

# The prevalence of burnout in health professionals working in palliative care: a systematic review protocol

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**Review question/objective** The objective of this review is to examine the evidence on the prevalence of burnout among health professionals working in palliative care.

More specifically, the review focuses on the following questions: What is the prevalence of burnout among health professionals working in palliative care? Is there a difference in the prevalence of burnout in different subgroups of health professionals working in palliative care (such as, but not limited to, nurses, physicians, social workers, psychologists)? Is there a difference in the prevalence of burnout among health professionals working in different contexts of palliative care (palliative care units, home care, hospices)?

**Keywords** burnout; end of life care; hospice; palliative care

## Background

As a consequence of medical advances, life expectancy is increasing; therefore, the number of people with incurable advanced disease is also increasing. This reality contributes to an increasing need of palliative care.<sup>1</sup>

According to the World Health Organization, palliative care is “an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual”.<sup>2(p.84)</sup>

The increased need for palliative care leads to, more than ever, health professionals providing this type of care, which further leads to multiple, stressful and demanding challenges: caring with scientific technical knowledge, caring with relational and human competencies, making important ethical decisions and constant contact with suffering, end of life and death of people for whom they care.<sup>3,4</sup> These challenges, according to several authors, can cause

physical, psychological and emotional distress as well as work-related stress, which if not treated in time put the health professionals members of the palliative care team (physicians, nurses, physiotherapists, psychologists, social workers, occupational therapists) working in different contexts of palliative care (palliative care units, home care, hospices) at risk of burnout.<sup>5-7</sup> The burnout concept was first mentioned in the 1970s by Herbert Freudenberg,<sup>8</sup> as a series of unspecified physical and psychosocial symptoms produced by an excessive energy requirement in the work, emerging usually in professions involving helping relationships.

Maslach and Leiter<sup>9</sup> expanded the concept of burnout. They redefined it as a crisis in relations with work and not necessarily a crisis with work people. According to these authors, burnout is defined as a syndrome of three dimensions: emotional exhaustion, depersonalization and a lack of personal accomplishment at the workplace that arise when functional coping strategies fail.<sup>9,10</sup>

Emotional exhaustion is produced when health professionals reach the limits of their capacity and cannot respond at an emotional level, which leads to emotional detachment from their work. Depersonalization refers to impersonal and distant contact whereby health professionals start to develop distant approaches with patients and colleagues, besides

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There is no conflict of interest in this project.

DOI: 10.11124/JBISIR-2016-2633

developing negative feelings and cynical attitudes. This reflects a lack of personal accomplishment, feelings of competence and professional success, manifested by a lack of motivation and decreased productivity at work, in other words, one's own accomplishments and achievements.<sup>5,10</sup>

Global crises have forced many health systems to undergo structural reform, which lead to a faster pace of work and greater demands. Ultimately it led to the increasingly high prevalence of burnout among health care professionals.<sup>9</sup> Freudenberger<sup>8</sup> identifies those predisposed to developing burnout as being overly dedicated professionals, perfectionists and compulsive, whose work is a substitute for their social life. According to Sá,<sup>11</sup> causes of burnout include personal factors such as the characteristics of employees and professional factors such as the working environment and organizational dynamics.

Maslach and Goldberg<sup>12</sup> report that burnout is a consequence of continued exposure to stressful events related to work. Maslach and Leiter<sup>9</sup> argue that burnout is not exactly a problem intrinsic to the person, but fundamentally results from the features of the organizational environment in which the person performs his professional functions.

When the workplace is viewed as hostile and excessively demanding, both economically and psychologically, emotional, mental and spiritual exhaustion develops because of decreased levels of energy and enthusiasm. Thus, dedication and commitment to work are significantly reduced, health professionals become cynical and distant, and they disengage from their work.<sup>5,10</sup>

According to Pavelková and Bužgová,<sup>7</sup> working with dying patients is considered to pose an even high risk of burnout, and the difficult situations faced by hospice nurses has drawn attention to the concept of burnout for the first time. In palliative care, high demands are placed on the health professionals, because “they encounter suffering and the transience of life, seemingly futile battle, helplessness and grief”.<sup>7(p.218)</sup>

In this context, some studies have been conducted to identify the impact of burnout on health professionals working in palliative care. The studies showed that the level of burnout among professionals working in palliative care was lower than that of professionals working in other contexts.<sup>13–15</sup> These studies, however, have not been systematically assessed.

