Most doctors would acknowledge the risks of coming to work sick (for example, while infected with influenza)—not only the danger of spreading infection among patients, but also the risk of feeling subpar physically and, as a result, practicing suboptimally. However, almost all have done it, notes Eric Widera, MD, director of hospice and palliative care at the San Francisco VA Medical Center and associate professor of clinical medicine in geriatrics at the University of California-San Francisco.

“Doctors may feel an overwhelming dedication and sense of duty to their work, their teams, and their patients, and undervalue the risks of coming to work when feeling ill,” he says. “How is burnout different than that?”

Accumulated, unresolved, interpersonal, and work-related stresses can lead to a syndrome characterized by detachment, cynicism, and ineffective performance, which is often called burnout, Dr. Widera says. “When we forget about taking care of ourselves—when we feel that we’re the only ones who can really do this job—we expose patients, families, loved ones, and fellow team members to potential harm.”

This heightened sense of duty by some hospice and palliative medicine (HPM) physicians, coupled with a lack of institutional support, a sense of loyalty to colleagues, and an unwillingness to confide in others or ask for help, can trigger a vicious cycle of stress leading to emotional distancing and disengagement from patients as a self-protective mechanism. This in turn leads to greater depersonalization from the work and burnout. Particularly in HPM, with its emphasis on personal rapport, careful listening, and whole-person responses to the range of needs of seriously ill patients, this kind of distancing can undermine the whole point of the service.

There is extensive literature on burnout among health professionals, which finds that one-half or more of both physicians and medical trainees experience symptoms of burnout. These include emotional exhaustion, loss of energy, depersonalization, a low sense of accomplishment from their work, decreased ability to show empathy, and compassion fatigue. Burnout suggests more than just work stress; rather, it is more like a feeling of having nothing more to give to the job.

A study in Archives of Internal Medicine found that 45.8% of physicians across specialties already suffer from a symptom of burnout—a higher rate than the researchers expected and higher than most other occupations or professions. Emergency medicine, general internal medicine, neurology, and family medicine physicians reported the highest rates of burnout. Personal manifestations of burnout identified in the literature include substance abuse, automobile accidents, marital and family discord, physical health problems, and even higher than average rates of suicide among doctors.

“Burnout is the opposite of engagement with your work,” Dr. Widera says. “Tasks that used to energize you become unpleasant and unfulfilling. Over time, the loss of energy turns into exhaustion, feeling involved with your job turns into depersonalization and cynicism, and what used to feel like a sense of efficacy turns into an overwhelming sense of personal ineffectiveness. Burnout happens to highly motivated and committed professionals—the type of people who choose to go into hospice and palliative care.”
That makes it imperative for HPM professionals to learn and practice techniques of self-care to protect themselves from burnout. “For me, the heart of self-care is recognizing that it’s not actually just about me,” Dr. Widera says. “The cost of the lack of self-care is a much bigger problem. If we come to work in a suboptimal place, it affects our patients and our teams,” leading to medical errors and patient dissatisfaction with care. Instead, the physician should focus energy on rebuilding engagement, “promoting an environment that supports the development of energy in [the] work, involvement in the care of patients, and personal effectiveness.”

More Research on Burnout and Its Antidotes

Although burnout research has focused mostly on general medical settings or other specialties, several recent studies speak directly to the experience of HPM. Swetz and colleagues surveyed HPM physicians regarding their methods for avoiding burnout and finding fulfillment in their work, uncovering a variety of strategies to promote personal well-being that emphasize physical health, professional relationships, and transcendental perspectives. A Portuguese research team detailed burnout levels and protective factors in palliative care nurses and physicians, and Australian researchers concluded from three questionnaires of physicians that “levels of psychiatric morbidity and burnout in palliative medicine are not higher than in other specialties.”

Kearney and colleagues have described practices of empathy, engagement, and “being connected” as keys to professional survival, as is an educational program designed to enhance mindful communication.

More recently, a team at the Carolinas Palliative Care Database Consortium, a community/academic quality partnership between Duke University and three area community-based palliative care organizations, has been studying the phenomenon, prevalence, and characteristics of burnout in the context of palliative care workforce concerns.

“There is a lot of turnover of physicians, advanced practice providers, and nurses in our field, which we think may reflect high caseloads, exhaustion, and burnout,” explains researcher Arif Kamal, MD, director of palliative care and quality research at Duke University Medical Center. “We wanted to gain perspectives on how burnout affects our precious professional resources, determine the prevalence of the problem, and learn what techniques clinicians are using to protect themselves.”

An electronic survey including the Maslach Burnout Inventory (www.mindgarden.com/products/mbi.htm) was sent to all members of AAHPM last year and through relevant social media. A total of 1,200 respondents, mostly physicians but including other clinicians as well, “makes this the largest burnout survey by far in our field,” Dr. Kamal says. “We also gathered data on median age, longevity, plans to stay in the field, and reasons for considering leaving.”

The survey sampled job responsibilities and coping behaviors and asked respondents whether they would still opt for HPM if they could revisit their career choices. “We requested e-mail addresses from anyone willing to do qualitative follow-ups and we’ll be conducting focus groups to get a narrative sense of what burnout feels like,” Dr. Kamal says.

