

Promoting Resiliency among Palliative Care Clinicians: Stressors, Coping Strategies, and Training Needs

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Abstract

Background: Palliative care clinicians (PCCs) are susceptible to burnout, as they regularly witness immense patient and family suffering; however, little is known about their specific challenges and training needs to enhance their long-term sustainability.

Objective: The purpose of this qualitative study was to explore common stressors, coping strategies, and training needs among PCCs in efforts to inform the development of a targeted Resiliency Program.

Methods: Utilizing a semistructured interview guide, we conducted a series of in-depth interviews with 15 PCCs at the Massachusetts General Hospital.

Results: Content analysis highlighted three main areas of stressors: (1) systematic challenges related to managing large, emotionally demanding caseloads within time constraints; (2) patient factors, such as addressing patients' mutable needs, managing family dynamics, and meeting patient and family demands and expectations; and (3) personal challenges of delineating emotional and professional boundaries. Engaging in healthy behaviors and hobbies and seeking emotional support from colleagues and friends were among the most common methods of coping with stressors. In terms of programmatic topics, PCCs desired training in mind-body skills (e.g., breathing, yoga, meditation), health education about the effects of stress, and cognitive strategies to help reduce ruminative thoughts and negative self-talk. A majority of clinicians stressed the need for brief strategies that could be readily integrated in the workplace.

Conclusions: These results suggest that an intervention aimed to enhance PCC sustainability should focus on utilizing a skill-building approach to stress reduction that imparts strategies that can be readily utilized during work hours.

Introduction

THE DEMANDS OF PROVIDING HOLISTIC CARE to patients with advanced illness can be overwhelming. Palliative care clinicians (PCCs) are a group of specialists who tend to the medical, psychosocial, and spiritual needs of terminally ill patients and assist them with understanding and coping with illness progression, functional losses, death and dying.¹ In addition to managing emotionally laden caseloads, PCCs work as consultants on large, interdisciplinary teams; accordingly, they function as medical conduits, negotiating with and balancing the needs of their team members, patients, and families.² Collectively, these experiences can exacerbate work-related strains; challenge PCCs' sense of competency;³ and engender feelings of frustration, unresolved grief, per-

ceived loss of control, and role confusion.^{1,4} Feeling emotionally and physically encumbered, PCCs may lack adequate resources to cope with the demands of their job. Consequently, practicing professionals are inherently susceptible to experiencing elevated, chronic levels of stress and burnout.^{1,5}

Burnout has been employed extensively in the literature to characterize a psychological phenomenon that develops in response to repeated exposure to stress in the work environment.⁶⁻⁸ Studies investigating the prevalence of burnout among medical professionals indicate that burnout is a common problem; however, research understanding the stress experience among PCCs remains limited.⁴ Burnout syndrome has been associated with widespread negative outcomes for both patients and providers. Among providers, it has been

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linked to more medical errors, diminished sense of empathy and compassion for patients, impaired decision making, more adverse events, higher rates of physical and psychological morbidity, and overall work dissatisfaction.^{5,6,9,10} Among patients, clinician burnout has been evidenced to decrease patient compliance with medical treatment, decrease their satisfaction with and trust in providers, and impair the quality of care received.^{5,6,9} Accordingly, identifying ways to mitigate PCCs' risk for developing burnout is warranted.

There is a dearth of research investigating interventions that prevent burnout and promote resiliency, specifically among PCCs. The purpose of this study is to examine the work experiences among a multidisciplinary team of PCCs (i.e., physicians, nurses, nurse practitioners, and social workers) in efforts to understand the challenging aspects of palliative care work and their methods of coping with these stressors. In addition, this study aims to highlight important training needs and skills in efforts to inform the next study phase, which includes development of a targeted resiliency program for PCCs.

Methods

Design and participants

This qualitative study was part of a single-arm pilot trial aimed to develop and evaluate the effects of a Relaxation Response Resiliency Program for Palliative Care Clinicians ("3RP PCC") on the well-being of PCCs employed at the Massachusetts General Hospital (MGH) in Boston, Massachusetts. A description and evaluation of the program will be included in a separate report.

The MGH/Partners HealthCare institutional review board approved all study procedures. Potential participants were first informed about the study at a PCC meeting; subsequently, they received an e-mail describing the parameters of study participation. PCCs who expressed interest were given an opportunity to review the study consent form and discuss concerns with a study staff member. PCCs who completed a consent form were enrolled in the study.

