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**Brief Report**

**Tackling the Pandemic a Year Later: Burnout Among Home Palliative Care Clinicians**

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**Abstract**

**Context.** The COVID-19 pandemic strongly challenged healthcare workers, disrupting their work routine and impacting on their professional life. A previous investigation explored levels of burnout and psychological morbidity among palliative care professionals (PCPs) during COVID-19 first wave.

**Objective.** To update data about burnout and psychological morbidity among PCPs after a year of COVID-19 pandemic.

**Methods.** The same questionnaires on burnout (Maslach Burnout Inventory, MBI) and psychological morbidity (General Health Questionnaire 12 items, GHQ-12) were administered a year after. Differences in MBI and GHQ-12 scores obtained in the two studies (COVID2020 and COVID2021), as well as distributions of PCPs showing burnout symptoms and psychological morbidity were analyzed and compared. We also explored the association between the three dimensions of burnout and socio-demographic and professional characteristics.

**Results.** The sample consisted of 145 PCPs (59% physicians and 41% nurses). Response rate (70.4%) was quite similar to the previous study (73.2%). No differences were observed in the frequency of burnout between COVID2021 and COVID2020; the PCPs in COVID2021 reported marginally higher level of EE ($P = .049$) and this result is confirmed in physicians ($P = .010$) while no difference was observed in nurses ($P = .326$). In addition, the percentage of cases showing psychological morbidity significantly decreased.

**Conclusion.** Our findings show stable levels of burnout and decreasing levels of psychological morbidity among PCPs one year after the onset of the COVID-19 pandemic. However, more research is needed to detail the significance of emotional exhaustion dimension, a variable influenced by the survey. J Pain Symptom Manage 2022;63:e349–e356. © 2021 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.

**Key Words**

Cancer, COVID-19, palliative care, pandemics, burnout, psychological distress

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**Introduction**

In Italy, Coronavirus 2 (SARS-CoV-2) has affected about 4.3 million and caused more than 130,000 deaths since the emergency started.

The pandemic has followed a fluctuating trend composed of successive peaks and valleys resulting in containment measures. Vaccination and the reshaping of many daily habits have allowed a progressive resumption of private and working life activities; however, the worldwide persistence of the Coronavirus 2 continue to engage and worry citizens and authorities.

The outbreak and evolution of the pandemic have strongly challenged the healthcare system and have put a strain on healthcare professionals, especially during the peaks. Hospice and palliative care teams found themselves dealing with demanding and stressful challenges imposed by
the spread of the contagion, lockdown and emergency restrictions.

Patient care during a pandemic is at risk due to extreme pressure on health services.\(^5\) Home and community palliative care have an important role both in reducing symptoms and caregiver burden for patients with life-threatening diseases and in preventing hospital admissions for patients near the end of life.\(^9\)

Italy was the first western country to be alarmingly affected by COVID-19 and impact of contagion was crushing for the National Health System. In Italy, COVID-19 emergency exerted an unprecedented pressure on palliative care services during the first wave of pandemic in 2020 forcing the palliative care teams to re-organize procedures and guidance according to the changing needs.\(^7\) Home palliative care for patients with advanced cancer have been even more essential to reducing admissions to hospitals in light of reduced availability of health-care facilities; in addition to the use of personal protective equipment, also telephone consultation and triage were adopted in order to avoid unnecessary contacts.\(^8\)

Although health services have partially stabilized, one year after the beginning of the pandemic PCPs have still to deal with many uncertainties about the general health situation and work organization challenging their ability to adapt and overcome a prolonged stress condition.\(^9\)

In our previous study, conducted during COVID-19 first wave, we observed that changes imposed by pandemic did not negatively affect workers’ levels of burnout but seemed to cause a worsening in their psychological distress.\(^10\) The aim of the present brief report is to update our findings by analyzing levels of burnout and psychological morbidity after one year of pandemic, in order to characterize the evolution of these dimensions and the adjustment of PCPs working in the pandemic era.

