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Development and Implementation of a Resilience-Based Intervention to Support Palliative Care Clinicians

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Abstract

Palliative care (PC) clinicians are at risk of developing burnout. There is therefore a need to develop interventions based on well-designed participatory research to support the resilience of PC staff. This study aims to develop, implement and evaluate the integration of an intervention to support the resilience of a multidisciplinary PC team. A participatory research based on Medical Research Council (MRC) recommendations for developing complex interventions was conducted. A two-part intervention targeting both collective and individual resilience was developed, implemented and assessed. Part I (collective resilience) was based on an appreciative inquiry and Part II (Individual resilience) involved meaning and mindfulness. The participants were members of multidisciplinary and specialized PC team in the province of Quebec (Canada). The team was composed of physicians, nurses and other professionals. Questionnaires and qualitative interviews were administered. A qualitative thematic analysis was performed, which suggested that participants perceived positive impacts of the intervention on team cohesion, meaning at work, self-regulation, awareness to self-care, quality of presence and coping with stress. Improvements were also suggested. Based on its preliminary evaluation, the designed intervention may have potential to improve PC providers' resilience, but organizational components must be better integrated for future research and practice.

Keywords: Resilience; Mindfulness; Meaning; Palliative Care; Intervention

Introduction

Palliative care (PC) clinicians[i] ([i]Includes physicians, nurses and other professionals who provide end-of-life care) are confronted to the suffering of patients and their families on a daily basis [1,2]. PC clinicians also face frequent ethical, moral and interpersonal conflicts. The complexification and technologization of care and the constantly-escalating workload may also represent sources of stress for PC clinicians [3]. Considering the ageing population and the increasing chronicity of life-threatening illnesses such as cancer, the workload in PC is also at risk of intensification [4].

The heavy demands of working in PC are sources of stress on emotional, professional and organizational levels [5]. In fact, it is estimated that nearly 50% of PC clinicians may experience distress as a consequence of workplace adversity [6]. These professionals are at particular risk of developing burnout, [7] compassion fatigue [8] and secondary traumatic stress [9]. Moreover, recent data indicate that the burnout rates are rising in this population, affecting 61% of the members of the American Academy of Hospice and Palliative Medicine. This represents a historic high and one superior to the other medical specialties [10]. The deleterious effects of stress on PC staff's health and well-being are likely to negatively affect the quality of care offered by them [1]. The high prevalence of burnout may also lead to issues in retention and absenteeism [11] which, in turn, further pressure PC teams.

Over the past decade, initiatives promoting support of PC staff and their resilience to stress have multiplied. Resilience is most often conceptualized as the capacity to respond to stressors in a healthy way and cope effectively with adversity [12]. It may also be defined as the capacity to return to a zone of stability in the midst of challenging circumstances [13]. Building resilience in PC may imply both individual and organizational/systemic factors [1,14].

Interventions aimed at building resilience and preventing burnout among PC clinicians are still at an early phase of development [1]. These past few years, systematic literature reviews have been completed in the hope of determining the effectiveness of interventions aimed at promoting resilience among PC staff [15,16]. These interventions fall into five categories: support groups, stress management, education, meaning-centered interventions and mindfulness [2]. To this day, it is impossible to determine which of the aforementioned would most efficiently prevent burnout among PC clinicians and support their resilience to stress [15,16]. Most of the intervention programs include one or more of the listed strategies, but the integration of organizational and institutional components remains limited [2,14].

Recent systematic reviews on resilience to burnout suggest that in order to build and support PC staff's resilience to stress, interventions should: 1) include personal and organizational components [1,14]; 2) be developed in collaboration with active PC teams to root the interventions in their needs [15,16]; 3) stem from strong theoretical roots [15] and; 4) be implemented with well-designed research, following Medical Research Council (MRC) guidelines [15]. The present study directly results from these recommendations.

This study aims to develop, implement and evaluate the integration of an intervention to support the resilience of a multidisciplinary team in PC. To this end, we have based this participative study on the four-phase process recommended by the Medical Research Council (MRC) regarding the development, implementation and evaluation of complex interventions [17]. In this article, we will present Phases I and II, which respectively correspond to the development of the intervention, and its implementation. We will also provide an overview of the preliminary evaluation and recommend improvements on the intervention for its subsequent phasxes.