Participants completed in-depth interviews using a semi-structured interview guide with open-ended questions. The interviews were used to elicit perspectives of (1) common challenges and stressors within the palliative care setting; (2) methods of coping with work-related stressors; and (3) specific training needs. All interviews were facilitated by a clinical social worker that was trained in qualitative interviewing; they were carried out face to face and were on average 30 minutes in length. All interviews were audiorecorded and transcribed by study staff in preparation for analysis.

Data analysis

Two coders, trained in qualitative methods by the senior author, developed a content-related coding structure through an iterative process. Content analysis of all interviews was independently performed by three coders as a first level of abstraction. Two coders compared all data that were discrepant, unexpected, or unclear to raw data until consensus was attained. The codes were further collapsed into subcategories and major categories; each subcategory was defined by direct citations from the transcripts. Major categories and subcategories were discussed until mutual agreement was reached.

Results

Table 1 details the demographic information for the whole sample. A total of 16 clinicians were approached for participation in the study, and 15 (93.8%) opted to consent and complete the interviews. Table 2 presents the major categories and subthemes of our findings with corresponding quotes.

Systemic stressors

Limited resources. Time constraints were a commonly identified stressor; specifically, having a shortage of specialty staff who do PC work contributed to a portion of the time pressures cited, particularly with the concomitant rise in demand for PC services. The majority of clinicians interviewed described difficulty managing the individual needs of patients given their ever-growing caseloads; this often incited guilt as providers grappled with ways to effectively allocate their time. PCCs struggled with estimating how long an encounter would take, as their functional role may vary based on a patient's emotional state or the recent provision of bad news. Accordingly, respondents frequently struggled with feeling overextended, lacking enough time to spend with their patients. These stressors were exacerbated by their inability to debrief with colleagues between encounters. Many opted out of taking breaks due to time pressures. This left little time to process events from previous encounters or to grieve a recent loss; as a result, most of the respondents noted feeling mentally and emotionally unprepared as they rushed to their next case.

TABLE 1. DEMOGRAPHIC CHARACTERISTICS OF PALLIATIVE CARE CLINICIANS (N=15)

<i>Demographic characteristic</i>	<i>N (%)</i>	<i>Mean ± SD</i>
Age		43.8 ± 8.1
Gender		
Male	3 (20.0%)	
Female	12 (80.0%)	
Race		
White	13 (86.7%)	
Asian	1 (6.7%)	
Black or African American	1 (6.7%)	
Ethnicity		
Hispanic	0 (0%)	
Non-Hispanic	15 (100%)	
Marital status		
Never married	7 (46.7%)	
Married/living as if married	7 (46.7%)	
Divorced/separated	1 (6.7%)	
Children under 18 at home		
Yes	5 (33.3%)	
No	10 (66.7%)	
Role in PC service		
Physician	6 (40.0%)	
Nurse practitioner	6 (40.0%)	
Clinical social worker	2 (13.3%)	
Registered nurse	1 (6.7%)	
How long in PC Service		
< 1 year	1 (6.7%)	
1–5 years	7 (46.7%)	
6–10 years	7 (46.7%)	
Hours per week in PC Service		47.6 ± 8.4

Competing demands. Competing role demands were also a commonly cited challenge among PCCs. Clinicians reported a need to negotiate their time between administrative duties, patient needs, and staff requests. For example, some respondents were concerned about the amount of time spent locating patients and their families, writing treatment notes, and interfacing with other colleagues. Time constraints were particularly magnified by the amount of care coordination involved, especially with the increase in requests for PC consults.

Conflicting expectations. Many were overwhelmed by some of their colleagues' expectations. For example, providers from patients' primary medical team often questioned PCCs' treatment decisions, especially when symptom control was not readily achieved. These emotions were particularly elevated when there was provider discord regarding the goals of treatment. This discordance not only incited distress but also engendered feelings of helplessness and incompetence among PC clinicians.

Unpredictable schedules. The capricious nature of their schedules was another frequently cited stressor. Participants commonly reported feeling compelled to work longer hours at the expense of their personal needs in efforts to accommodate work demands. The number, complexity, and severity of their cases precluded them from accurately estimating length of encounters. Participants generally agreed that it was difficult to predict when they would be called to meet with a patient and how long they would spend during an encounter. Accordingly, many stated that they often stopped planning activities for fear of not fulfilling commitments.

Patient-centered stressors

Intensity of cases. A resounding theme among clinicians was the chronicity with which they are exposed to sadness, pain, loss, and grief. Clinicians conveyed the challenges of working in an emotionally charged environment wherein they were often the communicator of bad news. Losses were particularly prominent for these participants, as they felt the nature of palliative care drew them very close to patients. Privy to some of the most intimate moments of patients, the clinicians felt this familiarity and connectedness with the patient population accentuated losses. PCCs were particularly touched by patients who were young or who had young children, as clinicians personally identified the most with these cases.