**Methods**

**Study Design and Sample**

The participants were PCPs (physicians and nurses) working for the National Tumor Assistance (ANT) in 11 Italian regions. The results obtained by the investigation conducted on the PCPs after one year from the beginning of the COVID-19 emergency (COVID2021) have been compared with data collected on the PCPs during the first wave of COVID-19 pandemic (COVID2020).\(^10\) The questionnaires and the setting were the same for both the studies. Based on the changes in the composition of the ANT staff during the last year, we can assume that the PCPs participating in COVID2020 and COVID2021 survey were mostly the same (90%). No specific exclusion criteria were set, with the exception of the PCPs who declined participation.

The workload remained substantially stable for the PCPs participating in COVID2020 and COVID2021 survey: the number and the functional status of patients entering in assistance as well as the total number of home visits/phone calls were quite similar between the first semester of 2020 and 2021 (3144 vs. 3171 patients entering in assistance with a mean Karnofsky Performance Status of 45.7 ± 15.6 vs. 45.5 ± 16.5 in the first semester of 2020 and 2021, respectively; total number of home visits/phone calls: 154,733 vs. 155,361 in the first semester 2020 and 2021, respectively). Participants provided the informed consent for participation to the investigation, data analysis, and publication.

The COVID2021 survey was conducted after one year from the beginning of the COVID-19 outbreak in Italy and data were collected from May 3rd to June 1st 2021. All the PCPs (n = 206) working in ANT were invited to participate by an e-mail explaining the aim and the method of the research and reporting the link to the questionnaires. The data were anonymously collected on a web-based platform (www.survio.com) and the answers were analyzed using the Survio analyzing tool. The investigation was approved by the Ethical Committee of the Central Area of Emilia Romagna (619-2020-OSS-AUSLBO).

The details about COVID2020 have been previously described.\(^10\)

**Measures**

**Socio-demographic and professional data.** Gender, age, marital status, offspring, profession, years of experience in palliative care and geographical area of work were recorded.

**Maslach Burnout Inventory.**\(^11\) Burnout was measured by the Italian version of the Maslach Burnout Inventory (MBI). The questionnaire consists of 22 items investigating different aspects of burnout syndrome ascribable to 3 specific dimensions: emotional exhaustion (EE, 9 items), depersonalization (DP, 5 items) and personal accomplishment (PA, 8 items). The methods for the analysis have been previously described.\(^10,12–14\)

**General Health Questionnaire - 12 items.**\(^15,16\) The questionnaire aimed to identify the risk of developing psychological morbidity in general population. The results have been analysed as formerly described.\(^10\)

**Statistical Methods**

The comparison of the MBI subscale scores and GHQ-12 total score between PCPs participating to the two studies was analysed by Mann-Whitney U Test, the distribution of PCPs showing burnout symptoms (MBI) and psychological morbidity (GHQ-12) was compared between the two studies by Chi Square test.
The association between the dimensions of burnout (Emotional Exhaustion, Depersonalization and Personal Accomplishment) and clinicians’ characteristics (study, gender, geographical area, age, profession, offspring and years in palliative care) was explored by General Linear Models (GLMs). For each GLM, Model 1 (with all the dependent variables) and Model 2 (considering only the variables resulted significant in Model 1) have been shown. The significance threshold was set at .05.

The statistical analyses were executed by SPSS 27.0 for windows (SPSS Inc., Chicago, IL, USA).

**Results**

The present study considered the results from the sample of PCPs responding to the COVID2021 survey (145 out of 206 PCPs, response rate 70.4%). In the previous COVID2020 response rate was 73.2% (145 out of 198). All the participants have been working at the home palliative care program for advanced cancer patients.

Table 1 presents a summary of the socio-demographic and professional characteristics of the enrolled PCPs. The COVID2021 sample consisted of 86 physicians (59%) and 59 nurses (41%) while the COVID2020 sample included 77 physicians (53%) and 68 nurses (47%). In both the surveys most of the participants were women (68%–67%, respectively), married or cohabitant (53%–59%, respectively), with children (52%–64%, respectively) and the average age was 42 and 45 years, respectively. The distribution according the years of work in palliative care and the geographical area of work is quite similar in both surveys (Table 1).

