

Burnout Syndrome in Palliative Care Professionals: A Systematic Review of Prevalence, Associated Factors, and Coping Strategies

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Abstract

This systematic review aims to evaluate the prevalence of burnout, its associated determinants, and the coping strategies employed by palliative care professionals. Burnout, characterized by emotional exhaustion, depersonalization, and diminished personal accomplishment, poses a significant threat to clinician well-being and the quality of care delivered to patients with life-limiting illnesses. A comprehensive search of PubMed and Embase identified eleven eligible studies published between 2021 and 2025. Following thematic synthesis, four overarching themes were identified: (1) work-related stress: heavy workloads, emotional demands and lack of support, (2) burden of burnout: the unique stressors facing palliative care professionals, (3) impact of the COVID-19 pandemic: increased workloads and exposure to high-risk environments, and (4) coping strategies: symptom recognition and etiological factors, organizational support and resilience factors. **Conclusion:** Burnout remains a pervasive challenge in palliative care, and sustained, evidence-based organizational strategies are essential to protect clinician well-being and ensure high-quality patient care. Future research should determine the long-term effectiveness of these interventions and assess whether tailored approaches are required for specific professional groups and care settings.

Key Words: Palliative Care ■ Burnout Syndrome ■ Coping Strategies ■ COVID-19 ■ Occupational Stress.

Introduction

Burnout syndrome encompasses emotional exhaustion, depersonalization, and reduced personal accomplishment, and is particularly prevalent among healthcare professionals caring for patients at the end of life (1, 2). Its consequences extend beyond individual well-being, affecting clinical performance and the quality of patient care (1, 2). Prior research by Kavalieratos et al. reported alarmingly high burnout rates among palliative care clinicians, warning that sustained occupational pressures could reduce the workforce by up to 50% over the next decade (1). Gonçalves et al. further demonstrated that burnout levels among palliative care physicians increased significantly

during the COVID-19 pandemic, illustrating how external crises exacerbate psychological strain (2).

The factors contributing to burnout in palliative care settings are complex and multifaceted. The core components of burnout syndrome, emotional exhaustion, depersonalization, and reduced personal accomplishment, are particularly pronounced among healthcare workers involved in end-of-life decision-making and managing the emotional repercussions of patient loss (3, 4). A study that enrolled 69 health professionals established a correlation between elevated cortisol levels, perceived stress, and burnout, suggesting a biological basis for the psychological strain experienced by these professionals (5). The COVID-19 pandemic has added further complexity to the

burnout landscape, as reported by Elghazally et al., who indicated that healthcare workers faced unprecedented challenges, including extended working hours, high-pressure decision-making, and fears of infection, all contributing to heightened burnout levels (6).

Podoroghin and Paladi also noted a consistent rise in workplace stress and exhaustion among medical staff during the pandemic, underscoring the ongoing nature of this crisis (7). The consequences of burnout extend beyond individual health issues, influencing clinical decision-making and the overall quality of care. Research has shown that burnout can result in increased medical errors, diminished empathy towards patients, and a general decline in professional effectiveness, raising significant concerns in palliative care, where compassionate communication and decision-making are paramount. The relationship between burnout and decision-making processes within palliative care settings warrants further exploration, as an understanding of these dynamics could inform strategies to alleviate burnout and enhance care outcomes (4, 8).

The objectives of this review were to synthesize recent evidence on burnout among palliative care professionals by examining the prevalence of burnout, its underlying causes, and the coping mechanisms described in studies published between 2021 and 2025. Through this structured analysis, the review aimed to clarify the key determinants of

burnout and highlight the most relevant findings emerging from the current literature.

Materials and Methods

A systematic search of PubMed (MEDLINE) and Embase was conducted for studies published between 1 January 2021 and 31 December 2025. The complete search strategy included MeSH terms (PubMed) and Emtree terms (Embase), together with the core keywords “burnout” and “palliative care”, combined using Boolean operators. Due to heterogeneity in study designs and measurement tools, meta-analysis was not feasible; instead, a narrative and thematic synthesis was performed. *Inclusion Criteria:* Human studies; Participants aged ≥ 18 years; Articles published in English. Publications dating within the last five years; Observational or qualitative studies reporting burnout or coping outcomes in palliative care. *Exclusion Criteria:* Non-English publications; Pediatric populations; Publications not within the last five years; Duplicates; Studies conducted on non-medical workers; Studies not involving palliative care professionals or not reporting burnout/coping outcomes. Lack of full-text availability.

