

# **EPEEC for Veterans**

Education in Palliative and End-of-life Care for Veterans

## **Trainer's Guide**

Module 15

## **Professional Self-Care**

**Emanuel LL, Hauser JM, Bailey FA, Ferris FD, von Gunten CF, Von Roenn J, eds. EPEC for Veterans: Education in Palliative and End-of-life Care for Veterans. Chicago, IL, and Washington, DC, 2012.**

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## Module 15 trainer's notes

### Principal message

Professional self-care is a core competency for clinicians of every discipline engaged in palliative care. The basic premise is that we need to engage in healthy self-care activities if we are to be available and able to care for veterans and their families. All clinicians must take active steps to prevent the syndrome of 'burnout.'

### Module overview

Self-care is a core competency in palliative care. It begins with an acknowledgment that it is important. We cope with numerous stresses in the course of our work. Those stresses may be related to the social culture in which we live, the institutional culture in which we work, patients and their families, and those things that are personal. We need to recognize the manifestations of stress and enlist our colleagues and friends to help us recognize what we can't see ourselves. We can look for those manifestations in the same domains we look for suffering in our patients: physical, psychological, social and spiritual. Coping strategies involve building both organizational and personal strategies to cope in each of these domains.

### Preparing for a presentation

#### 1. Assess the needs of your audience

Choose from the material provided in the syllabus according to the needs of your expected participants. It is better for participants to come away with a few new pieces of information, well learned, than to come away with a deluge of information, but remembering nothing.

#### 2. Presentation timing

The suggested timing for each part of this module is:

Introduction	2-3 minutes
Presentation	35 minutes
<u>Summary</u>	<u>3-7 minutes</u>
Total	40-45 minutes

### **3. Number of slides: 17**

### **4. Preparing your presentation**

This module can be presented using slides or it can be presented without slides as a facilitated discussion using participants' own experiences. You may also wish to use slides to facilitate more personal discussions. In the included slides are sections for group discussion and individual reflection. As with the other modules, the text in the syllabus was not designed to be used as a prepared speech. Instead, the slides have been designed to trigger your presentation.

### **5. Preparing a handout for participants**

The syllabus text and slides in the **Trainer's Guide** are designed to be reproduced and provided to participants as a handout, either in its entirety, or module by module. If the entire curriculum is not being offered, please include the following in each handout:

- **EPEC for Veterans Front Cover Page**
- **EPEC for Veterans Acknowledgment Pages** (to acknowledge the source of the material)
- Syllabus and slides for **Module 15**

### **6. Equipment needs**

- computer with DVD capability or separate DVD player
- flipchart and markers for recording discussion points

## **Making the presentation**

### **1. Introduce yourself**

If you have not already done so, introduce yourself. Include your name, title, and the organization(s) you work for. Briefly describe your clinical experience related to the information you will be presenting.

### **2. Introduce the topic**

Facilitate a group discussion of the issues around professional self-care.

- Consider starting with an open-ended question like: "What are the personal stresses of palliative care?" or "How do you take care of yourselves so you can do this work?" Alternatively, you could begin with an anecdote of your own.
- Identify the domains where stressors occur. Usually these include physical, psychological, social and spiritual domains.

- Consider coping strategies at both the organizational level (team meetings, enough staff, vacation time) and personal level (physical, psychological, social, and spiritual).
- Facilitate comments about what the stresses are and how to cope with them.
- Try to help everyone participate.

### **3. Review the session objectives**

### **4. Present the material**

#### **Recommended style: Case-based**

As a facilitator, you can share a case or experience in your own life in which you felt stress and/or noticed signs of burnout. This can be used to focus the discussion and also lead to others sharing cases of their own.

### **5. Key take-home points**

1. Self-care is a core competency in palliative care.
2. Commitment to work, a sense of control, and a sense of challenge are marks of successful self-care.
3. Recognize stressors in the social, institutional, patient/family, and personal domains.
4. Key dimensions of burnout are exhaustion, cynicism, and a sense of personal ineffectiveness.
5. Burnout arises from chronic mismatches between people and their work settings.
6. Burnout, in contrast to depression, is specific to the work context.
7. Personal responses to help mitigate burnout include outside interests (such as art) and recreation, talking with others, developing supportive friendships, and spiritual pursuits, exercise.