Methods

Participants

This study was a partnership with the multidisciplinary PC team of a university hospital in the province of Quebec (Canada).

The team was composed of PC-specialized physicians, nurses and professionals (psychologists, social worker, pharmacist, music therapist, spiritual care counselor). The research project[ii] ([ii]Sociodemographic details are omitted to preserve participants' anonymity) obtained two different ethics certifications from the participating institution; one for Phase I and one for Phase II.

Procedure

The study unfolded over two phases, each composed of distinct steps, as recommended by the MRC-UK, [17] described in table 1. Each of the steps was carried out with the help of an implementation committee, made up of two researchers and five members of the medical team (clinicians and managers). The committee met twenty times over the course of the study, which lasted two years.

Data collection

The MRC-UK recommends the collection of descriptive and qualitative data for Phases I and II[iii]. ([iii]Phases III & IV correspond to randomized-controlled studies). For Phase I, to determine the needs of the team, qualitative interviews were conducted with 21 members of the multidisciplinary team. The interviews ranged from 37 minutes to 80 minutes and were conducted by a trained PhD candidate in psychology. The interviews aimed at describing the support needed by the team, as well as sources of stress and support in the workplace. The interviews were recorded, transcribed verbatim and analyzed thematically [18]. For more details about the thematic analysis, the reader can refer to Braun, & Clarke (2006) [17]. The main findings of the needs study guided the development of the complex intervention and is briefly presented in the results section.

At Phase II, descriptive and qualitative data were collected in order to preliminarily evaluate the perceived effects of the intervention. Questionnaires were administered to 42 participants following the intervention, starting with seven questions (Figure 1), answerable with the help of a 5-point Likert scale ranging from "strongly agree" to "strongly disagree", followed by five open-ended questions, aimed at collecting the participants' impressions and suggestions for improvement. Qualitative interviews were then conducted with 10 of these participants and were also recorded, transcribed verbatim and analyzed thematically [18].

Results

Phase I: Elaborating the Intervention

Per the recommendations of MRC-UK, phase I of the development process for the complex intervention included: 1) the review of existing relevant intervention programs, 2) identification of the team's needs and 3) the development of the intervention.

Table 1: Steps and Objectives of Phase I & II (Adapted from MRC-UK).

Phases	Objectives
Phase I- Development	• Review & describe existing intervention programs • Determine the needs of the PC team • Elaborate an intervention program based on the integration of the first two objectives
Phase II- Implementation & Evaluation	• Prepare for the intervention implementation • Implement and evaluate the effects of the support intervention on and with the PC team • Share the results and the team's feedback with all acting groups and collect their comments • Interpret all collected results and formulate recommendations

