*Original Article*

# Healthcare Professionals' Work-Related Stress in Palliative Care: A Cross-Sectional Survey



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## Abstract

**Context.** Providing palliative care can lead to work-related stress and ultimately to burnout. The need for palliative care will further increase due to population aging and people living longer with life-threatening diseases. Therefore, a healthy palliative care workforce is vital.

**Objectives.** This study aims to get insight into the experienced work-related stress among healthcare professionals providing palliative care in the Netherlands and their strategies and needs in relation to maintaining a healthy work-life balance.

**Methods.** A cross-sectional online survey among members of the Dutch Association for Palliative Care Professionals was conducted between February and March 2020. Burnout was assessed by the validated Burnout Assessment Tool. Self-constructed questions assessed strategies and needs of healthcare professionals providing palliative care regarding work-related stress.

**Results.** In total 179 eligible respondents responded (response rate 54%). Respondents were mostly female (79%) and older than 50 years (66%). Most respondents were nurses (47%) and physicians (39%). Two-thirds of respondents (69%) experienced a median level of burnout and 2% a (very) high level. Furthermore, 7% had been on sick leave due to burnout. Although healthcare professionals engage on average in 3.7 coping activities, a quarter (23%) felt that these activities were not sufficient to maintain balanced. Respondents feel a need for activities aimed at the team and organisation level such as feeling emotionally safe within their team.

**Conclusion.** Symptoms of burnout are quite prevalent among healthcare professionals providing palliative care in the Netherlands. Healthcare professionals have a need for team and organisation approaches to maintain a healthy work-life balance. J Pain Symptom Manage 2021;62:e38–e45. 

***Key Words***

*Palliative care, healthcare professionals, burnout, work-related stress, cross-sectional survey*

## Key message

This article reports the results of a cross-sectional survey on burnout. Although few healthcare professionals in palliative care experience severe symptoms of burnout, almost one in four healthcare professionals feel that their activities to deal with work-related stress are insufficient. Structural attention to work-related stress is needed in the workplace.

## Introduction

Healthcare professionals providing palliative care address the physical, psychological, social and spiritual

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care needs of patients with a life-threatening illness and their relatives. They often perceive providing palliative care as rewarding, derive meaning-in-life experiences from providing this care and experience personal growth as a result of caring for terminally ill patients.[1–4] However, repeated exposure to suffering and death and dying can be demanding and may be experienced as emotionally challenging.[5] It can also lead to work-related stress that ultimately can result in burnout.[6] Burnout founds its origin in caring occupations which due to its aim to help people in need can be experienced as emotionally stressful.[7] One of the early and common used definitions of burnout by Maslach et al describes burnout as a psychological syndrome involving emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment that occurred among professionals who work with other people in challenging situations (ref)[7] These constructs are also represented in the widely used Maslach Burnout Inventory (MBI).[8] Some criticism about the MBI are present regarding difficulties in the practical use of the MBI and psychometric issues.[9] The MBI calculates a separate score for each subscale, and no overall burnout sum score arises from the MBI. Due to the advantages of a sum score, many studies do calculate a sum score. However, there is variation in how this overall score is calculated and a wide variation in the assessment of burnout based on these three sub-scores is seen in studies. Furthermore, some concerns regarding the use of extreme statements in the MBI are present, as this might influence the reliability of the MBI. Therefore the concept of burnout has further evolved and this has recently resulted in a new burnout measurement; the Burnout Assessment Tool (BAT).[9] The BAT includes four constructs: exhaustion, mental distance, emotional impairment and cognitive impairment.[10]

A recent systematic literature review on the prevalence of burnout among healthcare professionals providing specialist palliative care showed that 17% of these healthcare professionals suffered from a burnout.[11] In other words, almost one in five healthcare professionals providing specialist palliative care are at risk of dropping out as a result of work-related stress. At the same time, as a result of a decrease in the working-age population and a growing need for palliative care in coming years due to people getting older and having more co-morbidities, the workload for healthcare professionals will likely further increase.[12–14] To be able to manage this rapid growth of palliative care needs, healthcare systems must adapt by focusing on integration and boosting of palliative care across healthcare disciplines on the one hand, and by fostering professionals providing palliative care by reducing work-related stress on the other.

