Universiteit
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The Netherlands

Care about care for healthcare professionals providing palliative care

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Citation
Dijxhoorn, A. F. Q. (2024, May 15). *Care about care for healthcare professionals providing palliative care*. Retrieved from https://hdl.handle.net/1887/3754287

Version:	Publisher's Version
License:	Licence agreement concerning inclusion of doctoral thesis in the Institutional Repository of the University of Leiden
Downloaded from:	https://hdl.handle.net/1887/3754287

Note: To cite this publication please use the final published version (if applicable).

General discussion

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The aim of this thesis was to gain insight into the emotional impact of providing palliative care on healthcare professionals in the Netherlands and to explore the strategies and needs of healthcare professionals in this regard. This general discussion provides an overview of the main findings of the studies presented in this thesis and discusses the methodologies used. This is followed by an interpretation of the findings. Finally, recommendations for practice, education, policy, and research are considered.

7.1 MAIN FINDINGS

Symptoms of burnout among healthcare professionals providing palliative care and effect of interventions

To explore the wellbeing of healthcare professionals providing palliative care, a systematic literature review was conducted to synthesize the current literature on the prevalence of (symptoms of) burnout among these healthcare professionals and the interventions to alleviate burnout symptoms **(Chapter 2)**. In total, 59 studies were included. No Dutch studies were found. Although the prevalence of burnout varied widely (3% - 66%), most studies reported that about one in five healthcare professionals experienced burnout. The studies that compared the prevalence of burnout between settings showed that healthcare professionals providing palliative care in general healthcare settings reported more symptoms of burnout than colleagues in specialised palliative care settings. Only ten studies reported on interventions to reduce symptoms of burnout in healthcare professionals providing palliative care. Of these studies, six reported (small) positive effects on the prevalence of burnout symptoms in the short term. The interventions in these studies used meditation, communication training, peer coaching and art therapy-based supervision. Almost all the interventions were aimed at the individual healthcare professional.

No conclusions could be drawn for the Netherlands based on the systematic literature review. In order to gain insight into the current Dutch situation an online survey on burnout symptoms and work-related stress was conducted in the beginning of 2020, just before the first lockdown due to the COVID-19 outbreak **(Chapter 3)**. The respondents were members of the Dutch Association for Palliative Care Professionals (Palliactief), mostly nurses and physicians working in general healthcare settings such as hospitals and home care. The survey (53.6 % response rate) showed that more than two-thirds (69%) of the 179 respondents had medium levels of symptoms of burnout and 7% had taken sick leave because of burnout. Although most healthcare professionals actively engaged in an average of nearly four activities to manage the

personal impact of their work, 23% of respondents expressed a need for supportive activities at a team and organisational level. The majority of the reported needs included allocating time to discuss impactful events with colleagues (55%) and feeling safe within the team (39%). The questionnaire study among 490 healthcare professionals, mainly generalists in palliative care, from three departments of an academic hospital **(Chapter 6**) showed similar results. Only 56 respondents (11% response rate) completed the questionnaire, and the majority had medium scores on the four subscales of the burnout questionnaire. They reported engaging in an average of almost four activities to remain balanced, but 57% of respondents still had unmet needs. This is substantially higher than in the survey of Palliactief members. The most frequently reported unmet needs were less work pressure (27%), more attention to work-related stress at work (25%), more support from their supervisor (25%), feeling safe within the team (23%) and more support from the organization (21%). Of the 56 respondents, 25% had a high score on one or more of the four subscales. These healthcare professionals had on average more unmet needs, in particular they were more likely to express a need for tools to deal with work-related stress and a need for individual coaching.

Perceptions and experiences of healthcare professionals regarding the emotional impact of providing palliative care

To gain a better understanding of the emotional impact of providing palliative care on healthcare professionals, two interview studies were conducted **(Chapters 4 and 5)**. The first interview study involved physicians and nurses, both palliative care generalists and palliative care specialists, working in hospitals, home care or nursing homes. The second interview study was conducted among nursing assistants working in nursing homes. All were palliative care generalists. Participants in both studies expressed positive emotional aspects of providing palliative care but also experienced a substantial emotional impact from it. Some differences were found between palliative care generalists and specialists such as a lack of experience with loss and death, or as a palliative care specialist to work with colleagues with little knowledge of palliative care.

In both studies, several factors were reported as contributing to coping with the emotional impact, such as receiving collegial support and having the opportunity to reflect on the (impact of) care with colleagues. At the same time, participants expressed experiencing barriers **(Chapter 4)** or having unmet needs **(Chapter 5)** regarding coping with the emotional impact of providing palliative care. Most of the

reported facilitators and needs go beyond the personal influence of the individual healthcare professional and require action at a team and organisational level.