An initial search of the Joanna Briggs Institute Database of Systematic Reviews and Implementation Reports, the Cochrane Library, PROSPERO, PubMed and CINAHL found no existing systematic review on the epidemiology of burnout among health professionals working in palliative care.

There has been a previous review that examined burnout among health professionals working in palliative care but was primarily limited to nurses and doctors, focused on an ethical perspective, in a limited period of time, and did not assess the methodological quality of included studies; the focus was only on mapping the research activity around the subject.<sup>16</sup>

This systematic review will synthesize the best available literature, between 1974 and 2015, across a wider range of professionals.

This review is guided by the methodology proposed by Joanna Briggs Institute for the conduct of the systematic review of prevalence and incidence data<sup>17</sup> and examines the available evidence on the prevalence of burnout among health professionals working in palliative care.

A precise estimate of prevalence for burnout among health professionals working in palliative care has immediate implications, in that vulnerable groups could be identified and measures could be taken to reduce their risk of burnout. It also has research implications, whereby interventions could be tested in high prevalence subgroups. This is important because, where there is a happy worker there is a satisfied patient; therefore, high-quality care for patients is preceded by high-quality care for employees.<sup>7</sup>

## **Inclusion criteria**

### *Types of participants*

This review will consider studies, conducted worldwide, that include all health professionals with qualifications (physicians, registered nurses, physiotherapists, psychologists, social workers, occupational therapists), caring for patients 18 years of age or older, working in palliative care.

Studies that include participants working in other contexts, different to palliative care, will be excluded unless the data are separated and analyzed by palliative care versus others areas of care.

### *Phenomena of interest*

This review will consider studies reporting on the point prevalence of “burnout” measured by any

burnout scale, such as, but not limited to, Maslach Burnout Inventory, Burnout Measure and Copenhagen Burnout Inventory.

### Context

This review will consider studies conducted in the context of palliative care, more specifically, palliative care units, home care or hospices.

### Types of studies

This review will consider any observational study designs including prospective and retrospective cohort studies, case-control studies and cross-sectional studies for inclusion.

### Search strategy

The search strategy aims to find published and unpublished studies. A three-step search strategy will be used in this review. An initial limited search of MEDLINE and CINAHL will be undertaken, followed by the analysis of text words in the titles and abstracts, and of the index terms used to describe the article. A second search using all of the identified keywords and index terms will then be undertaken across all databases included. Third, the reference list of all identified reports and articles will be searched for additional studies. Studies published in English, Spanish and Portuguese will be considered for inclusion in this review. Studies published after 1974 will be considered for inclusion in this review. This year was chosen because publications related to burnout in health care began to appear in the literature after 1974.

The databases to be searched will include:

CINAHL Plus with Full Text; PubMed; Scopus; SciELO.

The search for unpublished studies will include:

DART-Europe; OpenGrey; RCAAP – Repositório Científico de Acesso Aberto de Portugal; ProQuest – Health & Medical Complete; Banco de teses da CAPES ([www.capes.gov.br](http://www.capes.gov.br)).

Initial English language keywords to be used will be:

Burnout; Palliative; Hospice; “Home Care”; “End of Life”; “Health professionals”.

### Assessment of methodological quality

Articles selected for retrieval will be assessed by two independent reviewers for methodological validity

before inclusion in the review using standardized critical appraisal instruments from the Joanna Briggs Institute – Critical Appraisal Checklist for Studies Reporting Prevalence Data (Appendix I). Any disagreements that will arise between the reviewers will be resolved through discussion, or with a third reviewer.

### Data extraction

Data will be extracted from articles included in the review independently by the two reviewers, using a data extraction form, taking into account the review questions (Appendix II). Any disagreements arise between the reviewers will be resolved through discussion, or with a third reviewer. The authors of the primary studies will be contacted to provide missing or additional data.