As providing palliative care has unique aspects, it is of interest to develop interventions specifically aimed at reducing symptoms of burnout among healthcare professionals in palliative care. A recent systematic literature review showed a relatively small number of such tailored interventions to reduce symptoms of burnout among healthcare professionals providing palliative care.[15] Furthermore, another systematic literature review on interventions improving the psychological wellbeing of palliative care healthcare professionals showed little effect of the interventions on their psychological wellbeing.[16]

Current research is mainly focused on the specialist palliative care setting. In the context of current and future challenges palliative care is facing, it is important to gain insight into the work-related stress of healthcare professionals providing palliative care, in both the specialist and generalist setting. Furthermore, to develop effective interventions to reduce work-related stress and symptoms of burnout for these professionals, it is necessary to understand their needs regarding the physical and emotional impact of providing palliative care. Therefore, the aim of our research is to get insight into the experienced work-related stress among healthcare professionals providing palliative care in the Netherlands and what their strategies and needs are in relation to maintaining a healthy work-life balance.

## Method

### *Study Design*

A cross-sectional survey was conducted to assess symptoms of burnout among healthcare professionals providing palliative care in the Netherlands and their (copings) strategies and needs regarding work-related stress. We have used the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) recommendation for cross-sectional studies in order to ensure accurate and complete reporting of this observational study.[17]

### *Setting and Participants*

In the Netherlands all healthcare professionals are expected to provide generalist palliative care to patients with a life-threatening illness. They are supported by palliative care specialists when necessary. Therefore, in this study all members of the Dutch Association for Palliative Care Professionals (Palliactief) were invited to complete an online questionnaire. Palliactief is a multidisciplinary association including physicians, nurses and other professionals working in generalist and specialist palliative care. Members were eligible for the survey if they were healthcare professionals. Non-healthcare providers (researchers, policy makers) were excluded. In February 2020 an invitation to the online questionnaire was sent to all members of Palliactief, of whom 358 were healthcare professionals.

A reminder followed four weeks after the invitation and the questionnaire closed six weeks after the start, at the end of March 2020, due to the outbreak of coronavirus (Covid-19).

### *Measures*

Burnout was assessed by the validated BAT. This is a newly developed instrument based on recent research on the concept of burnout. After careful consideration among all authors it was decided to use the BAT and not the frequently used MBI. Main reason for this was the experienced difficulties in the use of the MBI which have been tried to resolve in the BAT.[9] The BAT consists of 33 questions and includes four core constructs: exhaustion, mental distance, emotional impairment and cognitive impairment. Total burnout is determined based on the four constructs. The BAT also assesses secondary symptoms, namely psychological distress and psychosomatic complaints. A 5-point Likert scale was used. Cut-off scores for low (1.00−1.55), median (1.56−2.79), high (2.80−3.64) and very high (3.65−5.00) total burnout scores were used.[10]

To assess how healthcare professionals deal with the physical and emotional impact of providing palliative care and their needs in relation to this theme self-constructed questions were used. Furthermore, sociodemographic characteristics were obtained including age, gender, profession, level of palliative care education and work-related information. Level of palliative care education was divided into three categories: no postgraduate palliative care education, postgraduate palliative care training and postgraduate specialist palliative care education. Palliative care training comprises a wide range of types of palliative care education ranging from short to extensive courses. Specialist palliative care education only includes educational programs that are directed at the specialist palliative care level.

