Special Article

Building Resilience for Palliative Care Clinicians: An Approach to Burnout Prevention Based on Individual Skills and Workplace Factors

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Abstract

For palliative care (PC) clinicians, the work of caring for patients with serious illness can put their own well-being at risk. What they often do not learn in training, because of the relative paucity of evidence-based programs, are practical ways to mitigate this risk. Because a new study indicates that burnout in PC clinicians is increasing, we sought to design an acceptable, scalable, and testable intervention tailored to the needs of PC clinicians. In this article, we describe our paradigm for approaching clinician resilience, our conceptual model, and curriculum for a workplace resilience intervention for hospital-based PC teams. Our paradigm for approaching resilience is based on upstream, early intervention. Our conceptual model posits that clinician well-being is influenced by personal resources and work demands. Our curriculum for increasing clinician resilience is based on training in eight resilience skills that are useful for common challenges faced by clinicians. To address workplace issues, our intervention also includes material for the team leader and a clinician perception survey of work demands and workplace engagement factors. The intervention will focus on individual skill building and will be evaluated with measures of resilience, coping, and affect. For PC clinicians, resilience skills are likely as important as communication skills and symptom management as foundations of expertise. Future work to strengthen clinician resilience will likely need to address system issues more directly. J Pain Symptom Manage 2016;52:284–291. *© 2016 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.*

Key Words

Resilience, burnout, well-being, work engagement, palliative care

Introduction

For palliative care (PC) clinicians, the work of caring for patients with serious illness can put their own well-being at risk. What they often do not learn in training, because of the relative paucity of evidence-based programs, are practical ways to mitigate this risk. Because a new study indicates that burnout in PC clinicians is increasing, we sought to design an acceptable, scalable, and testable intervention tailored to the needs of PC clinicians. In this article, we describe our paradigm for approaching clinician resilience, our conceptual model, and curriculum for a workplace resilience intervention for hospital-based PC teams.

How researchers see burnout has changed substantially. In 1974, Freudenberger (a psychologist) noticed how clinicians drawn by their ideals to work at a free clinic eventually became depleted by that work.[1] However, the ideas underlying burnout had appeared in popular literature before Freudenberger's initial report, notably in Graham Greene's 1960 novel "A Burnt-out Case" featuring an architect who leaves his successful practice to work at a leper colony in the Congo.[2,3] In the 1980s, Maslach established burnout as a psychological syndrome affecting professionals

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whose work involved service to others, characterized by emotional exhaustion, cynicism (originally called depersonalization), and feelings of ineffectiveness (originally called low personal accomplishment)—all symptoms at the level of the individual.[4,5] But subsequent research by Maslach and others demonstrates that burnout is also related to how systems structure work for individuals,[6] and some believe that intervening in burnout may require intervening in the system.[7] Most recently, clinicians familiar with positive psychology have argued that focusing on factors that lead to burnout might cause researchers to overlook factors that foster a clinician's ability to bounce back from stressful events.[8,9]

In this article, we outline a prevention paradigm for addressing burnout and resilience in PC that aims at upstream intervention. We discuss why burnout merits attention now, the early state of interventions for improving clinician well-being, and outline a new approach tailored to the needs of PC clinicians. Our conceptual model posits that clinician well-being is influenced by personal resources and work demands. We hypothesize that a clinician's personal resources could be augmented by training in resilience skills and that work demands could be modified in areas important for workplace engagement. This model suggests that targeting both clinician skills and workplace engagement will ultimately be needed for sustainable clinician well-being and clinical work that furthers the mission of PC. As a starting point, our project will focus on building resilience skills, and assessing workplace engagement. Our ultimate goal is to define how individual resilience skills could be learned and how workplace engagement could be maximized. Although our project has not yet yielded results, we hope that this description will stimulate dialogue about clinician burnout and resilience and further experimentation that will contribute to the well-being of clinicians in PC and other specialties.

Why Burnout Merits Attention Now

The prevalence of burnout appears to be increasing. A new study demonstrates that burnout in PC has reached a level that threatens to undo what PC has achieved. In a 2014 survey of AAHPM members, 62% of respondents met criteria for burnout, significantly more than other medical subspecialties and worse than historical data.[10,11] This same study documents that this high prevalence of burnout influences job turnover: almost half of these clinicians expect to leave their job in the next 10 years, with 24% citing burnout as the primary cause.[10] Combined with studies demonstrating that clinicians meeting criteria for burnout deliver poorer quality of care,[12,13] make more medical errors,[14–17] and display low empathy,[16,18] these data paint a worrisome picture of PC as a specialty unable to fulfill its mission because of workforce shortages and clinician underperformance due to burnout.

System issues may contribute to the high prevalence of burnout in PC clinicians. The rapid implementation of PC in U.S. hospitals has resulted in many small services dependent on one or two key clinicians,[19] working without clear productivity expectations, and ambitious goals for program growth. Many of these key clinicians have moved into PC from other specialties or graduated recently from PC fellowship training, so they experience the pressure of establishing their clinical credibility on top of normal developmental stresses for clinicians new to PC. Established PC services face different system stresses with referrals of increasing acuity, as straightforward cases no longer warrant routine PC consultation.

Finally, clinicians are poorly calibrated with regards to their awareness of burnout and resilience practices. In a large study of U.S. surgeons, 89% believed that their well-being was at or above average, although 70% had scored in the bottom 30% relative to national norms.[20] In a study of Australian registrars, only 10% scored high in resilience skills.[21] Although clinicians are aware that burnout is an occupational hazard, they may not realize how much they are affected themselves or may be reluctant to admit to themselves that they are experiencing burnout or may lack knowledge of what they could do to address burnout and resilience. Notably, use of effective coping mechanisms is associated with less burnout.[22]

The State of the Science on Clinician Well-Being

The existing state of interventions to prevent or treat burnout or improve clinician well-being shows that the science is in an early phase of development. Currently available interventions are almost entirely single-arm pre-post studies, and many lack evidence to indicate efficacy in improving well-being, creating behavioral changes in clinician practice, or reductions in burnout.[23–27] A notable exception was a randomized study of a mindfulness intervention that showed some gains in clinician well-being, albeit in a modestly powered small study.[28] Another notable exception is a single-arm study of 80 primary care physicians that demonstrated large changes in burnout and empathy,[29] involving an intervention based on mindfulness and reflective practice, but required a time commitment (>100 hours) unsuitable as a first-step intervention in a busy clinical setting. Another single-arm study, notable for including a multidisciplinary group of clinicians, found decreases in stress and increases in perspective taking with a 12-hour, five-session relaxation response intervention.[30] The