### **6. Summarize the discussion**

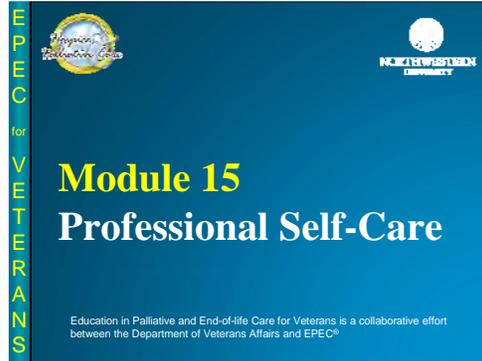
Briefly review each part of the presentation. Recap 2 or 3 of the most important points that were discussed.

### **7. Post-test/evaluation**

Ask the participants to evaluate the session.

## Abstract

Slide 1



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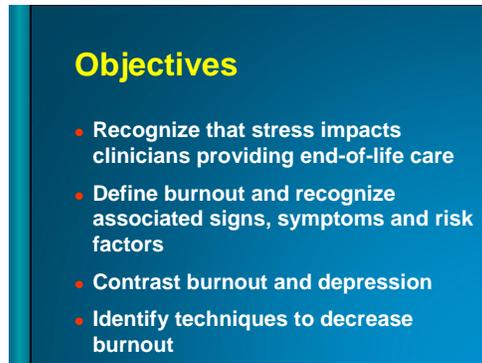
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Self-care is a core competency for clinicians of all disciplines. The goal of this module is to enable clinicians providing palliative care to understand work-related stress and to develop coping strategies to avoid burnout. Stressors from work with Veterans, families, and organizational demands can lead to symptoms of stress and burnout that can be manifested both at work and at home. Successful coping requires both organizational and personal strategies in each of the physical, psychological, social (professional and personal) and spiritual domains.

## Objectives

Slide 2



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After studying this module, clinicians will be able to:

- recognize that stress impacts clinicians providing end-of-life care;
- define burnout and recognize associated signs, symptoms and risk factors;
- contrast burnout and depression; and
- identify techniques to decrease burnout.

# Introduction

Slide 3



**Introduction**

- A core competency for clinicians in palliative care and many other fields

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Self-care is a core competency for clinicians. Without this skill, clinicians working in palliative care will not be able to sustain the knowledge, attitudes, and skills required for quality care. While this is a core competency for palliative and end-of-life care, it is also important for medical care in general.

Many clinicians find palliative care to be professionally and personally rewarding. What do those clinicians do to avoid having their professional life become burdensome? How do they manage to revitalize themselves when others are drained? How do they avoid exhaustion and continue to serve? How do they maintain sympathy without being enervated? How do they avoid burn out?

To answer those questions, this module first describes the issues that are common among clinicians involved in palliative and end-of-life care. Then, we provide a framework for thinking about those issues. Finally, we identify coping strategies with which clinicians can maintain professional and personal satisfaction.

# Sources of stress

Slide 4



**Sources of stress**

- Social: potential stigma of palliative care
- Institutional: sees death as failure, undervalues / resources palliative care
- Veteran / Family: "difficult" patients are not coping / neither is provider
- Personal: experiences both professional and at home

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Sources of stress fall into four broad categories: social, institutional, Veteran/family, and personal. While these categories are a helpful framework, most stress experienced by clinicians is actually a combination of these factors.

## **Social**

The culture in which we live and work plays an important role in our self-care and stress. Some have called this a “death-denying” culture.<sup>1</sup> Although the rise of palliative care may have changed this observation somewhat, many popular images, including images of health care, show youth and vigor rather than age and dependence. In addition, advertising messages from our health care systems also emphasize how they can promise health and the cure of illness. In this setting, palliative care may seem like a less-worthy or celebrated pursuit than curative care.

## **Institutional**

More specifically than the overall social culture, the institutional culture of medicine (or of a specific hospital or other facility) may regard a Veteran’s death as failure - arising, for example, from insufficient scientific knowledge as well as personal failure to adequately apply existing knowledge. If death is perceived of as a failure, it might be hard to view the specific successes of palliative care in a symptom control or helping support a family as valuable. Because of the strenuous (and effective) acculturation process during clinical training, we may internalize this value. Failure is often not something that we clinicians value as a group.

## **Veteran/family**

Both Veterans and families may have personalities or coping styles that we may find problematic. This may lead to communication problems between us and the Veterans and families. We may find individual Veterans to have difficult personalities or to be making choices with which we do not agree. There is a broad literature on “difficult” patients and the stresses they can induce in clinicians.<sup>2,3,4</sup> One important observation about “difficult” Veterans and families is that it is most often the situation which is difficult and not the Veteran him or herself. Without some means for coping, this can be unduly stressful. It is crucial, therefore, to try not to focus the problem on the Veteran or the family on ourselves, but rather on the interaction.