Peer support as potential instrument to support healthcare professionals providing palliative care

In response to the need of healthcare professionals as reported in **Chapter 3** for more time to reflect with colleagues on impactful events, a Peer Support pilot was conducted **(Chapter 6)**. Peer Support is an intervention in which healthcare professionals who are involved in an adverse event, are offered support through conversations with a trained colleague to help them cope with the stress and anxiety following the event. Many hospitals in the Netherlands have a Peer Support Program to support healthcare professionals after their involvement in pre-defined potentially traumatic events, such as a serious patient safety incident. As an accumulation of small events can also potentially lead to a traumatic emotional impact on healthcare professionals, this may be mitigated by timely intervention. The aim of this pilot study was therefore to assess the feasibility and applicability of a Peer Support Program to address the emotional wellbeing of healthcare professionals providing palliative care in a single academic hospital.

Of the 56 participants who responded to the questionnaire, 25% had a high score on one or more of the burnout subscales. They were considered to be the intended target group for the pilot study. In addition to the needs that emerged within group as a whole, they also reported a need for tools on how to deal with work-related stress and for individual coaching. Six healthcare professionals indicated that they would like to join the Peer Support Program but only four participated in the program and three completed the evaluation questionnaire. All three would recommend Peer Support to their colleagues. For those who chose not to join the Peer Support Program, the time investment and the inconvenient timing of the pilot were reported as practical reasons for not participating in the current program.

7.2 REFLECTIONS ON THE USED METHODOLOGIES

The studies in this thesis used a variety of observational methodological approaches, including a systematic literature review **(Chapter 2)**, cross-sectional surveys **(Chapter 3 and 6)**, qualitative interviews **(Chapter 4 and 5)** and a pilot intervention study **(Chapter 6)**.

Study selection

The results of the systematic literature review **(Chapter 2)** were largely determined by the search string and selection criteria. Although we developed a broad search, emotional impact is such a wide-ranging topic with many related concepts that we were not able to include all terms (see Appendix A). As a result, we may have missed some relevant studies. Because in the selection process we only included studies that reported on the prevalence of burnout we may have excluded studies that provide insight into a broader concept of the wellbeing of healthcare professionals. We intentionally made this demarcation to avoid comparing different outcomes.

Assessment of burnout

The Maslach Burnout Inventory (MBI) was the most commonly used instrument in the studies included in the systematic literature review **(Chapter 2)**. However, we found large variations in the use of this validated questionnaire, which made it difficult to compare the results and to conduct a meta-analysis. Limitations of the MBI include differences in interpretation of the response categories, and the absence of an overall score.[1] A systematic literature review on burnout among physicians illustrates the heterogeneity in the use of the MBI. This review included 182 studies, of which 156 used a version of the MBI to assess burnout. These 156 studies used more than 47 definitions of overall burnout prevalence.[2] In 2019 the Burnout Assessment Tool (BAT) was developed. This validated questionnaire aims to overcome the limitations of the MBI by creating items that refer directly to burnout symptoms, omitting reversed items, and providing a single burnout score.[3] Because the BAT is a relatively new instrument and norms for the Netherlands are not yet available, it is more difficult to compare the results with other target groups. Nevertheless, we decided that the BAT was the most appropriate questionnaire for our studies and therefore chose to use it in the two surveys **(Chapter 3 and 6)** to assess levels of (symptoms) of burnout.

Recruitment

Healthcare professionals for the interview studies **(Chapters 4 and 5)** were recruited via the network of colleagues working in the field of palliative care, using convenience sampling. This strategy may have introduced selection bias, because this network consists mainly of healthcare professionals who have an interest in palliative care. In addition, healthcare professionals who showed interest in participating in the interviews are also likely to have some affinity with the personal impact of providing palliative care. Furthermore, both interview studies were conducted among a fairly homogeneous group of female participants with a Dutch cultural background, which limits the generalisability of the results.

Regarding the recruitment for the pilot study of the Peer Support program **(Chapter 6),** our chosen approach might have been a limitation. By asking potential participants via e-mail to complete a questionnaire might have been perceived as a barrier to join the program. Although there was support from the heads of the participating departments and the e-mail was sent by them, a more personal approach for example by means of presentations about the pilot at the different departments, could have helped to provide healthcare professionals with a better understanding of the intervention's content and the aim of the pilot study. Lastly, timing might have been unfortunate since a lot of attention was paid to work-related stress during the COVID-19 pandemic and its aftermath for example via the app Digital Stress Buddy at LUMC.[4] Healthcare professionals therefore may have been somewhat saturated regarding this subject.