### Data synthesis

If appropriate, statistical meta-analysis using the Cochrane RevMan software will be used to combine quantitative data extracted from the included studies in statistical meta-analysis; all results will be subject to double data entry. Data will be pooled using either the random-effect or the fixed-effect model depending on the heterogeneity of the included studies. When pooling proportions for meta-analysis, a transformation of the data will be required. *Logit* transformation of the prevalences will be applied, because *logits* are more likely to have a normal distribution, which is essential for pooling data. Prevalence estimates will be transformed to logits to improve their statistical properties. The final pooled *logit* will be back transformed, resulting in pooled prevalence and 95% confidence intervals.<sup>17,18</sup>

Heterogeneity will be statistically assessed using the standard  $\chi^2$  test (subgroup analyses based on healthcare professional classes included in this review will be also explored) and a significance level of 0.05 will be adopted. However, when statistical pooling is not possible, because of substantial heterogeneity of the included studies data, we will present the forest plot resulting of the multiple studies; this is useful for displaying how prevalence estimates vary between studies. In addition, data will be presented in narrative form including tables and figures to aid in data presentation wherever appropriate.<sup>17,18</sup>

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Appendix I: Appraisal instruments

**JBI Critical Appraisal Checklist for Studies Reporting Prevalence Data**

Reviewer \_\_\_\_\_ Date \_\_\_\_\_

Author \_\_\_\_\_ Year \_\_\_\_\_ Record Number \_\_\_\_\_

	Yes	No	Unclear	Not applicable
1. Was the sample representative of the target population?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Were study participants recruited in an appropriate way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Was the sample size adequate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Were the study subjects and the setting described in detail?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Was the data analysis conducted with sufficient coverage of the identified sample?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Were objective, standard criteria used for the measurement of the condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Was the condition measured reliably?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Was there appropriate statistical analysis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Are all important confounding factors/ subgroups/ differences identified and accounted for?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Were subpopulations identified using objective criteria?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Overall appraisal:    Include     Exclude     Seek further info

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## Appendix II: Data extraction instruments

**Reviewer ID:** (ID given by the primary reviewer)  
**Revision date:** (Date of when the form is filled in)  
**Title:** (Title of the study)  
**Author(s):** (Names of all the authors of the study)  
**Journal:** (Journal in which the article has been published)  
**Year of publication:** (Year in which the article has been published)  
**Aims of the study:** (Objective of the study)

**Study design:** (prospective and retrospective cohort studies, case-control studies, cross-sectional studies, case series, case reports)  
**Measurement instrument:** (description of the measurement instrument, validity and reliability of the instrument, measurement bias, time point of data collection)  
**Setting:** (Palliative care units, hospices, home care)  
**Sample characteristic**  
**Sample size:** (number of patients)  
**Type of Participants:** (Nurses, social workers, physicians, physiologists, others)

**Results** (Point prevalence will be reported as percentage with a 95% CI. When the number of health professionals is reported, the percentage can be calculated using the equation: number of health professionals with the condition/sample size)

Prevalence n/N (%)

**Proportion of health professionals with burnout**

- Nurses \_\_\_\_\_
- Social workers \_\_\_\_\_
- Physicians \_\_\_\_\_
- Psychologists \_\_\_\_\_
- Others \_\_\_\_\_

**Proportion of health professionals with burnout in different contexts**

- Palliative care units
  - Nurses \_\_\_\_\_
  - Social workers \_\_\_\_\_
  - Physicians \_\_\_\_\_
  - Psychologists \_\_\_\_\_
  - Others \_\_\_\_\_
- Hospice
  - Nurses \_\_\_\_\_
  - Social workers \_\_\_\_\_
  - Physicians \_\_\_\_\_
  - Psychologists \_\_\_\_\_
  - Others \_\_\_\_\_
- Home care
  - Nurses \_\_\_\_\_
  - Social workers \_\_\_\_\_
  - Physicians \_\_\_\_\_
  - Psychologists \_\_\_\_\_
  - Others \_\_\_\_\_

Authors' comments

Reviewer comments