## **Personal**

Our personal experiences with life-threatening illness and death can shape our responses to dying Veterans. Some clinicians that have been in practice many years still remember experiences in training that were challenging, frustrating or even abusive. They may have witnessed abandonment, or felt abandoned themselves during the formative years when they were developing their professional and personal responses to dying Veterans. Others may have witnessed “bad” deaths of loved ones, friends, and Veterans. These experiences, if not addressed, can lead to stress when caring for the dying.

## Expressions of stress

Slide 5

### Expressions of stress

- Stress can be conceptualized with four main domains
  - physical
  - emotional
  - social
  - spiritual
- Imagine how stress affects you in one or more of these domains

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Stress can cause suffering. If this suffering is not recognized, it can prevent the professional growth and development. Although not as severe, this may be analogous to the situation of suffering for Veterans in palliative care. If suffering is not recognized and addressed, Veterans cannot achieve their goals and expectations. Clinicians may be similar. Cicely Saunders' model of "total pain" with its physical, psychological, social, and spiritual dimensions<sup>5</sup> can be applied to understanding the expressions of stress in clinicians. Again, this is not to equate the suffering of Veterans in palliative care with their clinicians but rather to suggest a common framework.

## Burnout

Slide 6

### Burnout

#### Three key dimensions

- Individual: Overwhelming exhaustion; feeling depleted emotionally and physically
- Interpersonal: Cynicism and detachment from job; callous / lacking empathy
- Self-evaluation: Feeling ineffective; lacking in achievement and productivity at work

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Burnout, a psychological syndrome, is a *response to chronic interpersonal stressors on the job*.<sup>6</sup> The concept of burnout was first developed in the 1970s.<sup>7</sup> It can be experienced in multiple contexts.

The syndrome of 'burnout' is the result of not heeding the warning signs of cumulative stress. When we give out more than we rejuvenate, burnout can result. As clinicians, we need to be alert to the warning signs of stress both in ourselves and in our colleagues in order to prevent burnout.

The three key dimensions of burnout are the following:

- **Individual**, exemplified by an overwhelming exhaustion; feelings of being overextended and depleted of one’s emotional and physical resources;
- **Interpersonal**, exemplified by cynicism (or depersonalization) and detachment from the job; cynicism refers to a negative, callous, or excessively detached response to various aspects of the job; and
- **Self-evaluation**, exemplified by a sense of ineffectiveness and lack of accomplishment; ineffectiveness refers to feelings of incompetence and a lack of achievement and productivity at work.

One commentator suggests, “The root cause of burnout lies in people’s need to believe that their life is meaningful, and that the things they do—and consequently they themselves—are important and significant.”<sup>8</sup> When work ceases to be meaningful, symptoms of burnout can ensue.

## Models of burnout

Slide 7

**Models of burnout**

Mismatch in six domains between the person and their work

- Workload
- Community
- Control
- Fairness
- Reward
- Values

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Slide 8

**Complex interplay**

- Heavy workload causes stress

*But is offset by*

- Supportive community
- Recognition and reward for work well done
- Values of the mission of palliative care
- Level of control over situation
- Effective work-life balance

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Six areas of work life come together in a framework that encompasses the major organizational antecedents of burnout. These include:

- workload;
- community;
- control;

- fairness;
- reward; and
- values.

Burnout arises from chronic mismatches between people’s expectations or needs and their work settings in some or all of these areas. Some evidence suggests that individuals’ values may play a central mediating role for the other areas. Alternatively, people may vary in the extent to which each of the six areas is important to them. Some people may place a higher weight on rewards than on values; while others may be prepared to tolerate a mismatch regarding workload if they receive praise, good pay, and have good relationships with colleagues.

Research has focused on the degree of match or mismatch between the person and six domains of the job environment.<sup>6</sup> The greater the gap or mismatch between the person and the environment, the greater the likelihood of burnout. The greater the fit, the greater the likelihood of engagement with work.

## Job engagement

Slide 9

**Job engagement**

- The opposite of job burnout
- This may be the person who says that their “job” isn’t work
- Looks forward to working, seeing colleagues, patients, families

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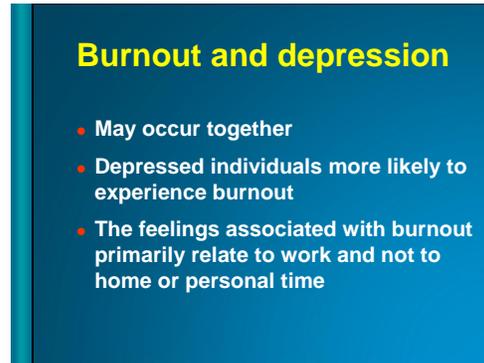
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Some studies have looked at sources of satisfaction among oncologists. These include dealing well with patients and relatives, having professional status and esteem, deriving intellectual satisfaction, and having adequate resources to perform one’s role.<sup>9</sup>