Representativeness and generalisability

The representativeness of the study populations of the two surveys might be limited due to the specificity of the target group **(Chapter 3)** and the low response rate **(Chapter 6)**. This limits the generalisability of the studies. The survey among healthcare professionals providing palliative care **(Chapter 3),** had a fairly good response rate of 54%, despite being sent at the start of the COVID-19 pandemic. This response rate and wide variety of healthcare professionals who participated, combined with the use of a validated instrument, led to valuable insights. Although it is still possible that those who responded are structurally different from those who did not respond, these results can be seen as an indication of all members of the Dutch Association for Palliative Care Professionals (Palliactief). However, by distributing the questionnaire only among members of Palliactief, and thus to healthcare professionals who are consciously involved in palliative care, the outcomes cannot be properly compared to other healthcare professionals in the Netherlands. In the pilot study on Peer Support **(Chapter 6)** the response rate for the questionnaire was low, with only 11% of invited healthcare professionals responding. Therefore, they do not accurately represent the total group of healthcare professionals working in their departments.

7.3 INTERPRETATION OF THE FINDINGS

Healthcare systems around the world are facing a growing demand for care. Meanwhile, the outflow of healthcare professionals has increased significantly in recent years. The results of a Dutch survey show that in 2022, almost 40% of healthcare professionals sometimes think about leaving the healthcare sector, and about 12% plan to actually change jobs to work outside the healthcare sector in the coming year.[5]

While 70% of healthcare professionals state they are passionate about their work, 16% regularly or often feel emotionally exhausted. With growing demands for care, the (emotional) care burden for all healthcare professionals involved in palliative care will increase. How are these healthcare professionals affected by the provision of palliative care? And how can they be supported to maintain or find balance in this regard? This section discusses the findings from the different studies in this thesis about how healthcare professionals are affected emotionally by providing palliative care, what their needs are and how they can be supported in this regard.

Elements of providing palliative care that have an emotional impact

Much attention has been paid to the high prevalence of (symptoms of) burnout among healthcare professionals in general. Frequently cited causes of work-related stress among healthcare professionals, which can ultimately lead to burnout, are high workload, high administrative burden and low autonomy.[6-8] During the COVID-19 pandemic, there has been a growing recognition of the emotional impact on healthcare professionals of caring for so many dying patients, and of the often intensive conditions in which healthcare professionals work. This has contributed to an awareness that caring for patients in the face of death requires something different than providing curative care. The studies in this thesis indeed show that caring for patients who are in need of palliative care, even outside a pandemic, is experienced as different from providing curative care, and involves some additional stressors on top of those already known of work-related stress. The interview studies demonstrated that providing palliative care is often perceived as beautiful, but also as something that affects the healthcare professionals personally **(Chapters 4 and 5)**. These positive experiences, such as feelings of fulfilment, receiving gratitude and personal growth and negative experiences, such as feelings of powerlessness coexist **(Chapter 4)**. An Australian interview study among 20 physicians working in a specialist palliative care service also found a wide range of strong work-related emotions.[9] The authors reported that many doctors felt providing palliative care was personally rewarding, but also led to feelings of exhaustion, anger or irritability outside of work. These emotions were provoked by specific elements of providing palliative care that are also identified as impactful in our studies, such as confrontation with death and grief and conflicting personal values **(Chapter 4 and 5)**.

In addition, interviews with nursing assistants working in nursing homes revealed that they felt torn between experiencing the added value of building a personal relationship with the residents and the greater emotional impact this has when a resident dies **(Chapter 5)**. Similarly, a qualitative study among 26 healthcare assistants working in

residential care facilities in New Zealand reported that participants felt that the 'familial' relationship they had with residents was key to providing individualised, high-quality care, for dying patients, but also led to stronger feelings of bereavement after the death of a resident.[10] This duality when building a personal relationship also emerged in the interviews held with clinicians in this thesis **(Chapter 4)**. They mentioned that a long-term therapeutic relationship contributed to a greater emotional impact. This was also seen among junior doctors on a palliative care rotation who reported struggling with the balance between maintaining a professional distance and simultaneously being close to the patients to gain trust and remain human.[11] Genuine emotional understanding of patients is associated with increased personal wellbeing of healthcare professionals, higher levels of job satisfaction and lower levels of stress.[12, 13] In addition, the empathic processes underlying such relationships increase helping behaviour, promote good communication and a considerate social style.[12] Personal connection enhances the quality of care. On the other hand, the emotional and cognitive labour required for this is also demanding for healthcare professionals. Empathy is a multidimensional process, influenced by characteristics of the healthcare professional, the patient and the setting and has multiple levels of complexity.[12] However, because of the multifaceted process that empathy influences, it is difficult to determine the balance between the added value of empathy for both the patient and the healthcare professionals on the one hand, and the burden experienced by the healthcare professional on the other.

In summary:

- ➔ In the provision of palliative care, other stressors are experienced than in providing curative care;
- ➔ Providing palliative care gives simultaneously positive and negative feelings;
- ➔ Healthcare professionals experience a duality in building personal relationships with patients and the greater emotional impact this has when their patients die.