### *Data Analysis*

All data of respondents was analysed using STATA (version 16.1, StataCorp Texas). Respondents who completed all four core constructs of the BAT were included in the analysis. Descriptive analysis was used to describe sociodemographic characteristics, work characteristics and prevalence of (symptoms of) burnout. The nonparametric Kruskal Wallis test was used to assess significant differences in total burnout scores between type of profession, setting, age, years of experience in palliative care, palliative care education and number of patients dying on average per month. A *P*-value of 0.05 was considered to be statistically significant. All open questions were analysed by AD and if needed new categories were added after discussion with NR and LB.

### *Ethical Considerations*

In the Netherlands, according to the Central Committee on Research involving Human Subjects this type of study is exempt from approval of a medical ethics committee, therefore no application was submitted.[18] The online questionnaire was administered anonymously and participation was voluntary. Invitation to the survey was sent by the office manager of Palliactief in order to comply to the General Data Protection Regulation.

## *Results*

The online questionnaire was completed by 192 respondents (53.6% response rate) of which 179 were eligible for inclusion in the analysis (Supplement 1). Seventy-nine percent was female and most respondents were older than 50 years (66%). Nearly half of the respondents were nurses (47%), 39% were physicians and 13% were other healthcare professionals such as chaplains, physiotherapists or psychologists (Table 1).

The majority of respondents reported more than 20 years of work experience in healthcare and more than 11 years of work experience in palliative care. Most respondents reported additional palliative care training: 84% of nurses and 94% of physicians. In addition, 60% of nurses and 90% of physicians had received specialist palliative care education (Table 2).

### *Prevalence of Symptoms of Burnout*

Sixty-nine percent of respondents scored a median level of burnout, with 2% reporting a high or very high burnout score. Most respondents showed median levels on the four main constructs: exhaustion (55%), mental distance (49%), emotional impairment (78%), and cognitive impairment (70%). Furthermore, 8% of the

*Table 1.*
**Sociodemographic Characteristics of Study Population (n = 179)**

| Healthcare Professionals' Sociodemographic Characteristics* | % (n) n (= 179) |
|---|---|
| Gender | |
| Male | 20% (35) |
| Female | 79% (141) |
| Age | |
| ≤30 | 1.7% (3) |
| 31−40 | 9.5% (17) |
| 41−50 | 22% (39) |
| 51−60 | 40% (72) |
| ≥61 | 26% (46) |
| Profession | |
| Nurse | 47% (85) |
| Physician | 39% (69) |
| Other healthcare professional[a] | 13% (23) |
| Worksetting | |
| Homecare | 23% (42) |
| Nursing home | 7.8% (14) |
| Hospital | 39% (69) |
| Hospice | 20% (36) |
| Other[b] | 8.9% (16) |

[a]Other professions include chaplains, physiotherapists and psychologists
[b]Other worksettings includes mainly healthcare professionals working in several settings
*Missing data did not exceed 5%

*Table 2*
**Work Experience and Education Characteristics of Respondents by Profession**

| | Nurses (n = 84) % (n) | Physicians (n = 69) % (n) | Other HCP (n = 23) % (n) |
|---|---|---|---|
| Experience in healthcare (yrs) | | | |
| 0–10 | 4.8% (4) | 7.2% (5) | 17.3% (4) |
| 11–20 | 12% (10) | 28% (19) | 26% (6) |
| ≥ 21 | 83% (70) | 65% (45) | 57% (13) |
| Experience in palliative care (yrs) | | | |
| 0–5 | 26% (22) | 15% (10) | 22% (5) |
| 6–10 | 20% (17) | 23% (16) | 8.7% (2) |
| 11–20 | 25% (21) | 32% (22) | 30% (7) |
| ≥21 | 27% (23) | 30% (21) | 39% (9) |
| Education in palliative care | | | |
| Yes, postgraduate specialist PC education* | 60% (50) | 90% (62) | 27% (6) |
| Yes, postgraduate PC training | 24% (20) | 4.3% (3) | 45% (10) |
| No postgraduate PC education | 17% (14) | 5.8% (4) | 27% (6) |
| Mean number of patients in the palliative phase in care (per month) | | | |
| ≤5 | 8.3% (7) | 13% (9) | 23% (5) |
| 6–20 | 50% (42) | 57% (39) | 54% (12) |
| 21–50 | 33% (28) | 25% (17) | 23% (5) |
| ≥51 | 8.3% (7) | 5.8% (4) | 0% (0) |
| Mean number of patients that die in which the healthcare provider is involved (per month) | | | |
| 0–1 | 3.6% (3) | 15% (10) | 14% (3) |
| 2–5 | 48% (40) | 58% (40) | 64% (14) |
| 6–10 | 36% (30) | 17% (12) | 18% (4) |
| ≥11 | 13% (11) | 10% (7) | 4.5% (1) |