An overview of the study selection process is presented in Figure 1. A PRISMA-based screening identified 1,358 records; after applying the eligibility criteria, eleven studies met the inclusion criteria. (9, 10).

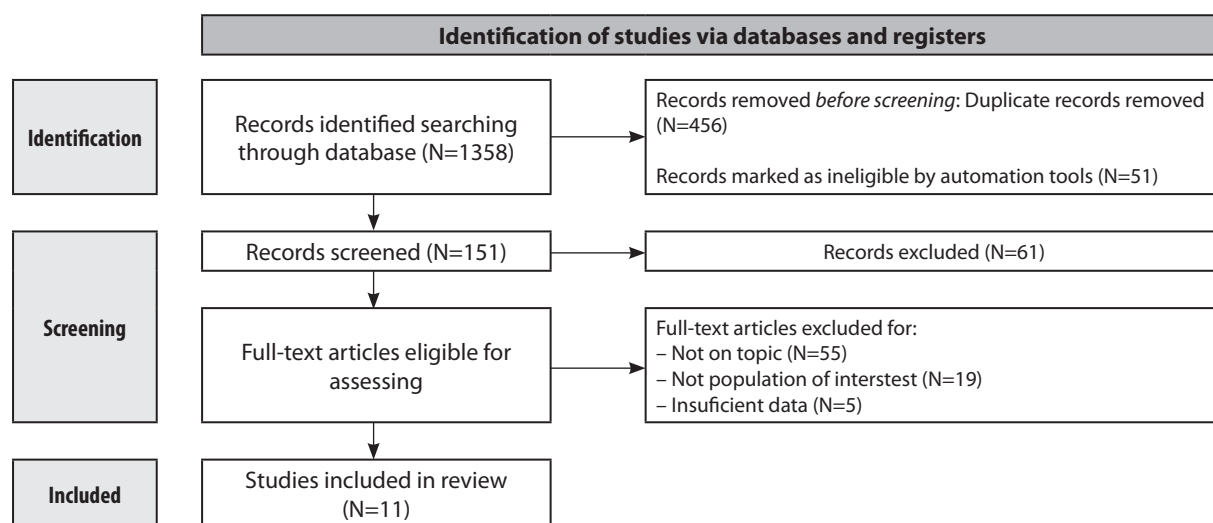


Figure 1. PRISMA flow diagram of the study selection process (10).

Results

Thematic synthesis identified four major themes: work-related stress, the burden of burnout, the

impact of COVID-19, and coping strategies. Table 1 summarizes the characteristics and findings of the included studies.