Differences in emotional impact between providing generalist palliative care and specialist palliative care

Zooming in on the differences in the emotional impact of providing palliative care, studies demonstrate that healthcare professionals providing care in general care settings report higher rates of burnout than their colleagues working in specialist palliative care settings, such as hospices or palliative care units **(Chapter 2)**. This may be explained by several reasons. For example, palliative care generalists are unlikely to have deliberately chosen to provide palliative care. Moreover, often they did not realise beforehand that providing palliative care is a substantial part of their work.

Other possible explanations are that in general settings there is little attention for the emotional impact of providing palliative care and that many healthcare professionals are not trained in palliative care. Furthermore, palliative care specialists indicated that they found it stressful when they were surrounded by colleagues with insufficient knowledge of palliative care **(Chapter 4)**. This made them reluctant to transfer the care to these colleagues because they feared that palliative care needs would be recognized too late, and this would compromise the quality of care.

Focusing on education, receiving palliative care training plays an important positive role in the stress experienced by healthcare professionals and the prevalence of burnout.[14,15] Studies have shown that healthcare professionals with more palliative care training are more aware of the purpose of the care they provide, resulting in less frustration or reduced feelings of failure.[15,16] Furthermore, when palliative care education focuses not only on the practical knowledge of providing palliative care, but also reflects on the potential personal impact of providing palliative care, it can create awareness in healthcare professionals. Awareness can be described as the tendency to be conscious of one's own experiences in daily life.[17] It consists of a combination of self-knowledge and empathy, enabling healthcare professionals to attend to both the needs of their patients and their own needs.[17] A cross-sectional study among Spanish palliative care professionals found that those with higher levels of awareness were better able to cope with death.[17]

In specialist palliative care settings, teams often actively pay attention to the potential emotional impact of providing palliative care. This is another possible explanation for the lower levels of burnout found in specialist palliative care settings compared to generalist settings.[18] In practice we see that in many hospices or palliative care units, standard team meetings are held to provide an opportunity to discuss how the healthcare professionals are personally affected by their work. Well-led group meetings can contribute positively to the wellbeing of healthcare professionals and have been associated with reduced burnout.[19]

In summary:

- ➔ Providing palliative care in general care settings is associated with higher burnout rates than in specialist palliative care settings;
- ➔ Possible reasons for this difference are that palliative care generalists may not have deliberately chosen this field, they have no specific education and in general settings there is little attention for the possible impact;

➔ Education and group meetings can create awareness and help reduce work-related stress.

Interventions to reduce emotional impact of providing palliative care

Various interventions have been developed to support healthcare professionals who provide palliative care in dealing with the emotional impact of their work. These interventions are often aimed at improving communication skills, meditation interventions or creative therapy. Unfortunately, studies most included in our literature review were of poor to fair quality and reported little to no effect (**Chapter 2**). Another literature review of psychological interventions to improve the wellbeing of healthcare professionals working in palliative care settings also revealed only small improvements in psychological outcomes in only two out of nine included studies.[20] Most of the included studies were methodologically weak. Almost all of the included studies in both literature reviews were aimed at the *individual* healthcare professional. This individual approach to dealing with the personal impact of work has several shortcomings. First, it does not match the needs of healthcare professionals to be supported on a team and organisational level. In this thesis **(Chapters 3 and 6)**, respondents reported they already engage in a range of self-care activities to cope with the emotional impact of providing palliative care but feel this is not enough. They express unmet needs at a team and organisational level, such as more attention from the organisation to work-related stress, more support from their supervisor, time to discuss impactful events with colleagues, and feeling safe within their team **(Chapters 3 and 6)**. This need for support at a team and organisational level also emerged from other studies. A study among 177 oncologists showed that the majority would find it helpful in coping with the death of a patient when emotions such as grief would be validated as a normal and acceptable part of their work in oncology.[21] Second, offering only individual-oriented interventions may send the message that burnout and the experienced work-related stress are an individual problem, both in terms of impact, cause and solution. Burnout and poor healthcare professional wellbeing are associated with poor patient safety outcomes and increased absenteeism.[22, 23] In addition, the youngest generations constituting and entering the workforce highly value work-life balance and having a supportive environment in their work.[24] Organisations should respond to these needs by developing and maintaining a stable workforce. Therefore, healthcare professionals' wellbeing is a shared responsibility of the individual healthcare professionals, managers/supervisors and healthcare organisations as a whole.