Managing patient and family expectations. A majority of the clinicians reported difficulty managing family and patient expectations, especially when their expectations conflicted with the function of and/or capabilities of palliative care. For example, clinicians described instances where patient discomfort had addictive or psychological underpinnings and could not be relieved with medication. Other patients struggled with intractable pain. Both types of cases proved to be taxing, particularly when providers and patients alike anticipated that PC involvement would lead to better symptom control. Clinicians imparted the sadness and disappointment they felt when their patients' symptoms remained unabated.

Personal challenges

Setting boundaries. Nearly all of the clinicians had trouble compartmentalizing home and work life. For exam-

ple, some struggled to keep their mind off work when at home; consequently, work stressors impinged on their moods and rendered them unable to attend to familial obligations. Relatedly, many participants had difficulty setting limits on the length of time spent with patients given their distress and evolving needs. This frequently contributed to feelings of guilt, as PCCs felt pressured to choose between cases in efforts to effectively allocate their attention. To compensate, many clinicians often overstepped their own delineated boundaries and worked longer hours in their endeavor to meet with as many patients as possible. This not only impacted their family life because of cancelled plans, but it further compounded their feelings of inadequacy, as they felt it diminished the quality of care provided.

Recognizing and accepting limitations. Most participants felt it was hard recognizing when they were feeling overwhelmed; as a result, they did not allow themselves adequate time to reflect on and process their emotions. Generally, all felt compelled to reach beyond their emotional constraints to "fix" their patients and meet the expectations of their team members.

Coping strategies

Physical self-care (i.e., diet, physical activity, sleep, hobbies). Participants acknowledged the importance of attending to their own basic needs both inside and outside of work in efforts to remain present and fully engaged in palliative care work. Part of self-care involved organizing the workplace in a way that fostered a positive and aesthetically pleasing environment. At home, participants endeavored to maintain a healthy diet (e.g., vegan, no sugar, limited caffeinated beverages) and engage in physical activity, including walking, running, dancing, hiking, and biking. Stress-reducing hobbies included cooking, gardening, reading, or knitting. Lastly, many strived to maintain healthy sleep schedules, though several reportedly struggled to establish routine sleep patterns due to their work schedules.

Emotional and physical distancing. This notion of disconnecting oneself presented as a common coping strategy among clinicians, particularly in the workplace. Several described the need to briefly disengage from their work in efforts to regain composure and preserve psychological equilibrium during challenging periods. For example, some opted to gain physical distancing by going for a walk or simply seeking a "time-out" space. At home, many engaged in mind-body techniques, such as meditation or breathing exercises. Others distracted themselves by "shutting it off" or shifting their minds to thinking about their families.

Social and emotional support. Seeking support from colleagues and friends was another frequently cited coping strategy. Almost all of the clinicians conveyed the importance of shared experiences and gaining emotional support from coworkers. Most felt comfortable approaching colleagues for help processing difficult cases; though restorative, some felt that at times it perpetuated negative emotions. Others sought opportunities to regain personal emotional nourishment through e-mail exchanges or by going out for lunch. Providers practiced similar coping styles at home,