Table 1. Characteristics of the Included Literature

No.	Authors and year	Study design	Sample	Main findings
1.	Hwang Koh et al., 2024 (11)	Qualitative, collecting data	18 palliative clinicians	Supportive leadership and strong team communication reduce burnout; collaborative environments and institutional commitment to staff well-being foster resilience.
2.	Fattori et al., 2023 (12)	Cross-sectional	106 clinicians	Home-care staff reported more communication with colleagues and families; inpatient hospice workers had lower peer support and higher exposure to aggression; caregiver-related burnout was higher in inpatient settings.
(3.	Koh et al., 2022 (13)	Qualitative	18 clinicians	The study identified numerous challenging situations, such as dealing with abusive patients and their families, experiencing 'bad deaths,' the deaths of young patients, handling complex cases, and facing multiple deaths or difficult cases simultaneously. The emotions encountered in these situations included feelings of being overwhelmed, helplessness, failure, and a sense of injustice.
4.	F.Gonçalves & Gaudêncio, 2023 (14)	Quantitative, correlational	34 health care providers	Burnout risk affected 55.9% of participants, especially nurses and physicians; emotional exhaustion and depersonalization were prominent; burnout was not directly linked to quality of life.
5.	Dijxhoorn et al., 2021 (15)	Cross-sectional	344 professionals	69% of participants reported moderate burnout, and 7% required sick leave. On average, participants used 3.7 coping strategies to manage work-related stress. These activities included talking to colleagues about impactful events (84%); engaging in leisure activities such as sports, walking, gardening, or listening to music (84%); peer coaching (50%); and team consultation (40%). However, 23% of participants considered these strategies insufficient.
6.	J. V. Gonçalves et al., 2021 (16)	Cross-sectional	153 nurses	High levels of personal (46%), work-related (44%), and patient-related burnout (22%); predictors included specialization, health status, unit type, working hours, and COVID-19 assignments.
7.	Tan et al., 2024 (17)	Qualitative	19 nurses	Five themes emerged: burnout recognition, contributing factors, triggers, coping strategies, and resilience; meaning-making was central to emotional resilience.
8.	Ghazwani, 2022 (18)	Cross-sectional	44 physicians	Emotional exhaustion (18.2%), depersonalization (25%), and reduced accomplishment (25%); burnout was influenced by job role, administrative support, staffing, and medication availability.
9.	J. V. Gonçalves et al., 2023 (2)	Cross-sectional	75 physicians	Personal burnout (43%), work-related burnout (52%), patient-related burnout (21%); physical activity and exclusive palliative care practice were protective; COVID-19 had significant emotional impact.
10.	Y. Wu et al., 2025 (19)	Multicenter cross-sectional	164 practitioners	Burnout prevalence was 44.6%; 31.5% had severe exhaustion and depersonalization; 74.6% reported low accomplishment; training, workload, psychological support, and employment conditions influenced burnout.
11.	R. Tan et al., 2025 (20)	Qualitative	15 hospice nurses	Identified self-care strategies, benefits, and barriers; social support and self-worth were central to coping.

The Prevalence

Across studies, burnout prevalence among palliative care professionals ranged from 43% to 55.9%, with emotional exhaustion and depersonalization affecting both nurses and physicians (14, 16, 18, 19). Dijkhoorn et al. reported that 69% of 344 professionals experienced moderate burnout, and 7% required medical leave (15). Gonçalves et al. found high personal (46%), work-related (44%), and patient-related burnout (22%) among nurses (16). Burnout was more common among inpatient hospice workers, women, and health assistants (12). These findings confirm that burnout is widespread and influenced by care setting, gender, role, and organizational factors.

Work-Related Stress

Dijkhoorn et al. identified heavy workloads, emotional demands, and limited organizational support as major stressors contributing to burnout (15). Wu et al. reported that 31.5% of practitioners experienced severe emotional exhaustion, with risk increasing significantly among those working more than five years in palliative care or performing frequent overtime (19). Career uncertainty was strongly associated with depersonalization. These stressors collectively contribute to exhaustion, detachment, and reduced professional fulfillment.

The Burden of Burnout

Burnout in palliative care is intensified by the unique demands of this work. Fattori et al. showed that both inpatient hospice and home-care staff face major psychosocial risks, though their interaction patterns differ. Home-care workers reported more frequent contact with patients and caregivers, which can be either supportive or stressful depending on context (12). Consistent with this, Gonçalves et al. found lower quality of life and higher burnout among palliative care professionals due to the emotional intensity of their roles (14). Ghazwani EY, using the MBI in a cross-sectional study of 44 clinicians, reported emotional

exhaustion in 18.2% and depersonalization and reduced accomplishment in 25%, indicating a notable prevalence of burnout that may impair care quality (18). Another cross-sectional study using sociodemographic data, WHOQOL, and the MBI further demonstrated how burnout affects multiple dimensions of well-being in oncology and palliative care staff (2).

Wu et al. showed that burnout is substantial and multifactorial (19). High work intensity increased the risk of severe emotional exhaustion nearly tenfold, while optimism about career prospects reduced exhaustion but was linked to lower personal accomplishment. Positive clinician-patient relationships and diversified insurance payment models helped mitigate burnout, particularly emotional exhaustion. Overall, these findings highlight the heavy burden of burnout in palliative care and the interplay between workload, career perceptions, and interpersonal dynamics (20).