In summary:

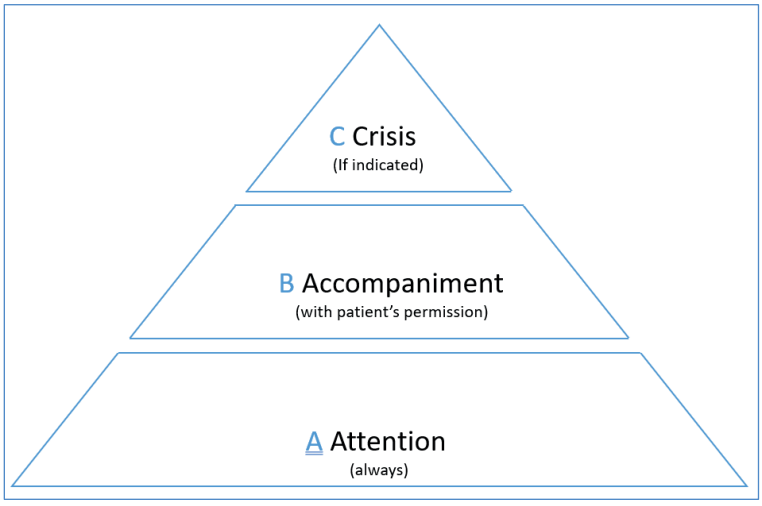
- ➔ Interventions to support with the emotional impact of providing palliative care often show small improvements;
- ➔ Most interventions are directed at the level of the individual and do not address two other important levels, namely the team and the organisation.

7.4 RECOMMENDATIONS FOR PRACTICE, EDUCATION AND ORGANISATION/ POLICY

Several recommendations to support healthcare professionals to maintain, gain or restore their personal emotional wellbeing while providing palliative care emerge from the main findings of this thesis.

To support the diverse needs of healthcare professionals in relation to the emotional impact of providing palliative care at the organisational, team, and individual levels, we advise using the ABC model (Figure 1). This model has its origin in spiritual and existential care to address the wellbeing of patients in the palliative phase. ABC stands for A) *Attention*, B) *Accompaniment* and C) *Crisis*.[25]

Figure 1 ABC model for spiritual and existential care

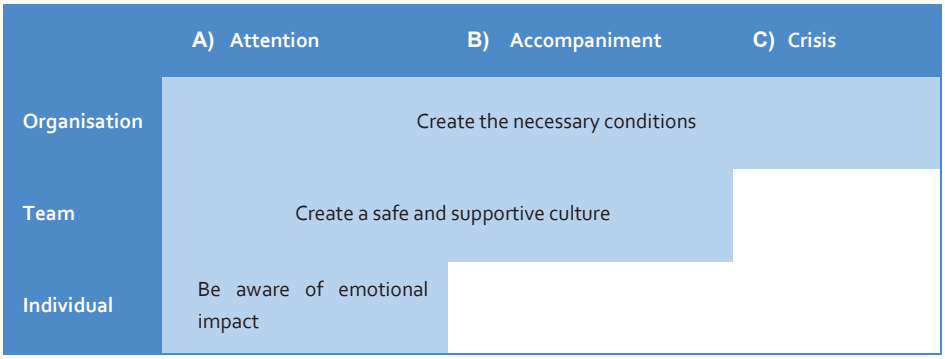


The National Guideline for Existential and Spiritual Aspects of Palliative Care advises that the first step (A) is that healthcare professionals pay *Attention* to existential/spiritual issues in the care of every patient receiving palliative care.[25] This can be done through an open attitude and/or a brief exploration of spiritual needs. If a patient indicates they would like *Accompaniment* regarding existential/spiritual care,

the healthcare professional involved will do so by taking step B: talking with the patient about his/her existential/spiritual concerns and process, or by paying attention to any rituals that the patient or family might want. To be able to do step B, clinicians should have some basic knowledge of spiritual care. If there are indications for a spiritual *Crisis*, the patient needs specialized care and should be referred to a spiritual counsellor (step C).

To use the ABC model to provide support in relation to the emotional impact of providing palliative care, it has been adapted (Figure 2). In addition to the level of treatment as known from the original ABC model (*Attention*, *Accompaniment* and *Crisis*), in this adapted model a distinction is also made for the organisational, team and individual level.

Figure 2. Model for care for healthcare professionals providing palliative care. Inspired by the ABC model of the national guideline Existential and spiritual aspects in palliative care



The main focus of the model is on *Attention*. All three levels, the organisational, the team and the individual level, have an important role in this. Similar to the original ABC model, *Attention* should be given to the emotional impact of providing palliative care for every healthcare professional. If this is not sufficient, *Accompaniment* and *Crisis Intervention* should be available and the need for further support should be monitored. Due to the many differences in impactful situations, between healthcare professionals and between organisations, no single solution can be provided at all these levels. Therefore, this model should not only lead to stepped care, but also offer a range of interventions to meet the different possible needs.