Table 2 shows the comparison of the level of burnout of the PCPs between the two studies according the three different methods previously described: i) considering the MBI subscale scores as continuous variables, the PCPs of COVID2021 showed marginally higher level of EE ($P=.049$) and this result is confirmed in physicians ($P=.010$) while no difference was observed in nurses ($P=.326$); ii) analysing the frequency of burnout according the cut off from the Italian Maslach Manual, and iii) according the definition criteria described by Shanafelt et al. no differences were observed between COVID2021 and COVID2020.

Table 3 reports the psychological morbidity of the PCPs participating to the two surveys. Analysing the GHQ-12 score as a continuous variable, there was only a trend towards improvement in 2021 ($P=0.068$). However, analysing the results of GHQ-12 according the cut off indicated in literature, we observed a significant decrease of percentage of the PCPs showing psychological morbidity in COVID2021 study compared to COVID2020 ($P=0.002$). Subgroup analysis showed significance among physicians ($P=.011$) and only a trend among nurses ($P=.075$).

Table 4 shows the association between clinicians’ characteristics and burnout dimensions (EE, DP and PA subscale scores) by general linear models. The initial model (Model 1) explored study (COVID2020 vs COVID2021), gender, geographical area, profession (physician vs. nurse), offspring and years of work in

| Table 1 | Socio-Demographic and Professional Characteristics of PCPs Working in ANT Participating to COVID2020 and COVID2021 Surveys |
|---------|----------------------------------------------------------------------------------------------------------------------------------|
| Study   | COVID2020 PCPs, n = 145 | COVID2021 PCPs, n = 145 | COVID2020 Physicians, n = 77 | COVID2021 Physicians, n = 86 | COVID2020 Nurses, n = 68 | COVID2021 Nurses, n = 59 |
| Gender  | Men 47 (32%) | 48 (33%) | 28 (36%) | 32 (37%) | 19 (28%) | 16 (27%) |
|         | Women 98 (68%) | 97 (67%) | 49 (64%) | 54 (63%) | 49 (72%) | 43 (73%) |
| Age, mean (±St. Dev.) 42 (±12) | 45 (±12) | 48 (±10) | 49 (±10) | 36 (±10) | 38 (±12) |
| Marital status | Unmarried 59 (41%) | 49 (34%) | 19 (25%) | 18 (21%) | 40 (59%) | 31 (52%) |
|         | Married/cohabitant 77 (53%) | 86 (59%) | 51 (66%) | 61 (71%) | 26 (38%) | 25 (42%) |
|         | Separated/divorced 9 (6%) | 7 (5%) | 7 (9%) | 5 (6%) | 2 (3%) | 2 (3%) |
|         | Widowed - | 3 (2%) | - | 2 (2%) | - | 1 (2%) |
|         | With children Yes 75 (52%) | 93 (64%) | 48 (62%) | 65 (76%) | 27 (40%) | 28 (47%) |
|         | No 70 (48%) | 52 (36%) | 29 (38%) | 21 (24%) | 41 (60%) | 31 (52%) |
| Yrs of work in palliative care | <2 yrs 27 (19%) | 17 (12%) | 10 (13%) | 6 (7%) | 17 (25%) | 11 (19%) |
|         | 2-5 yrs 40 (28%) | 27 (19%) | 18 (23%) | 10 (11%) | 22 (32%) | 17 (29%) |
|         | 6-10 yrs 23 (16%) | 31 (21%) | 11 (14%) | 21 (24%) | 12 (18%) | 10 (17%) |
|         | >10 yrs 55 (38%) | 70 (48%) | 38 (49%) | 49 (57%) | 17 (25%) | 21 (36%) |
| Geographical area of worka | Northern Italy 49 (34%) | 53 (37%) | 28 (36%) | 33 (38%) | 21 (31%) | 20 (34%) |
|         | Central Italy 32 (22%) | 33 (23%) | 17 (22%) | 21 (24%) | 15 (22%) | 12 (20%) |
|         | Southern Italy 64 (44%) | 59 (41%) | 32 (42%) | 32 (37%) | 32 (47%) | 27 (40%) |

*ANT = National Tumor Assistance; PCPs = palliative care professionals.