*Job engagement* is conceptualized as being the opposite of burnout. It involves energy, involvement, and efficacy. It involves a sustainable workload, feelings of choice and control, appropriate recognition and reward, a supportive work community, fairness and justice, and meaningful and valued work. Engagement is also characterized by high levels of activation and pleasure. Engagement is a persistent, positive-affective-motivational state of fulfillment in employees that is characterized by vigor, dedication, and absorption.<sup>6</sup>

## Burnout and depression

Slide 10



**Burnout and depression**

- May occur together
- Depressed individuals more likely to experience burnout
- The feelings associated with burnout primarily relate to work and not to home or personal time

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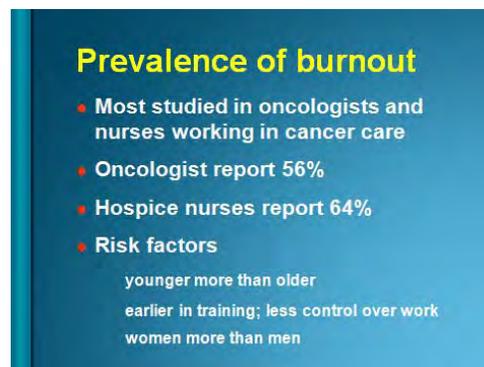
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Burnout is a problem that is specific to the work context, in contrast to depression, which tends to pervade every domain of a person's life. However, individuals who are more depression-prone are more vulnerable to burnout.<sup>6</sup>

Burnout and depression can be differentiated.<sup>10</sup> A reduced sense of superiority and a perceived loss of status are more characteristic of depressed individuals than for individuals who are burnt-out. It seems that burnt-out individuals are still 'in the battle' for obtaining status and consider themselves as potential winners, while depressed individuals have 'given up.'<sup>10</sup> Overall, depression is more pervasive than burnout, affecting home and work life; depression is more severe than burnout, affecting function more dramatically and depression is more likely to be associated with self-destructive behavior such as suicidality.

## Prevalence of burnout

Slide 11



**Prevalence of burnout**

- Most studied in oncologists and nurses working in cancer care
- Oncologist report 56%
- Hospice nurses report 64%
- Risk factors
  - younger more than older
  - earlier in training; less control over work
  - women more than men

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The prevalence of burnout has been studied in a number of different populations.

### Oncologists

In a large study of stress in oncologists, 56% of oncologist subscribers to the *Journal of Clinical Oncology* reported experiencing burnout in their professional lives.<sup>11</sup> When asked to define the specific nature of their burnout, 56% mentioned frustration or a sense

of failure, 34% depression, 20% disinterest in practice, and 18% boredom. Almost 50% felt that burnout was inherent to the practice of oncology. Institution or university-based oncologists on salary reported a lower incidence of burnout (47%) than those in private adult oncology practice (63%). Burnout was measured using an author-constructed questionnaire, as opposed to the Maslach Burnout Inventory, which is often used to measure burnout.<sup>12</sup> The Maslach inventory asks questions related to issues such as frustration, irritation, pressure, and lack of time. It has been validated in many settings.

## Nurses

Among hospice nurses, one investigator found rates of burnout of up to 64% on one of the subscales of the Maslach inventory.<sup>13</sup>

## Risk factors

Slide 12



**Risk factors**

- Personality characteristics
- Baseline mental health issues
- Lower levels of self-reported spirituality

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A number of individual, cultural, and personality characteristics are associated with burnout. Below are examples of risk factors which investigators have shown are related to burnout.

## Individual risk factors

### Age

Those under 30 or 40 years of age have more burnout than those over 30 or 40. Age is confounded with work experience, so burnout may be more of a risk earlier in one's career.<sup>6</sup> However, in another study, age < 55 years was an independent risk factor for burnout.<sup>14</sup>

### Stage in work life

In studies of physicians, residents report greater levels of burnout than attending physicians.<sup>15</sup>

## **Gender**

In the *Physician Work Life* study, women were 1.6 times more likely to report burnout than men.<sup>16</sup> The odds increased by 12-15% for each additional 5 hours worked per week over 40 hours. Female oncology housestaff and nurses have reported higher levels of emotional exhaustion and psychological distress than staff physicians of any gender or male housestaff. Of all the groups, female house staff show the greatest sense of demoralization and the least sense of accomplishment within a highly stressed environment. In only one study were male oncologists at more risk of burnout than female oncologists.<sup>17</sup>