The model also implies that addressing the emotional impact of providing palliative care is a shared responsibility, and the foundation for this lies within the organisation. Organisations should create the right conditions for individual healthcare

professionals and teams to build on. Interventions should be part of a broader, system-wide approach. By taking responsibility as an organisation for the emotional wellbeing of healthcare professionals and creating the right conditions for interventions at the organisational, team and individual level, several goals can potentially be achieved. First, such a system-wide approach may be more effective than the individual approaches. An individual approach does not address the causes of stress at the team and organisational level and the related needs that are beyond the individual healthcare professionals control.[26] An approach that includes both individual oriented and team interventions and is embedded in an organisation that provides necessary conditions has potentially more impact.[27] The healthcare organisation and the team should therefore be part of the solution, leading to a system-wide approach.[28] Second, a more comprehensive approach might prevent *Crisis*, which is more desirable than treating work-related stress or symptoms of burnout as this is often accompanied by absenteeism of healthcare professionals. Third, when organisations convey work-related stress as a shared responsibility and provide the necessary conditions, it can empower healthcare professionals to take action regarding their personal wellbeing.

Create necessary conditions: organisation level

Include support for dealing with the emotional impact of providing palliative care in policy plans

It is recommended that organisations create the necessary conditions to ensure that the unmet needs of healthcare professionals can be met at the organisational, team and individual level. To create these conditions, it is necessary to include goals regarding support for dealing with the emotional impact of providing palliative care in the policy plans. Necessary conditions include making time available for activities, appointing employees with an assignment in drawing up a program regarding the emotional wellbeing of healthcare professionals and increasing knowledge within the organisation regarding the theme.

Design a Support program

Organisations should use a program-based approach to meet the various needs which may differ per healthcare professional and per situation. In such a program it is desirable not only to build in support for healthcare professionals who suffer from too great an emotional impact of providing palliative care (*Crisis Interventions*), but also to focus on prevention by through *Attention* and *Accompaniment*. It is advisable to simultaneously pay attention to the balance in the team. It is argued that burnout is contagious: the attitudes and emotions of burned out healthcare professionals impact the wellbeing of their colleagues.[29, 30] In addition to individual wellbeing, it is also

essential to consider any imbalance in the team, which may require the implementation of other conditions than when solely focusing on the individual wellbeing. Also, for organisations that already have a good structure for the personal wellbeing of healthcare professionals, it is recommended to see whether there is sufficient recognition of the emotional impact of providing palliative care. After all, workload and long working hours require a different approach than dealing with the emotional impact of caring for people who have a life-threatening condition or frailty.

Implement a broad support program across the organisation

To gain ideas for interventions for a broad support program, organisations can learn from other professions and domains such as psychiatry or uniformed personnel (Military, fire brigade, police). The first guideline for Psychosocial Support for Uniformed Persons was drawn up in 2010. It took ten years and the COVID-19 pandemic before the initiative emerged for the first guideline Psychosocial Support for Healthcare Professionals.[31] Figure 3 shows some examples of interventions that can be implemented relating to *Attention*, *Accompaniment* and *Crisis*. One example is to discuss the experiences of healthcare professionals providing palliative care during progress meetings. Other potential interventions include ensuring that managers/supervisors are adequately equipped to recognise the emotional impact on employees and how to initiate conversations about this and clear communication within the organisation that there extra support is available when *Attention* is not enough.

Ensure continuous palliative care training for all healthcare professionals and availability of palliative care specialists

Besides a program for support in dealing with the emotional impact of providing palliative care it is also important that organisations ensure that healthcare professionals receive the appropriate palliative care education. Organisations that expect their healthcare professionals to provide (generalist) palliative care should take responsibility towards their healthcare professionals and their patients. This can be done through palliative care training and sufficient availability of palliative care specialists. In the Netherlands, the program Optimize Palliative Care Education (in Dutch: Optimaliseren Onderwijs PZ (O2PZ)) works on the integration of education in palliative care in the basic curriculum for different healthcare professions.[32] However, the current workforce often lacks fundamental knowledge to actually function as a palliative care generalist. This leads to feelings of inadequacy in providing palliative care among healthcare professionals and leads to stress. It is therefore recommended

Figure 3 Examples of interventions aimed at emotional support for healthcare professionals providing palliative care

	A) Attention	B) Accompaniment	C) Crisis
Organisation	• Include the emotional impact and related needs of healthcare professional as topic in the progress meetings of employees • Provide training about the emotional impact of providing palliative care	• Ensure that managers/supervisors are adequately equipped in recognising the emotional impact on employees • Make sure it is known that there is extra support available when Attention is not enough • Focus on timely involvement of a palliative care specialist in complex palliative care	• Appoint a psychologist within and/or outside the organisation
Team	• Arrange team trainings such as workshops on building team competencies • Organise teambuilding activities • Set an example as manager/supervisor regarding dealing impactful situations • Provide role models • Establish mentorship • Organise structural team discussions such as intervision or day start meetings	• Appoint a team member with signalling function • Organise the opportunity for reflection after impactful events	
Individual	• Know yourself • Ensure you have the right training • Reflect on the positive aspects of providing palliative care		

that organisations draw up a plan to train them appropriately in this regard. The O2PZ program offers teaching material on varying topics such as the use of measurement instruments or how to talk about death. Healthcare organisations can use these materials to train their staff. In addition, organisations must ensure that sufficient palliative care specialists are available so that palliative care generalists can consult

them when the care for patients in the palliative phase becomes complex. Palliative care specialists can offer guidance, education, and support to palliative care generalists.[33] This is likely to alleviate stress experienced by palliative care generalists.