TABLE 2. PALLIATIVE CARE CLINICIAN INTERVIEW FINDINGS: CATEGORIES, THEMES, SUBTHEMES, AND SUPPORTING QUOTATIONS

<i>Category</i>	<i>Themes and subthemes</i>	<i>Supporting quotation</i>
Systemic stressors	<i>Limited resources</i>	“Time is a huge part of it. There are days when we just have so many patients when you can hear people asking for more and you just have to put it on hold, sometimes directly address it or sometimes not.”
	<i>Competing demands</i>	“There’s no bread and butter palliative care consult these days. I feel like because people are more accepting of us and want us involved, they’re getting us involved earlier which is great....But a lot of times it feels like, ‘This is going to be difficult, or this patient has a terminal illness, so let’s just call palliative care.’”
	<i>Conflicting expectations</i>	“Recognizing that there are some things that we can’t do....I think we in palliative care are more comfortable with uncertainty....I don’t feel like the medical system or the other caregivers are as aware or accepting of that....So I feel like it’s a lot of pressure put on us in palliative care to have an outcome that we know we can’t ever get to....How do you convey that to everyone else that doesn’t make it look like you’re giving up?”
	<i>Unpredictable schedules</i>	“Sometimes I don’t know at 5:59 whether I’m going to be out at 6:00 or 6:30. You don’t know because you think [it’ll be] a 15-minute patient...and you walk through the door and there’s five family members there because they just happened to come from out of town and they have a million questions and before you know it your 15-minute...turns into an impromptu two-hour family meeting.”
Patient-centered stressors	<i>Intensity of cases</i>	“It seems like we see a younger population....[It’s sometimes very hard] to separate myself from that, because I identify with folks that are more my age...and it’s also just brutal watching young people with young children.” “You see this kind of loss and illness and suffering and you realize how vulnerable all of us are and how little control we all have....It causes me to be always aware of the fragility and even in my moments of extreme happiness, that at any moment this could change. And it’s hard to live without any barrier to that knowledge.”
	<i>Managing patient and family expectations</i>	“Maybe 60% of these patients’ pain is true physical pain that can be relieved with a medicine that I have at my disposal, and maybe another 20% is suffering existential crisis about dying and death, and maybe another 20% is anxiety or unresolved feelings about something else and I feel like I can’t address all of that myself....Yet the expectation is give me a medicine and make this all go away in a few minutes, and that can be overwhelming.”
Personal challenges	<i>Setting boundaries</i>	“We’re so used to listening to others and taking on their suffering a little bit and it’s hard to set those boundaries. I don’t know if everyone struggles this way, but I think figuring out where that boundary should be is often a little bit challenging. I don’t want to set it so far that people don’t feel they can open up to me and share with me, but I also don’t want to be at the point where I can’t stop thinking about the patients when I come home at night.”
	<i>Recognizing and accepting limitations</i>	“One of the biggest challenges is trying to sort through what I as an individual can manage and help with, and what I as part of a system need to manage and how to use the system, and also setting realistic expectations for myself but also for patients and families about what can be done and what I can do.”

(continued)

TABLE 2. (CONTINUED)

Category	Themes and subthemes	Supporting quotation
Coping strategies	<i>Physical self-care (i.e., diet, physical activity, sleep, hobbies)</i>	"I need to take a certain amount of downtime, just kind of quiet time, and so sometimes it's just cooking a meal in my house but no radio and no TV, but I just need to observe some quiet time."
	<i>Emotional and physical distancing</i>	"Sometimes I go into the bathroom and I sit in the stall for a few minutes, and just try to get some physical space where there's no one around me, and quiet space because you know nobody's going to be knocking on the door, so sometimes I just do that and take five."
	<i>Social and emotional support</i>	"We work in a really small office and I think one of the things we use to keep each other going is humor, so we joke around quite a bit with this little group of folks that we work with in the outpatient world."

wherein they often leaned on family members to process emotions; others simply made an effort to be fully present when spending time with their spouse and children. PCCs also turned to their religious community, either through prayer, attending a house of worship outside of work, or visiting the chapel during work, for spiritual strength and comfort.

Training needs and preferences

Mind-body skills training. Although several clinicians had a general awareness of relaxation skills, nearly all mentioned the desire to learn more about or fine-tune mind-body skills, including meditation, breathing, mindfulness group mantra, or yoga.

Cognitive skills. Similarly, PCCs shared a desire to acquire cognitive skills to manage stress, and to recognize and accept their limits. Interestingly, many articulated an interest in understanding how to utilize cognitive reframing, acknowledging a need to often shift their response to stress during hectic workdays. They also wanted strategies to help reduce ruminative thoughts and negative self-talk, particularly when these thoughts impacted sleep.

Stress education. Participants expressed an interest in a program that offered information about the physiology of stress and the long-term impact of stress on the body and mind. Many felt that this knowledge would help raise their awareness of internal cues, thereby providing a link between physiological signals and distressing thoughts. In effect, clinicians explained this might facilitate their recognition of specific cases or patients that triggered distress.

Brief strategies to implement in real time. A majority of clinicians stressed the need for brief strategies that could be readily integrated in the workplace. Participants uniformly agreed that it would be helpful to learn techniques to help break the day, create balance, and be easily practiced when time is limited, particularly when running between encounters. Even more, they wanted strategies they could disseminate within their own practice to both their patients and their colleagues.

Enhancing resilience. A resounding theme was the need for skills to enhance their resilience in the face of ad-

versity. A few clinicians expressed concern at the thought of remaining in this field of work for more than a few years; others desired to continue their work but worried about burning out. As a result, almost all of the clinicians voiced a need for learning skills that would allow them to stay present with their patients while at the same time effectively managing their chronic exposure to stress.