## **Personality factors**

### **Compulsiveness**

Some have hypothesized that for physicians, compulsiveness, “when present in conjunction with other characteristics of overly controlled emotions and low need for relaxation and pleasure, makes the medical student, and later the physician, more vulnerable than others to depression, alcoholism, psychiatric disorders, and suicide.”<sup>18</sup> An oncologist said, “Lots of us who feel overloaded and overworked create it ourselves. We start dancing to a tune that you’re called to play by yourself.”<sup>19</sup>

### **Early psychological health**

People who were psychologically healthier in adolescence and early adulthood are more likely to enter, and remain, in interpersonally demanding jobs, i.e., emotionally demanding ‘helper’ roles or jobs that deal with people in stressful situations, and they showed greater involvement and satisfaction with their work.<sup>20</sup>

### **Personality characteristics**

The personality characteristic of ‘hardiness’, consisting of commitment, control, and challenge, is associated with improved coping in house officers.<sup>18,21,22</sup> Hardiness is also associated with less demoralization and a greater sense of accomplishment.

### **Level of social support and spirituality/religion**

Female physicians with young children are 40% less likely to burn out when they have the support of colleagues, spouses, or significant others for balancing work and home issues.<sup>16</sup>

In an evaluation of burnout among nurses, fellows, and oncologists, those who reported being ‘quite a bit’ to ‘extremely’ religious had less diminished empathy or depersonalization and less emotional exhaustion on the Maslach Burnout scale, compared to those who were not as religious.

# Assessment

Slide 13

## Assessment

Use Table 1 to assess if you might have symptoms of burnout:

- Reflect on each item for 5-10 seconds
- If you feel comfortable write a few notes down that you might discuss in a small group
- Share only if you feel comfortable

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Although we usually think of assessment as something applied to patients, consider how it might apply to you. What are the signs and symptoms that you want to consider that might suggest burnout? To prevent or address burnout early, monitor yourself for signs and symptoms of burnout (see **Table 1**). This list is not a formal screen for burnout but rather presents signs and symptoms that can be associated with burnout.

**Table 1: Signs and symptoms of burnout<sup>23</sup>**

<b>Physical Symptoms</b>
Fatigue
Gastrointestinal disturbances
Headaches
Insomnia
Weight loss
<b>Emotional Symptoms</b>
Boredom
Depression
Frustration
Low morale
<b>Performance-related Issues</b>
Staff turnover
Impaired job performance (decreased empathy, increased absenteeism)
Deterioration in clinician-Veteran relationships
Less satisfaction, desire to reduce time seeing Veterans, more likely to order tests or procedures, interested in early retirement
An inability to leave work (working longer and longer hours), absenteeism, lower job satisfaction, or a decreased sense of personal accomplishment

## Overall coping strategies

Slide 14

**Coping strategies for burnout ...**

Institutional and organizational structures

- IDT meetings
- Support groups
- Schwartz rounds

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Slide 15

**... Coping strategies for burnout**

Personal coping

- Time alone– journaling
- Setting limits on workload using vacation and leave
- Supportive community within or outside of your work environment

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If stress is manifested in the physical, psychological, social, and spiritual dimensions then coping needs to be focused in the same domains. Coping strategies can be organizational or personal.

### Organizational structures

There are a variety of ways of coping with the stress of caring for Veterans and their families at the end of life that are best carried out at the organizational level.

Regularly scheduled care conferences permit the discussion of care of individual Veterans with others, including the stress that it brings. Simply sharing observations in the context of a case conference can be a clear benefit. The interdisciplinary team meeting that palliative care programs have can serve this function. Some participants called these “de-griefing” sessions after a particularly difficult case and bad/troubling death. Open, trusting sessions can help bring closure, reinforce a team spirit, and direct attention to the future. Some of these experiences can be a regular event, such as Schwartz Rounds which are interdisciplinary conferences on emotionally challenging cases.<sup>24</sup> These are not exclusive to palliative care and likely derive some of their benefit from being hospital-wide.

Some other organizational activities allow clinicians and others to achieve a personal closure with the family as well as the Veteran that touches on the spiritual domain. Some clinicians find it helpful to participate in the rituals that accompany death, such as the wake or funeral.<sup>25</sup> Others send condolence cards themselves, with team members, or with their office staff. Others make a condolence phone call. Some participate in annual or monthly or by-the-case candle lighting or prayer services.

## **Personal coping**

It is useful to develop an insight into what helps you sustain your own well-being. Time alone seems important for many clinicians.