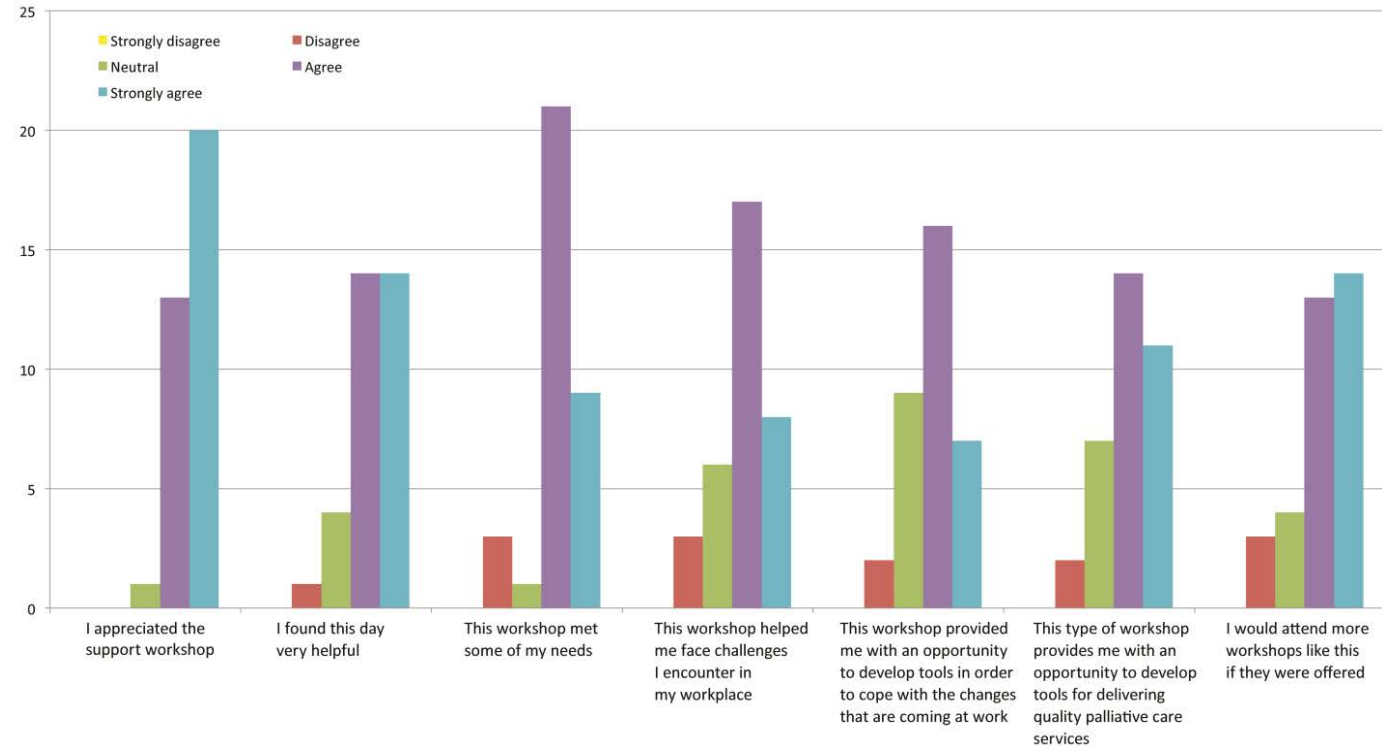

Figure 1: Appreciation of the collective resilience intervention.

Review of Existing Programs

A literature review was conducted to identify different interventions for PC staff. Findings were grouped into five main categories: support groups, educative interventions, cognitive and behavioral strategies targeting stress management, meaning-based interventions and mindfulness interventions. Organizational and individual factors promoting staff resilience were also reviewed.

These findings were presented to the implementation committee, and four specific approaches were discussed at more length, namely 1) meaning-centered interventions based on Victor Frankl's logotherapy [19-21]; 2) models and interventions based on resilience [1,12,13]; 3) interventions based on mindfulness [22-24] and 4) the contemplative approach to end-of-life care (Being with Dying) [25]. The specificities, strengths and weaknesses of these approaches are presented in table 2, as discussed with the implementation committee, to create a unique program inspired by these four initiatives.

Needs Study

The analysis of the 21 qualitative interviews lead to the conclusion that a program supporting resilience was greatly needed. Analyses revealed intense emotional suffering of the PC team members (confrontation to death, multiple losses/bereavements), as well as multiple adversity factors deepening distress, such as: the lack of human and material resources, the increasing technologization of care and the tendency to prioritize efficiency, both at the expense of a genuine human connection with patients. Feelings of helplessness, due to a high number of organizational changes over a short period of time, and the impossibility to deliver high-quality work due to these constraints were also mentioned. Powerlessness and suffering were intensified by the frustration of not being able to change the situation, and of not being heard or considered by management. As two team members mentioned:

And you know that type of pressure, changes, lack of resources, lack of staff… My biggest suffering is to think that this type of thing will burn this incredible team. I am so afraid that such a pressure will destroy that team… [P6].

So, the fact that you have to go through that… that emotional suffering and deal with the fact that everyone is dying around you... And then, on top of that, to have this… to feel not… unsupported and have, you know, these other emotions like these frustrations about the system and not being heard and the combination can be a bit overwhelming. [P4]

Conversely, the sense of belonging to the team and the impression of making a difference for patients were found to be sources of profound satisfaction for the participants. A synthesis of the main findings of the needs study is provided in table 3. The results of the needs study were discussed with the implementation committee and integrated with the literature review's findings.