*healthcare professionals with one of the following specialist palliative care education: Palliative Medicine for Health Care Professionals at the Cardiff University, UK., Palliative Care Education of the Dutch College of General Practitioners, Short course palliative care of the Dutch College of General Practitioners, Post graduate education palliative care for nurses.

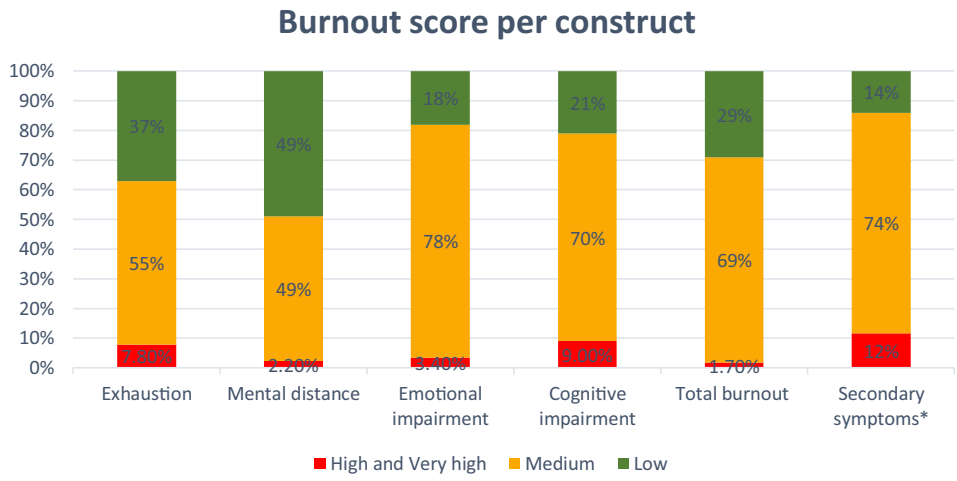


Fig. 1. Symptoms of burnout scores per scale. *Secondary symptoms includes psychological distress and psychosomatic complaints

respondents reported high or very high levels of exhaustion and 9% of the respondents had a high or very high level of cognitive impairment. Most respondents (74%) had a median level of secondary symptoms and 12% reported a high level of secondary symptoms (Fig. 1).

### *Univariate Differences in Burnout*

Older healthcare professionals scored significantly lower compared to younger healthcare professionals regarding burnout score (1.78 [.42] vs. 2.06 [.44], $P < 0.05$), exhaustion, (1.98 [SD.59] vs. 2.35 [SD .55], $P< 0.05$), and emotional impairment (1.68 [SD.45] vs. 1.94 [SD.51], $P< 0.05$). Furthermore, the burnout score differed between healthcare professionals with more than 10 years of experience in palliative care with those with less experience (1.77 [.43] vs. 1.87 [.43], $P< 0.05$). The burnout score did not significantly differ between professions, settings, type of palliative care education and