Discussion

Our findings highlight several areas of palliative care medicine that contribute to elevated distress and pose a risk for engendering burnout syndrome among palliative care clinicians. Consistent with past research,⁴ participants delineated a set of challenges that were largely associated with their work environment; specifically, time pressures, unpredictable schedules, and competing role demands were the most commonly reported concerns among these clinicians. Importantly, though clinicians identified chronic exposure to pain, grief, and loss as a stressor, they often attributed their distress to feeling powerless when patient symptoms were ambiguous or unmanageable. It is possible that these demands may elicit distress in PC clinicians because they have the potential to compromise the integral values that attract them to this field. Specifically, the central purpose of palliative medicine is the provision of compassionate and supportive care with the end goal of aiding symptom management, assisting with treatment decisions, and enhancing quality of life. Time pressures coupled with conflicting role demands may thwart clinicians' efforts to devote ample time to patients; accordingly, this can promote feelings of guilt, diminished sense of competence, and ineffectiveness as clinicians struggle to come to terms with their limitations. This may explain why clinicians in this study responded to these challenges by violating their own boundaries, often blurring the line between work and home. These findings corroborate existing studies that identify time constraints as a primary risk factor for distress among medical providers.⁶ It also highlights the importance of engendering changes in work structure and workload to facilitate resiliency and reduce clinician burnout.

In spite of these stressors, this sample of PCCs appeared to acclimate to the demands of their environment. Specifically, nearly all made some effort to engage an array of strategies to help modulate their emotional response to work strains. These findings are consistent with a recent survey of 40 U.S.

practicing hospice and palliative physicians conducted by Swetz and colleagues,¹¹ which highlight similar stressors and recommendations for preventing burnout. For instance, many clinicians strived to remain responsive to their basic self-care needs both inside and outside work by maintaining a healthy diet, remaining physically active, preserving sleep schedules, and maintaining a pleasant workstation. Further, most regularly engaged in a quiet, meditative practice or hobby in efforts to center themselves and gain emotional distancing. Elicitation of a peaceful state through the use of mindfulness and other mind-body techniques has been shown to help buffer against the negative effects of stress.¹² Equally important, participants actively sought ways to strengthen personal, professional, and spiritual relationships. These findings are worthy of attention, as the process of building resources through personal nourishment and fostering emotional, supportive connections has been evidenced to promote resiliency and thus diminish the consequences of stress.⁴

Despite the novelty of these findings, this study has some limitations. This study represents the perspectives of clinicians from only one medical institution in Boston. Because our population consisted of a convenience sample from a single institution, findings are limited in generalizability and may not reflect the opinions of clinicians beyond this sample. Future studies would benefit from understanding the experiences of clinicians across different settings to examine potential differences in stressors and training needs. Similarly, future studies would benefit from exploring the perspectives of clinicians who may have left the field due to stress or feeling burned out. Lastly, and equally important, issues of work stress and burnout is a concern for providers across diverse disciplines and specialties; accordingly, this research is applicable and should be extended to other providers who are confronted with similar challenges and daily stressors.

These findings have important implications for interventions aimed at targeting distress and promoting resiliency among PCCs. Although this sample of PCCs was well equipped with a multitude of coping strategies to manage the demands of their environment, nearly all voiced an interest in learning additional techniques they can build on to enhance sustainability and increase their likelihood of continuing to work in this field. Accordingly, targeted resiliency programs should consider providing PCCs with a collection of mind-body strategies, such as brief mindfulness and meditation, that can be readily integrated during work hours. Though many clinicians participated in some activities that elicited the relaxation response, not all clinicians had an established meditative routine. Equipping clinicians with a set of brief, mind-body tools can help regulate distress levels amidst the chaos of running between encounters, particularly when time constraints preclude their accessing other supportive resources. This is supported by research that encourages the use of present-focused approaches to help refocus clinicians who are otherwise immersed in death and dying.¹³

Future programs should also incorporate the use of cognitive strategies to help reduce ruminative thoughts and negative self-talk. For instance, helping clinicians reframe self-blaming thoughts associated with their inability to fulfill work obligations may be a fortuitous strategy. Particularly, it can help strengthen clinicians' efforts to uphold work-life boundaries as well as help move them towards personal acceptance of their

limitations. Lastly, imparting health education regarding the physiology of stress and the stress response can help clinicians recognize the physioemotional signs of stress, thereby enabling them to apply appropriate coping strategies rather than responding by overexerting themselves. Future interventions aimed at enhancing PCC resiliency and sustainability would benefit from targeting these needs to reduce the potential for burnout and ultimately improve patient care.

Author Disclosure Statement

No competing financial interests exist.

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