*aNorthern Italy (Emilia-Romagna and Lombardia); Central Italy (Tuscany, Umbria, Marche, Lazio); Southern Italy (Campania, Basilicata and Puglia).
Table 2

| Study | COVID2020 | COVID2021 | P | COVID2020 | COVID2021 | P | COVID2020 | COVID2021 | P | COVID2020 | COVID2021 | P |
|-------|-----------|-----------|---|-----------|-----------|---|-----------|-----------|---|-----------|-----------|---|
| Profession | PCPs, n = 145 | PCPs, n = 145 |     | Physicians, n = 77 | Physicians, n = 86 |     | Nurses, n = 68 | Nurses, n = 59 |     |
| MBI subscale scores, mean (± St. Dev.) | Emotional exhaustion (EE) | 12.7 (±7.2) | 15.1 (±7.9) | 0.049 | 13.3 (±7.6) | 15.6 (±7.1) | 0.010 | 11.8 (±6.5) | 14.1 (±8.9) | 0.326 | 13.7 (±7.2) | 16.1 (±8.9) | 0.178 |
|       | Depersonalization (DP) | 7.1 (±4.6) | 6.7 (±3.9) | 0.999 | 7.0 (±4.6) | 6.8 (±7.1) | 0.890 | 7.1 (±4.7) | 6.7 (±4.4) | 0.693 | 6.8 (±4.6) | 6.5 (±4.4) | 0.837 |
|       | Personal accomplishment (PA) | 36.4 (±6.1) | 35.8 (±6.3) | 0.722 | 36.5 (±6.2) | 35.3 (±5.9) | 0.075 | 36.4 (±6.1) | 36.6 (6.9) | 0.736 | 36.5 (±6.2) | 36.6 (6.9) | 0.736 |

PCPs showing burnout symptoms, n (%)^{a}

| High level of EE (≥24) | 12 (8.4%) | 22 (15.2%) | 0.075 | 7 (9.2%) | 13 (15.1%) | 0.254 | 5 (7.5%) | 9 (15.2%) | 0.165 | 8 (10.5%) | 13 (23.1%) | 0.011 |
| High level of DP (≥9) | 37 (26.1%) | 36 (24.8%) | 0.811 | 15 (19.5%) | 21 (24.4%) | 0.448 | 22 (33.8%) | 15 (25.4%) | 0.306 | 18 (23.8%) | 20 (34.4%) | 0.128 |
| Low level of PA (≥29) | 17 (11.9%) | 26 (17.9%) | 0.150 | 8 (10.5%) | 15 (17.4%) | 0.208 | 9 (13.4%) | 11 (18.6%) | 0.424 | 12 (16.2%) | 19 (32.8%) | 0.002 |

PCPs showing burnout symptoms, n (%)^{b}

| EE > 27 and/or DP > 10 | 31 (22.0%) | 35 (24.1%) | 0.666 | 14 (18.4%) | 20 (23.3%) | 0.451 | 17 (26.2%) | 15 (25.4%) | 0.926 | 22 (29.7%) | 30 (53.4%) | 0.011 |
| Low level of PA (≥31) | 25 (17.2%) | 40 (27.6%) | 0.403 | 12 (15.6%) | 19 (22.1%) | 0.309 | 13 (19.1%) | 12 (20.3%) | 0.895 | 20 (27.0%) | 32 (54.3%) | 0.022 |

ANT = National Tumor Assistance; MBI = Maslach Burnout Inventory; PCPs = palliative care professionals.

*Statistical analysis compared the MBI subscale scores between PCPs participating to the two studies by Mann-Whitney U Test.

Statistical analysis compared the distribution of PCPs showing burnout symptoms between the two studies by Chi Square test.