Developing the Intervention

Pooling the literature review and the needs study allowed us to identify the targets of the support program. In order to recognize the contribution of the team, break the feeling of isolation and address the organizational and institutional stress implied, the first component of the program (Part 1: Collective Resilience) aimed to support the team's collective resilience. The second component (Part 2: Individual Resilience, based on Meaning and Mindfulness) aimed at improving/supporting individual resilience, addressing the personal emotional suffering and encouraging self-care. The main characteristics of these components are presented in table 4[iv]. ([iv]A more detailed presentation is available in appendix A and B).

Phase II: Implementation/Evaluation

The preliminary evaluation of the support program corresponds to phase II of the process, as recommended by the MRC-UK. A summary of the themes emerging from the analyses of parts I & II are presented in table 5.

Part I: Collective Resilience

All members of the multidisciplinary team were invited to complete a questionnaire after their participation in Part I, the descriptive results of which are presented in figure 1. The qualitative analysis of the open-ended questions allowed to specify some positive effects of the activity and the necessity for improvement. Most participants (30/42) highlighted the positive effects of the activity on team cohesion. The collective reflection consolidated the team and procured the necessary feelings of unity and connectedness needed to support resilience. Many participants

Table 2: Summary of strengths and limitations of the programs reviewed.

	Meaning-Based Interventions	Resilience Interventions	Mindfulness Interventions	Being with Dying
Authors/ Studies	Fillion et al.	Back et al.	Dobkin; Kabat-Zinn	Halifax & Rushton
Strengths	Designed for clinicians Easy to implement	Include both individual and organizational factors	Provide the clinicians with tools	-Designed for all palliative care clinicians -Provide clinicians with tools
Limitations	-Do not include org. aspects -Does not provide tools	Essentially based on physicians studies (not all clinicians)	-Not feasible -Do not include organizational aspects	Content not available/ exportable to the workplace
Conclusion	Keep the format and content + complement	Keep the organizational factor and adapt for all clinicians	Include mindfulness + complement	Support the importance of mindfulness

Table 3: Emerging Themes: main findings of the needs study.

Major Themes	Sources of Suffering	Factors Accentuating Suffering	Factors Protecting from Suffering
Sub themes	-Interpersonal factors -Interprofessional factors -Organizational factors -Institutional factors	-Not being considered/heard -Feeling powerless in the situation	-Feeling supported by the team -Making the difference for patients -When patients show recognition
Implication for the intervention	Must include organizational and personal components	-Must include personal tools to deal with powerlessness -Must include the possibility to be heard and considered (group intervention)	-Must include an opportunity to connect with the team -Must put emphasis on sources of meaning to work (making the difference for patients)

Table 4: Characteristics of the two-part resilience intervention.

	Part I: Collective Resilience	Part II: Individual Resilience
Target	-Team cohesion -Reinforce team strengths to reconnect with collective meaning at work and face adversity -Institutional and organizational stress	-Individual stress management -Self-care -Meaning-making at work
Theoretical Roots	-Based on appreciative inquiry -Educational component on resilience to stress	Based on meaning-making and mindfulness
Format	-2 one-day workshops -Continuing education (staff paid to assist)	-4 two-hour sessions -Voluntary basis (outside of work schedule)
Participants	-50 staff members (nurses, md, professionals, managers)	10 participants (nurses and professionals)
Assessment	-Questionnaires	Assessed with pre- and post-intervention qualitative interviews

Table 5: Emerging Themes: perceived impacts of the intervention.

	Perceived Positive Impacts	Obstacles & Suggestions
Collective Resilience	-Team cohesion, belonging & healing connectedness -Collective meaning at work and discover shared meaning	-Activity was not sufficient -Necessity to ensure a structure allowing for regular team healing and building resilience
Individual Resilience	-Emotions recognition and self-regulation -Awareness to self-care -Quality of presence -Coping with stress -Meaning-making	-Incompatibility with the workplace -Necessity for a collective practice

(28/42) also mentioned having reconnected with gratifying and nourishing aspects of their jobs, after realizing that they were shared by most team members. Many (22/42) also pointed to a necessity for this type of activity to take place on a regular basis.