The possible emotional impact of providing palliative care should be an integral part of generalist palliative care education. After all, even with sound knowledge on providing palliative care, healthcare professionals can still be emotionally impacted by certain situations. Currently, education about self-care related to providing palliative care in the Dutch medical curricula is experienced as insufficient.[34] It is unclear to what degree self-care education regarding palliative care is included in other educational programmes in the Netherlands. To address self-care, palliative care education can learn from other disciplines. For example, in the Dutch psychiatry residency and in the postgraduate training to become psychotherapist personal therapy is included in order to develop the ability to identify, appoint, and control your own emotions and simultaneously address the emotions of others.[35,36] A study on coping strategies among a variety of healthcare professionals shows that psychologists report better self-care than physicians and nurses.[37] The authors suggest this may be explained due to psychologists being more aware of self-care as an effective coping strategy.

Create a safe and supportive culture: team level

It is recommended to create a safe and supportive work culture regarding the emotional impact of providing palliative care. Feeling safe in the team to share experiences of emotional impact and support from the manager/supervisor are important needs of healthcare professionals **(Chapter 3 and 6)**. Sharing experiences, support among colleagues and compassionate leaders are important aspects for realizing a healthy team culture.[38, 39] Achieving a healthy team culture is multifactorial and which interventions are appropriate differs per team and setting and cannot be achieved with one intervention. It is therefore important that the team members are involved in the decisions about which interventions are desirable with regard to *Attention* and *Accompaniment*. Examples of how to improve team culture include participating in relevant workshops or organising teambuilding activities.

Ongoing recognition of potential emotional impact of providing palliative care

Regarding *Attention*, it is recommended to implement interventions that support ongoing recognition of the potential impact of providing palliative care. Managers/supervisors play an important role in this as they influence the collective perception of values and priorities.[27] They can contribute to a safe, supportive and honest work culture by showing their own vulnerabilities, sharing losses and successes.

They can lead by example, for instance by taking time to reflect after a patient's death. Additional examples include having role models in the team in dealing with the emotional impact of providing palliative care, pairing less experienced healthcare professionals in palliative care with a more experienced mentor, and initiating team meetings in which emotionally impactful experiences can be shared. Such team meetings are preferably supervised by a trained professional who can ensure the emotional safety and quality of the meetings.[40] By encouraging healthcare professionals to talk to each other about the emotional impact of providing palliative care through such interventions, and by providing good examples, teams can work towards a culture in which this is normal. In addition to these recurrent meetings additional reflective meetings after an impactful event has occurred in the care of patients in the palliative care phase could be organised.

Signal the need for Accompaniment

To ensure that the transition from *Attention* to *Accompaniment* is initiated in a timely manner, managers/supervisors should ensure that an appropriate process is set up for this and that their team is equipped to recognize and validate a need for *Accompaniment*. This can be done, for example, by appointing members of the team for this purpose. On the one hand, these appointed team members can provide an accessible point of contact for colleagues who notice that *Attention* alone is insufficient for them. On the other hand, these appointed team members can also be the ones who actively monitor whether colleagues could use more support. This can be organised in various ways, for example by appointing one or two colleagues who are available for an entire team or by linking two colleagues to each other in a buddy system. Regardless of how this is organised, it is important that such a conversation can be conducted in an emotionally safe context and that a process of recognition, acknowledgement and formulation of needs and specific follow-up steps regarding *Accompaniment* can take place.

Be aware of emotional impact of providing palliative care: individual level

Know yourself

Being able to pay attention to the emotional impact of providing palliative care, begins with being aware of the possible impact. In the interviews held in this thesis **(Chapter 4)** it became apparent that many healthcare professionals, mostly palliative care generalists, had never or only to a limited extent previously consciously considered the emotional impact of providing palliative care on themselves. However, there seems to be an association between awareness and the use of protective self-care activities.[17] Hence, healthcare professionals should reflect on the emotional impact of providing

palliative care, identify their preferred coping style and personal needs, undertake basic self-care activities and be aware of the subsequent support that is available to them.