## **Journaling**

Some write in a journal regularly. Those who find it helpful describe the value of writing about daily activities and what feelings were experienced and dealt with. A surgeon said at an early EPEC conference that writing in a journal not only “got things off my chest” but also provided a review mechanism to learn how to handle problems or personal feelings better in the future.

## **Setting limits and the need to say no**

Many clinicians have commented on the need to say ‘no’. “No one can take advantage of you without your permission.” “It is very hard to do it, and you don’t get there overnight.” “It’s essential to set up personal boundaries, the world will go on without you.” Some noted that, particularly in the setting of private practice, if you say no, you worry about the business going to someone else—you have to get past that if you’re going to stay sane.”

## **Being with others**

Talking with others can help both with present problems, as well as plan for future stress. Use the advice of others to avoid excessive involvement in any individual case, as well as to validate our feelings. Those people can either be personal friends or professional colleagues.

We can also derive support from Veterans and families, themselves. While it is imperative to use other colleagues and team members to keep in balance, the gratitude from Veterans and families is one of the time-honored rewards of being a clinician. Inevitably, there are some Veterans to whom one feels closer than others.

## **Rituals**

Participating in organized religion and exercising religious practice is important for some. Some clinicians go to church, synagogue, mosque, temple and/or engage in private prayer nightly.<sup>26</sup> Some take time for spiritual retreats. Strength and balance can be found from their spiritual beliefs and these very personal activities. Outside of organized religion,

many describe spiritual activities around death, e.g., candle lighting, saying special prayers. Similarly, meditation and relaxation techniques may be helpful.

## Specific coping strategies

Slide 16

**Specific coping strategies**

- Identify the factors that predispose to emotions that might affect patient care
- Name and accept the emotion
- Respond constructively to the emotion
- Step back from the situation to gain perspective
- Consult a trusted professional colleague

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A variety of lifestyle management techniques may help clinicians maintain balance in their lives and decrease the risk of burnout (see **Table 2**).

**Table 2: Lifestyle management techniques**

Monitoring for and early recognition of symptoms
Maintenance of good nutrition
Spiritual life; meditation; spending time in nature
Effective grieving of losses
Decreased overtime work
Exercise: aerobics, yoga, tai chi
Energy work: Reiki, healing touch, therapeutic touch
Maintaining a sense of humor
Seeking consultation if symptoms are severe
Discussing work-related stresses with others who share the same problems; visiting counterparts in other institutions; looking for new solutions to problems

Changes in management strategies combined with educational interventions may further reduce burnout. Meier, Back and Morrison proposed an approach to physician awareness that involves identifying and working with emotions that may affect patient care. This involves looking at physician, situational, and patient risk factors that can lead to physician feelings and thus influence care.<sup>27</sup> This model can be applied to clinicians of many backgrounds. The steps include:

- identify the factors that predispose to emotions that might affect patient care;
- monitor for signs (behavioral) and symptoms (feelings) of emotions;
- name and accept the emotion;

- identify possible sources of the emotion;
- respond constructively to the emotion;
- step back from the situation to gain perspective;
- identify behaviors resulting from the feeling;
- consider implications and consequences of behaviors;
- think through alternative outcomes for Veterans according to different behaviors;  
and
- consult a trusted professional colleague.

More research needs to be done on organizational changes to decrease burnout. Hierarchical organizations with an overemphasis on standardization and efficiencies, combined with increasing expectations of perfection may promote burnout and reduce the quality of professional practice.<sup>28</sup> The underlying theme in burnout and work engagement is that group and management processes have to promote more open ways in which employees are better able to deploy their gifts in meaningful ways and to grow as human beings. It may be essential to measure moral climate, assess the culture of each workplace, and evaluate spiritual concerns of staff. The latter might include clarification and strengthening of meaning and purpose conducive to both personal vitality and agility of the organization.

Slide 17

**Self-care needs**

In your small groups write out:

- 2-3 actions that might to help you and your colleagues deal with burnout
- 1-2 actions that you might personally consider to help you deal with stress

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Interventions that combine changes in managerial practice with educational interventions, based on the six areas of work life, may decrease burnout.<sup>6</sup> People may be able to tolerate greater workload if they value the work and feel they are doing something important, or if they feel well-rewarded for their efforts. For example, a study by Fallowfield et al. showed improvement in the communication skills of oncologists that the authors hypothesized leads to personally and professionally more rewarding consultations, which can have a significant impact on clinical care and Veterans’ and clinicians’ well-being.<sup>29</sup> Other interactions for physicians, nurses, and others have included staff bereavement groups, self-reflection activities, and retreats.<sup>30,31</sup>

More recently, investigators from the University of Rochester reported on a study of the association of a program in mindfulness and decreased burnout among primary care physicians.<sup>32</sup> They used an intensive intervention in mindfulness meditation, self-awareness exercises and narrator exchanges and showed improvements in burnout and mood among their participants. Although this was done with primary care physicians, there may be a similar effect with palliative care physicians.