*Table 3*
**Univariate Comparison of the Total Burnout Score Between Different Characteristics**

| BAT-scales (M (SD) | N | Total BO Score (Mean and SD) | *P*-value |
|---|---|---|---|
| Profession | | | |
| Nurse | 85 | 1.81 (.42) | ***P* = 0.6107** |
| Physician | 69 | 1.82 (.42) | |
| Other | 23 | 1.79 (.55) | |
| Setting | | | |
| Homecare | 42 | 1.9 (.39) | ***P* = 0.3688** |
| Hospital | 69 | 1.9 (.45) | |
| Nursing home | 14 | 1.8 (.44) | |
| Hospice | 36 | 1.7 (.47) | |
| Age | | | |
| <40 yrs | 20 | 2.06 (.44) | ***P* = 0.0048** |
| ≥41 yrs | 157 | 1.78 (.42) | |
| Years of experience in palliative care | | | |
| 0–5 | 37 | 1.9 (.45) | ***P* = 0.0097** |
| 6–10 | 35 | 1.8 (.41) | |
| 11–20 | 50 | 1.9 (.35) | |
| >21 | 54 | 1.7 (.49) | |
| Education in palliative care[a] | | | |
| Postgraduate PC training | 23 | 1.81 (.42) | ***P* = 0.9645** |
| Specialist PC education | 112 | 1.81 (.42) | |
| No PC education | 18 | 1.86 (.44) | |
| Mean number of patients that die in which the healthcare provider is involved (per month) | | | |
| 0–10 | 156 | 1.8 (.43) | ***P* = 0.6196** |
| ≥11 | 19 | 1.8 (.50) | |

[a]only nurses and physicians were included in this analysis due to predefined specialised palliative care education options in survey.

number of patients who die under their care per month (Table 3).

### *Impact of Providing Palliative Care on Healthcare Professionals' Wellbeing*

The majority (64%) of the respondents reported no consequences of their work for their own wellbeing. One fifth of the respondents (20%) reported having experienced a period of stress symptoms such as insomnia, rumination, irritability and/or crying easily. Furthermore, 16% of the respondents had felt overloaded for a longer period (>four weeks) as a result of their work and 6.7% of the respondents reported to have been on sick leave due to burnout symptoms.

### *Coping Strategies Regarding Work-Related Stress*

Almost all respondents (97%) reported engaging in activities for dealing with work-related stress, with an average of 3.7 (SD 1.7) activities. These activities included mainly: talking to colleagues about impactful events (84%); leisure activities such as sports, walking, gardening or listening to music (84%); peer coaching (50%); and team consultation (40%) (Table 4). Overall, 23% of the respondents felt that their activities were not sufficient for them in coping with work-related stress.

*Table 4*
**Coping Activities Used by Healthcare Professionals Providing Palliative Care (n = 179)**

| Activity | Frequency (%) |
|---|---|
| Talk to colleagues about impactful events | 151 (84%) |
| Leisure activities (sports, walk, gardening) | 151 (84%) |
| Peer coaching | 90 (50%) |
| Team consultation | 71 (40%) |
| Variation in work activities | 62 (35%) |
| Distraction (education for example) | 49 (27%) |
| Mindfulness, meditation and yoga | 40 (22%) |
| Support by manager | 33 (18%) |
| Individual coaching | 18 (10%) |
| Getting support at home | 7 (3.9%) |
| Other | 5 (2.8%) |

*Table 5*
**Experienced Problems Related to Work-Life Balance by Healthcare Professionals Providing Palliative Care (n = 179)**

| Problem | Frequency (%) |
|---|---|
| Workload | 81 (45%) |
| Burden of administration | 78 (44%) |
| Long working hours | 59 (33%) |
| Working alone/little contact with colleagues | 33 (18%) |
| Lack of knowledge regarding work-life balance | 11 (6.2%) |
| Lack of palliative care knowledge | 7 (3.9%) |
| Lack of palliative care knowledge among colleagues | 6 (3.4%) |
| Other | 35 (20%) |
| No problem | 29 (16%) |