Table 3

| Study | COVID2020 | COVID2021 | P | COVID2020 | COVID2021 | P | COVID2020 | COVID2021 | P |
|-------|-----------|-----------|---|-----------|-----------|---|-----------|-----------|---|
| GHQ-12 score, mean (± St. Dev.) | 18.2 (±4.5) | 17.0 (±5.8) | 0.068 | 18.2 (±4.9) | 17.0 (±3.5) | 0.169 | 18.5 (±4.1) | 17.0 (±4.4) | 0.058 |
| PCPs showing psychological morbidity, n (%) | 64 (45.1%) | 40 (27.6%) | 0.002 | 34 (45.9%) | 23 (26.7%) | 0.011 | 30 (45.9%) | 17 (28.8%) | 0.075 |

ANT = National Tumor Assistance; GHQ-12 = General Health Questionnaire-12; PCPs = palliative care professionals.

*Statistical analysis compared the GHQ-12 score between PCPs participating to the two studies by Mann-Whitney U Test.

Statistical analysis compared the distribution of PCPs showing psychological morbidity (GHQ-12 score > 19) between PCPs participating to the two studies by Chi Square test.

palliative care (0 – 5 vs. 6 or more years) as regressors. Model 2 considered only the variables resulted significant in Model 1. The EE resulted the variable most likely influenced by the survey, with a significant association between COVID2021 and increased level of EE (P = .003). Moreover, increasing age was significantly associated to lower level of EE (P = <.001) and DP (P = .002) and higher level of PA (P = .001); PCPs living in Northern Italy showed higher level of EE (P = .014) and lower level of PA (P < .001) compared to Southern Italy. Analysing profession, physicians had higher level of EE (P = .001) and DP (P = .031) and lower level of PA (P = .032) compared to nurses; finally, PCPs without offspring showed increased level of DP (P = .022) respect to PCPs with offspring.

**Discussion**

The present study compared the levels of burnout and psychological morbidity among physicians and nurses working in home palliative care during first COVID-19 wave vs. one year after. We investigated whether the deep changes in work routine and the persistence of the health emergency over many months had negative effects on occupational and psychological well-being among palliative care professionals. After one year working in the context of the COVID-19 pandemic, PCPs showed rather stable levels of burnout, with a slight increase in emotional exhaustion. Although this difference was particularly relevant for physicians, both professional groups displayed the same trend. As for psychological morbidity, we observed a decrease in the percentage of professionals showing high levels of psychological distress.

The overall stability of burnout after a year of pandemic suggests that this challenging situation did not play a critical role in PCPs psychological adjustment to the new work routine. Although several studies have highlighted increased levels of burnout in healthcare workers during the pandemic,^17–20^ the present results
confirm our previous study conducted during the first wave showing lower level of burnout compared with a pre-COVID-19 investigation in home PCPs.21 Moreover, the level of burnout among home PCPs a year later is quite comparable.10 The awareness of being at the forefront of containing the pandemic along with the sense of responsibility toward their high-risk patients seems to remain steady during the whole period of pandemic continuing to foster their sense of professional satisfaction and personal accomplishment.22

The available literature on the psychological status of PCPs in a period before the pandemic reported a lower burnout levels compared with other medical discipline.12−16 Two studies reported a burnout frequency among PCPs of about 38%,23,24 while the prevalence of burnout widely ranged in the previous literature, based on work context, characteristics of the health care professionals and coping strategies.25−27 In an emergency situation, the psychological stress level of health workers is expected to increase, thus facilitating the onset of burnout and other distress-related syndromes.28,29 A qualitative study on 77 palliative care workers from 41 countries described the huge impact of the COVID-19 pandemic on their ability to deliver services and their financial status. These professionals reported increased workloads due to emergency situation and declared that pandemic placed them in vulnerable positions affecting their emotional well-being and resulting in distress and burnout.30 A survey on 14 palliative hospital teams in U.S.A. evidenced that COVID-19 exacerbated burnout experienced by the staff members while the use of coping behaviours (devaluation tactic) and external resources (co-workers and supervisor support) were found to have a positive effect on the teams.31

Although the number of PCPs showing burnout did not change over months, the mean level of emotional exhaustion (EE)—one of the three dimensions provided for Maslach conceptualization of burnout—seems to be higher after a year of pandemic, making EE the dimension most affected by time. The difference between physicians and nurses in the increase in EE is quite small and one possible explanation lies in different sample size between the two groups of professionals.