## Summary

Slide 18



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Many clinicians can find palliative care to be professionally rewarding, but working with Veterans and families facing serious illness is emotionally charged. The loss we face when our patients die can be cumulative. If we cannot find healthy outlets for our emotions, we may become less emotionally available to our families and friends, and less likely to take care of ourselves<sup>33</sup>. Self-care is critically important if our work-life balance is to be maintained. Burnout is prevalent among many clinicians. To prevent—or address—burnout, monitor yourself for the signs and symptoms of burnout. Management techniques can help to maintain balance in life and decrease the risk of burnout.

## Key take-home points

1. Self-care is a core competency of end-of-life care.
2. Commitment to work, a sense of control, and a sense of challenge are marks of successful self-care.
3. Recognize stressors in the social, institutional, Veteran/family, and personal domains.
4. Key dimensions of burnout are exhaustion, cynicism, and a sense of personal ineffectiveness.
5. Burnout arises from chronic mismatches between people and their work settings.
6. Burnout, in contrast with depression, is specific to the work context.

7. Personal responses such as outside interests ( e.g. art) and recreation, talking with others, developing supportive friendships, and engaging in spiritual pursuits or exercise, are all proven strategies to maintain work-life balance..

## Resources

Baumrucker SJ. Palliative care, burnout, and the pursuit of happiness. *American Journal of Hospice & Palliative Care*. 2002;19(3):154-6.

Rabow MW, McPhee SJ. Doctoring to Heal: fostering well-being among clinicians through personal reflection. *Western Journal of Medicine* 2001;174(1):66-9.

Novack DH, Suchman AL, Clark W, Epstein RM, Najberg E, Kaplan C. Calibrating the physician. Personal awareness and effective patient care. *JAMA* 1997;78(6):502-9.

Bram PJ, Katz LF. A study of burnout in nurses working in hospice and hospital oncology settings. *Oncol Nurs Forum*.1989;16(4):555-60.

Eastburg MC, Williamson M, Gorsuch R, Ridley C, Social Support, Personality, and Burnout in Nurses, *Journal of Applied Social Psychology* 1994; 24:1233-1250.

Aiken, LA; Clarke, SP; Sloane, DM; Sochalski, J; Silber, JH, Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction. *JAMA*. 2002;288:1987-1993.

Leiter MP, Phyllis Harvie P and Cindy Frizzell C, The correspondence of patient satisfaction and nurse burnout. *Social Science & Medicine*. 1998;47:1611-1617.

## References

- <sup>1</sup> Kübler-Ross E, Wessler S, Avioli LV. On death and dying. *JAMA*. 1972; 221(2): 174-179.
- <sup>2</sup> Groves JE. Taking care of the hateful patient. *New Engl J Med*. 1978; 298: 883-887.
- <sup>3</sup> Haas LJ, Leiser JP, Magill MK, Sanyer ON. Management of the difficult patient. *J Amer Fam Phys*. 2005; 72(10): 2063-2068.
- <sup>4</sup> Levine C, Zuckerman C. The trouble with families: toward an ethic of accommodation. *Ann Intern Med*. 1999; 130: 148-152
- <sup>5</sup> Clark D. “Total pain” disciplinary power and the body in the work of Cicely Saunders, 1958-67. *Soc Sci Med* 1999; 49: 727-736
- <sup>6</sup> Maslach C, Schaufeli WB, Leiter MP. Job burnout. *Ann Rev Psychol*. 2001; 52: 397-422.
- <sup>7</sup> Freudenberg HJ. Staff burnout. *J Soc Issues*. 1974; 30: 159-165.