### *Work-Life Balance Problems and Needs*

Most respondents (84%) experienced multiple problems with their work-life balance, with an average of 1.9 (SD 1.02) problems. Reported problems in maintaining a healthy work-life balance were high workload (45%), administrative burden (44%), and long working days (33%) (Table 5). The majority of respondents expressed a need to maintain or restore their work-life balance (87%). Most frequent mentioned needs were: time to talk with colleagues about impactful events (55%); feeling emotionally safe within the team (39%); and less work pressure (34%). Almost one fourth of the respondents (23%) reported that paying more attention to the emotional impact of providing palliative care is important (Table 6).

*Table 6.*
**Work-life Balance Related Needs (n = 179)**

| Work-life Balance Related Needs | Frequency (%) |
|---|---|
| Time to talk to colleagues about impactful events | 98 (55%) |
| Feeling safe within the team | 70 (39%) |
| Less work pressure | 60 (34%) |
| More attention for emotional impact | 42 (23%) |
| Peer coaching | 4 (2.2%) |
| Variate in work activities | 4 (2.2%) |
| Other | 31 (17%) |
| Nothing | 24 (13%) |

## Discussion

This first nationwide survey among healthcare professionals providing palliative care in the Netherlands had a moderate response rate and shows that more than two-thirds experience a median level of burnout. Some healthcare professionals even experience high levels of burnout, indicating a severe burnout. Furthermore, a significant number has felt being overloaded as a result of their work or even has been absent from work due to burnout. Being older and having more experience in providing palliative care is associated with a lower risk of (symptoms of) burnout. Almost all healthcare professionals providing palliative care are engaged in several activities to maintain a healthy work-life balance. Nevertheless, nearly a quarter of all healthcare professionals feel that these activities are not sufficient to maintain a healthy work-life balance. They encounter mainly organisational problems such as high workload, administrative burden and long working days. Important needs are related to sharing impactful events within the team, such as having more time to talk to colleagues and feeling emotionally safe within the team.

The levels of burnout found in this study are lower compared to those of healthcare professionals in the Netherlands who do not provide palliative care on a regular basis. Houkes et al. showed that approximately 20% of general practitioners in the Netherlands experienced a clinical burnout.[19] Similarly, a survey among members of the Dutch Anaesthesia Society demonstrated a prevalence of burnout of 18% among anaesthesiologists in the Netherlands.[20] The low percentage of high level of burnout in our study might be explained by multiple reasons. Firstly, the majority of respondents in this study had received specialist palliative care education. Therefore, they might be better equipped to provide palliative care and to cope with the emotional impact of providing this care than healthcare professionals providing generalist palliative care. This is in line with a study among palliative care teams in Portugal showing that healthcare professionals with postgraduate palliative care education have less symptoms of burnout compared to colleagues without this education. Additional palliative care education seems to be a protective factor for burnout.[21] Secondly, in our study most respondents had ample experience in providing palliative care, which also seems to be a protective factor. A US study among healthcare professionals providing palliative care showed that more experienced professionals were in less danger of developing burnout.[22] This might also be explained by the fact that more resilient healthcare professionals are more likely to continue working in this profession.[23] Interestingly, in our study no relation was seen between level of burnout and exposure to a higher number of dying patients per month. This is in line with a recent study on the level of exposure to death and levels of burnout among nurses and physicians in Israel, that showed no significant differences between healthcare professionals with high level of exposure to death and those with a lower exposure.[24] However, a study among German palliative care teams showed that the mean critical number of deaths per week was 4.4, indicating that there is a maximum of suffering and dying one can cope with.[25] The assessment of level of exposure to dying patients in our study was not specific enough to be compared with these studies.