Part II: Individual Resilience

Members of the staff were interviewed individually two weeks after participating in Part II (Individual Resilience based on Meaning and Mindfulness). The ensuing thematic analysis pointed to positive effects on 1) emotion recognition and self-regulation, 2) awareness to self-care, 3) quality of presence, 4) coping with stress and 5) finding meaning at work. Needs for improvements were also reported.

Perceived positive impacts: Participants who completed the intervention reported feeling more conscious of the quality of their presence when caring for patients and more conscious of the way they felt on a daily basis. The mindfulness exercises seemed to allow for improved self-knowledge and recognition of one's emotions. Moreover, they also seemed to realize the importance of self-awareness and the necessity for self-care.

I think it's about breathing, slowing down, you know, being more conscious, being conscious that like, OK, it's harder right now. Realize that. Stop for a little while [P2].

I realized… I used to think of being present for others. Now, it's important to be present for myself and take care of myself too. It's okay to stop, breathe and take care of myself [P4].

The professional challenges and the sources of stress to which nurses are confronted on a daily basis are immense. Some participants seemed more equipped to cope with their stress after participating in the group intervention:

You know, at the beginning it was full of stress and there were a lot of situations and it's like the situations haven't changed, but it's me, I see them differently. So it's like mindfulness kind of changed what I see in my work, maybe for the best, maybe by distancing me, maybe because I see myself being at a distance or little modified [P3].

Improved awareness following the intervention may allow participants to get a better sense of the meaning of their work and the importance of their role.

[…] when I take care of someone and I know I'm fully present, uhm, I think the interaction is generally of higher quality. So, I'm able to better listen. I'm able to, uhm, probably react better. You know, and there isn't always something to say, but, uhm, you know, the quality of the interaction is just better. I think the person feels it and then when I leave the situation, I think I feel more, what's the word? Rewarded, I guess [P9].

Needs for improvement: The intervention was also subject to criticism. Participants mentioned the incompatibility of the mindfulness tools at their workplace and the necessity for this practice to become collective, and not only individual, for it to be truly supporting.

And trying to do them three times a day, the different exercises of either respiration or "body scan", uhm, I was able to do it a little bit, either on my way to work or when I was home at night but there is, uhm, at work uhm, no! It was too, uhm, too busy and it slipped my mind. I was on automatic pilot […]. [P1]

For some participants, taking time for the mindfulness exercises would simply be incompatible with their professional reality. It seemed impossible, on a daily basis, to take the necessary time to accomplish short meditations, for example. Others pointed to a necessity for follow-ups beyond the duration of the intervention to support them in their practice. Some nurses also mentioned the necessity for this practice to be learned and integrated by the whole team, rendering it a collective, rather than individual, intervention[v]. ([v]Part II was optional. Ten clinicians (20%) participated in it).

I know it wouldn't be possible, but if there were like little groups for another like, maybe once a month, once every two months, just to see how everyone is dealing with it, like, what they learned. Refresh the memory a bit. It would have been helpful, but I don't think it's possible [P3].

I would just like for the whole team to get the training. And also, if we could integrate it in our work, it would be perfect. Because it helps us a lot to remind to take care of ourselves [P7].

Discussion

Compassion fatigue and burnout are increasingly prevalent in PC clinicians. These past few years, different interventions have been developed to support PC clinicians' resilience to stress and burnout [27,28]. Such interventions often lack 1) an organizational component [14] and 2) a rigorous process of development based on strong theoretical roots and on teams' specific needs [15]. The goal of this article was to describe the participative process of development and implementation of a complex intervention to support the resilience of a PC team. The intervention developed is comprised of two parts (collective & individual resilience). It is based on the study of the specific needs of this team, as well as on the most recent studies on the support of PC clinicians.

We followed the MRC-UK guidelines to develop and implement the intervention. Preliminary assessment was conducted with qualitative interviews and questionnaires. The preliminary qualitative evaluation brought to light promising aspects for each of the components of the intervention and pointed to necessary improvements. Based on these results and after having discussed them with the implementation committee, we draw a few conclusions and emit recommendations for future interventions.