- <sup>8</sup> Pines AM. Burnout: an existential perspective. In: Schaufeli W, Maslach C, Marek T, eds. *Professional Burnout: Recent Developments in Theory and Research*. Washington, DC: Taylor and Francis; 1993.
- <sup>9</sup> Barni S, Mondin R, Nazzani R, Archili C. Oncostress: evaluation of burnout in Lombardy. *Tumori*. 1996; 82(1): 85-92.
- <sup>10</sup> Brenninkmeyer V, Van Yperen NW, Buunk BP. Burnout and depression are not identical twins: is decline of superiority a distinguishing feature? *Pers Individ Differ* 2001; 30: 873-880.
- <sup>11</sup> Whippen DA, Canellos GP. Burnout syndrome in the practice of oncology. *J Clin Oncol*. 1991; 9: 1916-1921.
- <sup>12</sup> Maslach C, Jackson SE, Leiter MP. *The Maslach Burnout Inventory [Manual]*, 3<sup>rd</sup> ed. Palo Alto, CA: Consulting Psychologists Press; 1996.
- <sup>13</sup> Payne N. Occupational stressors and coping as determinants of burnout in female hospice nurses. *J Adv Nurs*. 2001; 33(3): 396-405.
- <sup>14</sup> Ramirez AJ, Graham J, Richards MA, et al. Mental health of hospital consultants: the effect of stress and satisfaction at work. *Lancet*. 1996; 347: 724-728.
- <sup>15</sup> Shanafelt TD, Bradley KA, Wipf JE, Back AL. Burnout and self-reported patient care in an internal medicine residency program. *Ann Intern Med*. 2002; 136(5): 358-367.
- <sup>16</sup> McMurray JE, Linzer M, Konrad TR, et al. The work lives of women physicians: results from the physician work life study. The SGIM Career Satisfaction Study Group. *J Gen Intern Med*. 2000; 15: 372-380.
- <sup>17</sup> Olkinuora M, Asp S, Juntunen J, Kauttu K, Strid L, Aarimaa M. Stress symptoms, burnout and suicidal thoughts in Finnish physicians. *Soc Psychiatry Psychiatr Epidemiol*. 1990; 25(2): 81-86.
- <sup>18</sup> Kash KM, Holland JC. Special problems of physicians and house staff in oncology. In: Holland JC, Rowland JH, eds. *Handbook of Psychooncology*. New York, NY: Oxford University Press; 1989; 647-657.
- <sup>19</sup> Vachon MLS. *Occupational Stress in the Care of the Critically Ill, Dying and Bereaved*. Washington, DC: Hemisphere Pub. Corp; 1987.
- <sup>20</sup> Jenkins SR, Maslach C. Psychological health and involvement in interpersonally demanding occupations: A longitudinal perspective. *J Organiza Behav*. 1994; 15: 101-127.
- <sup>21</sup> Kobasa SC. Stressful life events, personality and health: an inquiry into hardiness. *J Pers Soc Psychol*. 1979; 37(1): 1-11.

- <sup>22</sup> Kobasa SC, Maddi SR, Kahn S. Hardiness and health: a prospective inquiry. *J Pers Soc Psychol.* 1981; 42: 168-177.
- <sup>23</sup> Vachon, M. Burnout and symptoms of stress in staff working in palliative care. In: Chochinov HM, Breitbart W Eds., *Handbook of psychiatry in palliative medicine.* London: Oxford University Press. 2009; 303-319.
- <sup>24</sup> The Schwartz Center for Compassionate Healthcare:  
<http://www.theschwartzcenter.org>. Accessed January 24, 2011.
- <sup>25</sup> Irvine P. The Attending at the Funeral. *New Engl J Med.* 1985; 312: 1704-5
- <sup>26</sup> Curlin FA, Chin MH, Sellergren SA, Roach CJ, Lantos JD. The association of physicians' religious characteristics with their attitudes and self-reported behaviors regarding religion and spirituality in the clinical encounter. *Med Care.* 2006; 44(5): 446-53.
- <sup>27</sup> Meier DE, Back AL, Morrison RS. The inner life of physicians and the care of the seriously ill. *JAMA.* 2001; 286(23): 3007-3014.
- <sup>28</sup> Jones G, Sagar S, Wong R. The effects of stress on oncology staff. *CMAJ.* 2000; 163(7): 807.
- <sup>29</sup> Fallowfield L, Jenkins V, Farewell V, et al. Efficacy of a Cancer Research UK communication skills training model for oncologists: A randomized controlled trial. *Lancet.* 2002; 359(9307): 650-656.
- <sup>30</sup> Kearney MK, Weininger RB, Vachon ML, Harrison RL, Mount BM. Self-care of physicians caring for patients at the end of life: "Being connected... a key to my survival" *JAMA.* 2009; 301(11): 1155-64.
- <sup>31</sup> Medland J, Howard-Ruben J, Whitaker E. Fostering psychosocial wellness in oncology nurses: addressing burnout and social support in the workplace. *Oncol Nurs Forum.* 2004; 31(1): 47-54.
- <sup>32</sup> Krasner MS, Epstein RM, Beckman H, Suchman AL, Chapman B, Mooney CJ, Quill TE. Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. *JAMA.* 2009; 302(12): 1284-93.
- <sup>33</sup> Work-Life Balancing: Challenges and Strategies. Chittenden EH and Ritchie CS. *Journal of Palliative Medicine* 2011;14:870-874.