Prolonged exposure to work-related problems can lead to occupational physical and emotional exhaustion32 and this psychological response has been more evident in the PCPs working in Northern Italy, where the virus hit hardest in the first wave.

Table 4
General Linear Models Showing the Association Between Burnout Dimensions (EE, DP and PA Subscale Scores, Dependent Variables) and Clinicians’ Characteristics. For Each GLM, we reported Model 1 (With All the Dependent Variables) and Model 2 (Considering Only the Variables Resulted Significant in Model 1)

| Dependent Variable | Independent Variables | Model 1 | Model 2 |
|--------------------|-----------------------|---------|---------|
|                    |                       | Contrast Estimates | P  | Contrast Estimates | P  |
| Emotional Exhaustion | Study\(^a\) | 2.558 | .004 | 2.631 | .003 |
|                    | Gender\(^b\) | .479 | .613 | - | - |
|                    | Geographical Area\(^c\) | -1.799 | .130 | -1.870 | .110 |
|                    | North vs. Centre | -2.406 | .022 | -2.512 | .014 |
|                    | North vs. South | -2.200 | .000 | -1.75 | .000 |
|                    | Age | -3.366 | .001 | -3.261 | .001 |
|                    | Profession\(^d\) | -0.933 | .974 | - | - |
|                    | Offspring\(^e\) | .884 | .473 | - | - |
|                    | Years in palliative care\(^f\) | .015 | .976 | - | - |
|                    | Study\(^a\) | .159 | .767 | - | - |
|                    | Gender\(^b\) | -0.953 | .958 | - | - |
|                    | Geographical Area\(^c\) | -872 | .144 | - | - |
|                    | North vs. Centre | -872 | .144 | - | - |
|                    | North vs. South | -872 | .144 | - | - |
|                    | Age | -0.088 | .006 | -0.079 | .002 |
|                    | Profession\(^d\) | -1.278 | .026 | -1.222 | .031 |
|                    | Offspring\(^e\) | 1.136 | .045 | 1.250 | .022 |
|                    | Years in palliative care\(^f\) | -1.34 | .848 | - | - |
| Depersonalization  | Study\(^a\) | -0.846 | .245 | - | - |
|                    | Gender\(^b\) | .365 | .650 | - | - |
|                    | Geographical Area\(^c\) | 2.432 | .014 | 2.450 | .012 |
|                    | North vs. Centre | 3.085 | .090 | 3.093 | .000 |
|                    | North vs. South | 3.085 | .090 | 3.093 | .000 |
|                    | Age | .099 | .035 | .118 | .001 |
|                    | Profession\(^d\) | 1.711 | .040 | 1.755 | .032 |
|                    | Offspring\(^e\) | -1.479 | .559 | - | - |
|                    | Years in palliative care\(^f\) | .545 | .592 | - | - |

For each regression, the following independent categorical variables have been considered:

\(^a\)COVID2020(ref) vs. COVID2021;
\(^b\)Men(ref) vs. Women;
\(^c\)Northern Italy(ref) vs. Central and Southern Italy;
\(^d\)Physicians(ref) vs. Nurses;
\(^e\)Offspring(ref) vs. no offspring;
\(^f\)0−5 yrs(ref) vs. 6 yrs or more.
We found a weak association between burnout levels and PCPs age and professions; these results need further investigations considering that the literature on impact of COVID-19 pandemic on burnout appear still limited and conflicting.33 A combination of factors may be at the root of our findings of overall stability of burnout and decrease in percentage of PCPs showing psychological morbidity. A year after the beginning of COVID-19 outbreak, PCPs showed lower level of psychological morbidity as compared to during the first wave, when the level of distress was significantly higher than in the pre-pandemic period.10