The Impact of the COVID-19 Pandemic

The COVID-19 pandemic intensified existing challenges. Gonçalves et al. reported markedly higher burnout among palliative care physicians in Portugal, showing how external crises heighten vulnerability in this workforce (2). Their cross-sectional MBI assessment revealed high levels of personal (43%), work-related (52%), and patient-related burnout (21%) (2), underscoring the pandemic's substantial psychological impact on clinicians in emotionally demanding settings. Koh et al. found that difficult cases, such as caring for young patients or navigating complex family dynamics, trigger overwhelming emotions and helplessness, contributing to burnout (13). Additional predictors included palliative care specialization, perceived health, unit type, weekly hours, and COVID-19 assignments. Nurses in palliative units showed higher burnout due to the emotional demands of end-of-life care, further intensified during the pandemic. Those assigned to COVID-19 units experienced even greater burnout, reflecting the extreme strain of high-stress environments (16).

Coping Strategy

Coping strategies and resilience are crucial for reducing burnout. Tan's qualitative study showed that recognizing burnout symptoms and using effective coping methods helps palliative nurses build resilience through personal experience and supportive environments (17). Hwang Koh et al. similarly emphasized that strong leadership and organizational support are essential for preventing burnout and strengthening team resilience (11).

Challenging clinical situations often trigger intense emotions such as helplessness, failure, and injustice, core indicators of burnout. These reactions affect both clinician well-being and patient care. The study highlights the need for organizations to acknowledge these emotional burdens and provide structured support systems where clinicians can share experiences and process distress. Such environments enhance resilience and job satisfaction, which are vital in palliative care's emotionally demanding context (13). F. Gonçalves & Gaudêncio showed that high workload, weak organizational support, and poor coping strategies are major drivers of burnout. Heavy workloads and limited institutional backing were the strongest predictors, highlighting the need for supportive work environments. Wu et al. confirmed that excessive workload increases burnout risk, stressing the importance of proper ward organization and adequate nurse-to-patient ratios (14, 19). Qualitative evidence shows that coping is multidimensional. Tan et al. identified four key self-care domains among hospice nurses: physical health, psychological resilience, social support, and spiritual coping (20).

Discussion

This systematic review shows a high prevalence of burnout among palliative care professionals and identifies four interconnected themes: work-related stress, the burden of burnout, the impact of COVID-19, and coping strategies. These findings demonstrate that burnout in palliative care is a multidimensional phenomenon shaped by individual, organizational, and systemic factors.

Work-related stress emerged as a central determinant of burnout across the included studies. High workload, emotional demands, and repeated exposure to end-of-life situations were consistently reported, aligning with previous evidence (21, 22). Gómez-Urquiza et al. found that nearly 30% of palliative care nurses experience emotional exhaustion, depersonalization, and reduced personal accomplishment, driven by demanding work environments and psychological factors (21). Similarly, Pereira et al. highlighted compassion fatigue, ethical distress, and the influence of personality traits and years of service on professional quality of life (3). These findings support the conclusion that palliative care professionals face stress levels comparable to other high-intensity clinical settings (22).

The burden of burnout identified in this review mirrors the broader literature describing its psychological and professional consequences. Reduced empathy, impaired decision-making, and diminished job satisfaction were frequently reported (1, 3, 22). Kavalieratos et al. emphasized that burnout arises from individual, interpersonal, organizational, and policy-level factors, affecting clinicians' psychological well-being, patient care quality, and workforce sustainability (1). Feelings of inefficacy and self-criticism may lead some clinicians to consider leaving the field, reinforcing the structural nature of burnout in palliative care (3).