Ensure you have the right training
Insufficient knowledge about providing palliative care can lead to feelings of uncertainty and therefore increase the experienced emotional impact. Healthcare professionals must ensure that they receive adequate training in relation to the care they are expected to provide to their patients. Organisations have a responsibility in offering such training, but healthcare professionals also have a responsibility in addressing their needs in this regard. In addition, they can also increase their knowledge on palliative care by using existing training materials, for example via O2PZ.

Reflect on the positive aspects of providing palliative care
Many healthcare professionals experience that providing palliative care is accompanied by feelings of fulfilment and experiencing personal growth **(Chapter 4 and 5)**. It is recommended that healthcare professionals identify and share such positive experiences regarding providing palliative care. This can help them and their colleagues to become aware of these positive sides of providing palliative care which can be beneficial in dealing with the emotional impact.

7.5 RECOMMENDATIONS FOR FUTURE RESEARCH

Several recommendations for future research can be formulated. First, healthcare professionals providing palliative care in general healthcare settings report higher symptoms of burnout than colleagues in specialised palliative care settings **(Chapter 2)**. However, an accumulation of confrontation with suffering and dying on a regular basis has also been associated with high emotional impact on healthcare professionals.[41] On the other hand, some experience with caring for patients in the palliative care phase and witnessing death is perceived as helpful in coping with these experiences **(Chapter 4)**. Further research should:

- ➔ Investigate the impact of generalist palliative care education on the experienced emotional impact of providing palliative care;
- ➔ Consider if there is a tipping point between gaining necessary experience and being too often confronted with suffering and dying.
- ➔ Gain insight into how healthcare professionals with little exposure to suffering and death can be supported in gaining experience in dealing with these emotional challenges.

Second, healthcare professionals experience a struggle between on the one hand developing a personal relationship with their patients and on the other hand maintain professional distance to prevent being too greatly emotionally impacted **(Chapter 4 and 5)**. Further research should:

- ➔ Focus on understanding this apparent contradiction and which factors play a role in this.
- ➔ Assess how healthcare professionals can be supported in this balance between personal involvement and professional distance.

Third, most interventions regarding the emotional wellbeing of healthcare professionals providing palliative care are aimed at the individual healthcare professional. But unmet needs among healthcare professionals in this regard find their origin on the team and organisational level **(Chapter 3 and 6)**. This argues for a system-wide approach at the organisational, team and individual level to improve the resilience of healthcare professionals who provide palliative care. Further research should:

- ➔ Develop interventions at both team and organisational level that address the needs of healthcare professionals regarding the emotional impact of providing palliative care
- ➔ Investigate the experiences with a program-based approach to support the emotional wellbeing of healthcare professionals providing palliative care

The interpretation and comparison of research findings on the emotional wellbeing of healthcare professionals is challenging due to a broad use of terms. Lack of a clear definition for burnout and diversity in the use of burnout measurements **(Chapter 2, 3 and 6)**. However, the many symptoms experienced by healthcare professionals and rates of healthcare professionals leaving healthcare show that the problem is major and deserves serious attention. Further research should:

- ➔ Provide more clarity on the definition of burnout, or an appropriate other related concept that encompasses the wide range of experiences of healthcare professionals;
- ➔ Examine the appropriate and practical use of measuring instruments used in burnout research.

8.6 CONCLUSION

Providing palliative care is often experienced as rewarding, but at the same time it is emotionally demanding for healthcare professionals. The experienced emotional impact of providing palliative care does not have to be problematic if healthcare professionals are aware of this emotional impact, know how to manage it in their daily work, and are supported by their team and organisation. Awareness and normalisation of the potential emotional impact of providing palliative care on healthcare professionals is needed to maintain a healthy healthcare workforce in the coming years. A system approach at the organisational, team and individual level that ensures the right *Attention*, *Accompaniment* and *Crisis Intervention* at the right time has the potential to increase the resilience of healthcare professionals so that they can care for patients in the palliative phase while maintaining their emotional wellbeing. There is no 'one size fits all' approach, but it is about recognizing, acknowledging and taking tailored shared responsibility and action in the care for healthcare professionals providing palliative care.

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APPENDIX A: Concepts related to burnout and work-stress

There are numerous concepts that describe a state of being affected by work-related experiences. In the table below the most encountered terms are presented. This list is not exhaustive but gives an idea of the variety of concepts. The concepts in blue were used in the search string of the systematic literature review **(Chapter 2)**.

Term
Burnout
Chronic stress
Compassion fatigue
Coping
Cynicism
Depersonalisation
Emotional distress
Emotional exhaustion
Emotional impact
Emotional labour
Emotional strain
Job demands
Job stress
Mental exhaustion
Mental health
Moral distress
Moral injury
Occupational stress
Personal accomplishment
Personal balance
Personal impact
Professional quality of life
Psychological wellbeing
Resilience
Secondary traumatic stress (compassion fatigue)
Self-care
Self-management
Stress
Work-life balance
Work-related stress