Our study also shows that healthcare professionals are engaged in many activities to maintain a healthy work-life balance, predominantly talking to colleagues about impactful events, leisure activities, peer coaching, and mentorship. Similar activities were also seen in other studies.[26,27] A US study showed that hospice and palliative medicine physicians engage on average in four activities to prevent burnout. Most common reported activities by these physicians were: promoting their physical well-being by for example exercising; nurturing professional relationships with a focus on teamwork and collegiality and taking a transcendental perspective by engaging in spiritual exercises such as meditation. Furthermore, talking with colleagues and loved ones was an important need.[27] However, in our study respondents felt that these activities were not sufficient to maintaining a healthy work-life balance. This might indicate that the current activities individuals engage in do not fully match the needs of healthcare professionals providing palliative care. Moreover, healthcare professionals feel that it is important to share impactful events with colleagues. However, a frequent reported need is having time to talk to colleagues and a safe team culture in which it is possible to share impactful experiences. Therefore, more attention to the emotional impact of providing palliative care seems warranted.

It is important to address both the needs within the sphere of influence of the healthcare professionals themselves (individual level) as the needs related to team culture and policy within healthcare organisations. This whole-system approach to prevent burnout has also been emphasized by other studies[4,28–30] Harrison, et al state that current efforts to mitigate burnout in palliative care are mainly focused on the individual but should evolve to a system-level approach.[28] Although the individual level interventions remain important for decreasing the risk of burnout, placing the responsibility solely on the individual healthcare professional is not appropriate since it fails to address the structural causes of burnout. A dual approach on both individual and structural or organisational level is necessary to decrease the risk of burnout effectively.[4]

*Strengths and Limitations*

This study is the first Dutch survey to assess the level of symptoms of burnout among healthcare professionals providing palliative care in the Netherlands. The response rate (54%) was moderate and also a good distribution of nurses and physicians was present. However, selection bias may have occurred and this could lead to an overestimation of burnout symptoms. However, recent research showed that surveys may provide valid burnout estimates despite low response rates.[31] Other limitations of this study were that, firstly, healthcare professionals who currently experience (symptoms of) burnout are more likely to be absent due to sick leave and less likely to reply to the survey invitation emails. This probably has resulted in some selection bias due to the 'healthy worker' effect. Secondly, the generalisability of our results to other countries is limited as the organisation of palliative care in the Netherlands deviates from other countries.

*Implications for Practice and Future Research*

Work-related stress is common among healthcare professionals providing palliative care and currently used coping strategies do not seem to be sufficient for fully dealing with the emotional impact of providing this type of care. Clearly, due to the predicted shortage of healthcare workers in palliative care, it is important to better understand work-related stress in this field. Moreover, awareness of risk of burnout when providing palliative care and the importance of prevention is needed both at the individual level, the team level, and the organisation level.

As a result of the current COVID-19 pandemic awareness of the importance of the psychosocial wellbeing of healthcare professionals has increased.[32] Moreover, many healthcare organisations have started psychosocial support for healthcare professionals during this outbreak. For example, several hospitals in the Netherlands introduced a program for peer support or access to a psychological support team in dealing with the impact of Covid-19.[33,34] Hopefully this increased awareness will contribute to a sustainable change in mindset of healthcare organisations about their responsibility in addressing the psychosocial wellbeing of their healthcare professionals. It is essential to evaluate this support for its effectiveness and appropriateness to sufficiently address the emotional impact of providing palliative care.

## Conclusion

Symptoms of burnout are quite prevalent among healthcare professionals providing palliative care in the Netherlands and some even experience a high level of burnout. Most healthcare professionals providing palliative care are actively engaged in multiple coping activities. Nevertheless, currently used activities are not adequate to prevent median levels of burnout and healthcare professionals have a need for supporting activities at team level and organisation level. Due to the foreseen increasing demand for healthcare professionals providing palliative care, it is vital to keep a healthy workforce in palliative care. Therefore, it is of utmost importance to develop support that transcends the individual level, such as activities within the team and on the organisation level.

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