Workload, long periods of isolation and uncertainty of the future represent psychosocial risk factors that negatively impact the emotional adjustment of healthcare workers, worsening their mental health condition.9,34–36 Although the healthcare workers’ reaction to a prolonged emergency situation could became chronic stress lowering quality of life and psycho-physical well-being,37–39 our results are encouraging and likely reflect the adjustment of healthcare workers, largely related to work re-organization and successful individual self-care also considering that the workload for the PCPs remained substantially stable between the first semester of 2020 and 2021, in terms of number and functional status of patients entering in the home assistance program as well as regarding the number of home visits/phone calls.

Coping strategies are one of the individual, relational and environmental factors able to affect the expression of psychological adjustment among PCPs: their role and impact on the dimensions of burnout has been already observed both in other studies and in our pre-COVID-19 investigation.21,40 A recent qualitative study about perception of challenges during the COVID-19 outbreak in a similar PCPs sample reports similar findings.22 This previous study has investigated the type of operational strategies employed by PCPs to cope with the emergency and which of those strategies they found useful.22 Relying on telemedicine tools and the availability of practical and emotional support from colleagues seemed to be the most helpful strategies for physicians and nurses. The use of telephone and video visits may be an important factor, able to affect positively levels of distress if users evaluate this kind of tools as an opportunity rather than a threat to their work.11 Moreover, some PCPs operating in the home setting were already used to regularly using telemedicine in their clinical practice before the pandemic.

The high level of support and communication within the healthcare team reported in previous studies among PCPs,42,43 is a known protective factor against development of burnout syndrome and psychological distress.44 Summarizing evidence and recommendation for the palliative care response to COVID-19, Etkind and colleagues5 pointed out that facilitating camaraderie among staff is important in order to minimize potential negative effects caused by pandemic; together with improving connectedness and helping workers dealing with stress, this action is an organizational device able to ensure positive adjustment of PCPs. The ability to recognize and deal with events with strong emotional impact, being aware of own coping strategies, enhancing peer support and job resources, facing regularly suffering and death and working in team according to an interdisciplinary approach are all key elements of working in palliative care setting.

Until now, there are no studies on the long-term psychological outcomes among healthcare workers involved in COVID-19 outbreak, and the results about the psychological reaction in the face of precedent emergencies are variable.45 Considering we will have to fight with successive waves of the pandemic in the near future, it is mandatory to assess the PCPs psychological distress in order to put in place organizational policies supporting PCPs team and reinforcing their individual coping strategies. In our opinion, the continuous and frequent monitoring of the PCPs’ psychological state should be included within the institutional clinical good practice of the National Health System, as the global situation related to the pandemic is constantly changing and this could have consequences for both personal and professional emotional well-being, particularly among healthcare workers. The regular monitoring of burnout is a preventive action that has to be implemented independently by situations of medical emergency.21 All the more reason, a constant follow-up is planned to try to better understand the potential causes — or contributing causes — of a modulation of burnout and emotional exhaustion following new peaks of contagion and in a context of post-COVID new normal.

Strengths and Limitation

According to our knowledge, this is the first study involving a consistent number of home PCPs and monitoring the level of burnout before and during the first acute wave and a year after the beginning of the pandemic.

However, findings should be interpreted in the light of some limitations. The PCPs enrolled in the two previous studies were mostly the same who participated to the present study, but the staff composition has undergone some little inevitable changes in the last five years, especially concerning the nursing team.

Moreover, the emotional responses vary according to the phase of the pandemic and a possible weakness of the present study concerns the time of the data collection, coinciding with a period of vaccination and falling of infection rates; for this reason, there is a need to
continue with the monitoring of healthcare workers psychological well-being.

Conclusion

Our findings show stable levels of burnout and decreasing levels of psychological morbidity among PCPs one year after the onset of the COVID-19 pandemic. More research is needed to better characterize populations at elevated risk, and to determine the most useful organizational and individual strategies for mitigation of both burnout and psychological morbidity.

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