealing with the personal impact of work but might also take away perceived barriers to participate in interventions on the individual level. Lastly, also simultaneously, certain preconditions should be ensured at the organisational level, such as scheduling time for the offered interventions.

Conclusion

In this study we found that the Peer Support Program, as offered in this pilot study, did not reach the target group and does not appear to adequately meet the needs of healthcare professionals who experience high levels of burnout symptoms. This may be due to the way in which participants were approached, the timing of the study post-COVID, the time investment, or the Peer Support program itself. However, healthcare professionals do have a need to address the personal impact of their work and more attention from their supervisor or within the organisation is wanted. More research is needed to understand the factors that lead to low use of Peer Support Programs and how to best meet the needs of healthcare professionals who care for patients in the last year of their life and how to prevent or limit burnout among healthcare professionals.

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