Few studies combine individual and collective strategies to support PC clinicians' resilience. Our study suggests that the two-part structure was relevant and adapted to the needs of the team. However, an upholding structure should be implemented, in order to foster long-term changes in collective and individual resilience and increased organizational support would have to be mobilized to ensure the full deployment and endurance of the two components (Collective & Individual resilience). Proper resources and logistics, such as the schedules and cost of interventions, would have to be planned and integrated. Moreover, in future interventions, daily support for the integration of the mindfulness exercises, as well as the creation of a collective practice, would have to be integrated. Despite the fact that organizations have an ethical responsibility to support and protect them, organizational support is often hard to mobilize for these highly trained and talented clinicians [14].

The goal of this study was not to determine the efficacy of this intervention, as it is impossible to draw such a conclusion at this stage of our process. However, the qualitative evaluation conveyed important themes associated in the literature with clinicians' resilience, such as awareness, self-care, better coping with stress [26] and connectedness to colleagues [13]. Therefore, this intervention may improve PC providers' resilience and reduce the frequency or intensity of burnout among them. In the future, the intervention should be closely revised, organizational support would have to be better mobilized and qualitative and quantitative studies pre- and post-intervention would have to be conducted, in order to better evaluate the intervention.

Conclusion

Although the intervention developed is a promising avenue for the support of PC clinicians, this study has a few limitations. At the time of the intervention, the participating PC team was subject to important organizational changes and a dearth of human and material resources. These conditions could have increased the team's stress and may have had a negative impact on the their participation and dedication to the intervention. Nevertheless, the strength of this study resides, among other elements, in its participative and systematic nature. The developed intervention allowed targeting of many of the specific needs of the participating team. The systematic process of development also lead to rigorous content and pertinence for the intervention.

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Author Disclosure Statement

The authors declare no conflict of interest.

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Appendix A

Main Content of the Collective Resilience Intervention

	Content	Format
Introduction	-Goals for the day -Review of the needs study	Presentation
Activity I Meaning of care	What do you want most for patients and family members?	-Written exercise -Group discussion
Activity II Recognize strength and good care	Making a difference for patients/families through care	-Dyad discussion -Group discussion
Activity III Develop interiority and self-care	-Breathing and stretching -Quiet safe place	-Meditation -Education:"the safe place"
Activity IV Clarify team values and mission	As a team, what should we nourish,and cultivate for the future?	Brainstorming
Activity V Learning about stress and resilience	-Introduction to the resilience model. -Education on stress & resilience	Presentation
Conclusion	-Conclusion -Introduction to Part II (Individual Resilience)	Presentation

Appendix B

Main Content of the Mindfulness & Meaning Centered Intervention

Session Topic	Content/Activities
I Finding meaning & Disabling the automatic pilot	-Introduction to the program, participants, rules & facilitators -Mindful eating -Reflecting on "automatic pilot" -Exploring meaning-making and how to achieve it -The "Existential Vacuum" and characteristics of meaning -Body scan -Conclusion
II Engagement/responsibility & Dealing with barriers	-Mindful sitting & awareness of breathing -Attitude toward practice (discussion) -Dealing with barriers -Sharing about pleasant moments (activity) -Existential responsibility (mini-lecture + activity) -Breathing space (activity)
III New attitudes toward suffering & Attachment and aversion	-Mindful sitting & breathing awareness -Poem: *Wild Geese* -Sharing about unpleasant experience at work -Exploring a difficult situation in PC (activity + discussion) -Staying present with suffering/opportunity (lecture) -Mindful sitting and awareness of sounds and thoughts -Step to action: mindful yoga (activity) -The finitude of life (mini-lecture + activity) -Conclusion and home exercises
IV Experiential values & Developing/maintaining practice	-Mindful sitting & awareness of breathing and thoughts -Poem: *The Summer Day* -Love, nature and art (experiential exercise) -Reflections to actions : pleasure mastery and self-care -Integration of the three ways to discover meaning (activity) -Formal/informal practice & action plan (group discussion)