Analysis is still preliminary, Dr. Kamal reports, “but we have found protective factors such as being married, having children at home, working fewer hours, not working weekends and holidays, and having multiple onsite colleagues.” Researchers hope to end up with a
prioritized list of modifiable factors for institutions to adopt that could prevent people from leaving the field.

**Mindfulness and Other Preventive Strategies**

“As a specialty, we haven’t seriously addressed how to take care of each other. With rapidly expanding demand for our services, we’ll only be asked to see more and more patients,” Dr. Kamal says. HPM professionals need to get together and collaborate—both in their workplaces and across the specialty. Research is important, “but so is just talking about these issues as a field. There’s a fear that talking about our own job stresses means revealing that we are human.”

Duke recently started a monthly closed-door debriefing session for its palliative care clinicians to talk about difficult cases, with a focus on personal rather than clinical responses. Dr. Kamal says this debriefing session is modeled on the Schwartz Center Rounds professional support model developed at Massachusetts General Hospital (www.theschwartzcenter.org/ourprograms/rounds.aspx). “We also conduct critical reflection exercises with our residents,” he adds.

“We know certain emotions lead to stress and exhaustion. If you are seeing palliative care patients sequentially and allowing yourself to care about each of them, you may be creating stress hormones in your body,” says Louise Aronson, MD, associate professor of medicine at University of California-San Francisco and author of *A History of the Present Illness*, a book of stories from medical practice, several of which address burnout and palliative care.

“The first step is being aware of how you show stress, and if you are extremely grumpy or argumentative in situations where it’s not appropriate, or else constantly feeling tired,” she observes, “then it’s important to ask yourself, ‘What helps me when I’m feeling this way?’ Some data suggest that exercise gives you more of the good hormones and burns off stress. Third, hopefully you work in an environment where you can say to your team, ‘I’m feeling burned out,’ and not have it sound like, ‘I’m weak; I’m a loser; I’m letting you down.’”

Self-reflection might help clinicians recognize the need to take some time off before the symptoms of burnout escalate, Dr. Aronson says. “Write it down. Get feedback from others.”

It also is important to find ways to accommodate a professional’s need for time off without creating more stress for the rest of the team. These might include having access to float staff as backups, banking hours of work in advance of the need for time off, and sharing on-call or fallback coverage with other palliative care providers in the community, Aronson says.

According to Dr. Widera, the essence of self-care in the face of job stress is to restore the humanity of palliative care. “We should practice what we preach in family meetings—acknowledging that we’re human and that we have feelings. We should name what we’re feeling to give us more conscious control over that emotion. We should talk to the team, write it down, and use mindfulness techniques and reflection exercises. People have different ways of reflection—from physical exercise to mindful meditation. And we need to spend time on the things generally suggested to help with burnout.”

Those techniques include promoting strong teamwork; teaching good communication skills; adding variety into the job so it isn’t all spent with patients; emphasizing life/work balance through families, hobbies, and recreation; and taking the full complement of vacation days every year. Dr. Kamal recommends his colleague Brian Sexton’s “Three Good Things” (www.youtube.com/watch?v=57ru-P7EuMw), a resilience-promoting journaling exercise in which you jot down three good things that happened that day every night before going to sleep.
The Quest for Meaning

Hospice and palliative medicine doctors tend to talk more about wellness and self-care than other specialties, notes Elise C. Carey, MD, chair of the Section of Palliative Medicine at the Mayo Clinic in Rochester, MN, and cochair of the 2014 AAHPM & HPNA Annual Assembly, which included a plenary session on these topics. “We are more aware of the issues. That doesn’t mean we always do it. But a highly functioning palliative care team will spend time talking about how to keep the team and its members well,” Dr. Carey says. She also describes a state of “crispness—as opposed to burnout,” where a physician with a fair amount of self-awareness might recognize that he or she is getting close to the edge of burnout and needs to pull back.

Often what puts HPM physicians at risk of burnout is being placed in managerial roles earlier than would be ideal in their career trajectory, a need largely driven by the specialty’s youth and rapid growth. New fellowship graduates may be hired to build and run palliative care programs when their training emphasized clinical over administrative skills. Their institutions don’t always understand the realities of palliative care, including the time it takes to be successful, according to Dr. Carey. “They’re more used to measuring RVUs (relative value units of productivity), but what we do in palliative care is more likely to lead to cost avoidance. So palliative professionals can fall into a bind,” she explains.

“I have become burned out before. When it happened to me during my first year on faculty at my previous institution, I had started a new consultation service. Neither they nor I thought it would be successful, according to Dr. Carey. “They’re more used to measuring RVUs (relative value units of productivity), but what we do in palliative care is more likely to lead to cost avoidance. So palliative professionals can fall into a bind,” she explains.

Still, he notes, frequent encounters with death, dying, and grieving families can take their toll, contributing to emotional exhaustion, demoralization, and diminished capacity for caring. Experienced HPM professionals typically have found a way to negotiate these stressors. “If you haven’t found that capacity in yourself—if you can’t courageously find a way to live in a world where loss is inescapable, acknowledging that grief and loss in some way—it’s hard to continue in this field,” Dr. Larson says. “That means a philosophy of life enabling you to integrate and transform loss so that it’s not continually unsettling you.”

Ultimately, Dr. Larson argues, citing the late social psychologist Ayala Malach-Pines, what underlies many of these cases of burnout is the failure of the professional’s existential quest for meaning.

References


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