The impact of COVID-19 was a prominent theme across the included studies. Our findings confirm that the pandemic intensified anxiety, disrupted sleep quality, and increased emotional strain among healthcare workers. Korkmaz et al. reported high anxiety levels among staff working in COVID-19 services, with negative effects on sleep, quality of life, and problem-solving abilities (23). Wu et al. reported a burnout prevalence of 44.6%, at the upper end of previously documented international ranges (3–66%), reinforcing that burnout is not an isolated phenomenon but a systemic issue within palliative care practice (19). Research conducted during the pandemic also demonstrated that sustained systemic stress is associated with measurable inflammatory responses and adverse outcomes in vulnerable populations,

suggesting that chronic exposure to high stress may have both psychological and physiological consequences (2, 19, 24, 25).

Coping strategies and resilience mechanisms were widely discussed across the included studies. Effective coping requires both individual strategies; such as: exercise, mindfulness, emotional boundaries, and meaning-making; organizational and spiritual support (20, 26, 27). Tan et al. showed that meaning-making, reflection on death, and perceived professional value were central to resilience (20). Wu et al. further demonstrated that optimism regarding career prospects, access to psychological support, and participation in specialized training acted as protective factors (19). A scoping review by Yongpradern et al. identified five core elements of resilience-building interventions: regularity, self-care, mindfulness, reflective practice, and cognitive-behavioral therapy; along with three supporting components: peer support, educational sessions, and organizational support (27). The review included 12 studies from 11,470 initial citations, but noted limitations such as small sample sizes and inconsistent assessment methods; therefore, the effectiveness of these interventions remains inconclusive, and future research should develop palliative-specific assessment tools and standardized approaches (27).

A key limitation of this review is the variability in methodological quality across the included studies. Several studies had small sample sizes, and participant recruitment was often selective, with some studies enrolling only physicians or only nurses, rather than representing the full multidisciplinary palliative care workforce. These factors limit the generalizability of the findings and should be considered when interpreting the overall conclusions.

Future research should focus on the long-term impact of coping and resilience-building interventions, ideally through longitudinal designs and standardized assessment tools tailored to palliative care settings. Understanding how these strategies can be adapted to different professional groups may help develop more targeted and sustainable approaches to reducing burnout.

Conclusions

This systematic review shows a high prevalence of burnout among palliative care professionals and underscores the need for targeted interventions such as resilience training and mindfulness-based programs. While traditional therapeutic methods offer some benefit, approaches that strengthen emotional intelligence and adaptive coping may provide more durable improvements. Future research should examine how organizational support, workload adjustments, and systemic changes influence burnout reduction. Longitudinal studies are also needed to assess the long-term effectiveness of these interventions. Because different professional roles face distinct pressures, tailored strategies may enhance outcomes. Overall, these recommendations aim to improve clinician well-being and elevate the quality of care in palliative settings.

What Is Already Known on This Topic:

Burnout is widely recognized as a significant occupational risk for palliative care professionals, largely due to the emotional demands of end-of-life care, sustained workloads, and repeated exposure to patient suffering. Earlier studies consistently document high levels of emotional exhaustion, depersonalization, and reduced personal accomplishment in this workforce. Contributing factors frequently include staff shortages, limited organizational support, and persistent job pressure. Evidence from the COVID-19 period further shows that increased workload, psychological strain, and high-risk clinical environments intensified burnout among clinicians. Various coping approaches, such as resilience-building, social support, mindfulness, and meaning-making, have been described in the literature, although their effectiveness appears to vary across settings and professional groups.

What This Study Adds:

This review provides an updated synthesis of evidence published between 2021 and 2025, a period marked by substantial organizational and emotional pressures in palliative care. By integrating findings from both qualitative and quantitative studies, it clarifies how workload, emotional demands, and pandemic-related challenges interact with individual and institutional factors to shape burnout risk. The review also highlights protective elements such as supportive leadership, resilience-building, and meaningful clinician-patient relationships, offering a more nuanced understanding of coping mechanisms currently used in palliative care settings. Together, these insights outline practical directions for strengthening organizational support and improving strategies to mitigate burnout among palliative care professionals.

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tion of data: MDC, RMR, IRP, DGC, MMM and GFB; Drafting the article: MDC, RMR, IRP, DGC, MMM and GFB; Revising it critically for important intellectual content: RMR, DVM, AGR, DAT, MAM and CMP; Approved final version of the manuscript: All authors.

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