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Art therapy to reduce burnout in oncology and palliative care doctors: a pilot study

Megan Tjasink and Gehan Soosaipillai

ABSTRACT

Doctors are frequently exposed to work-related stressors putting them at risk of burnout and affecting patient safety. This has long been recognised in oncology and palliative care staff members, with as many as 70% of young oncologists in Europe reporting burnout. Our objective was to use art therapy, which has been shown to combat the symptoms of burnout, on a cohort of trainee doctors in these high-risk specialities. In this pilot study, an art therapist ran three courses for oncology and palliative care trainee doctors, each comprised of six art therapy sessions. The Maslach Burnout Inventory – Human Services Survey (MBI-HSS) was completed pre- and post-intervention and a feedback questionnaire completed at the end of each course. Eighteen participants were recruited. MBI-HSS scores from 14 participants showed that the mean pre-intervention scores of the participants demonstrated burnout. Following the course there were statistically significant improvements in emotional exhaustion (p=< 0.001) and personal achievement ($p = 0.011$) (removing one outlying participant's score from the latter). Feedback was overwhelmingly positive with most respondents finding the course 'very helpful'. The results of the pilot study demonstrated that six weeks of structured art therapy sessions resulted in positive change in our participants.

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Cancer; palliative care; burnout; compassion fatigue; art therapy; medical staff

Introduction

Burnout in doctors

All healthcare professionals, including doctors, need to pay attention to their well-being so that they can provide a safe and caring health service. The medical profession in the UK is facing a challenging and uncertain time (General Medical Council, 2017). There are pressures from staff shortages, increasing workloads, recent changes in the junior doctor contracts, and the impact of Brexit (General Medical Council, 2017). As care-giving professionals, doctors are exposed to stress and difficulties (Halliday, Walker, Vig, Hines, & Brecknell, 2016) as they care for patients who are frequently distressed by physical, psychological and social issues. This can be emotionally draining, putting doctors at risk of burnout (Lemaire & Wallace, 2017; Maslach, Jackson, & Leiter, 1997; Shanafelt et al., 2012).

Burnout, otherwise known as compassion fatigue, is a psychological syndrome which, in the case of public sector workers, has been shown to be detrimental to the care of patients (Maslach et al., 1997) and to the loved ones of those affected (Jackson & Maslach, 1982). Maslach described three fundamental components of burnout: feeling emotionally drained or overextended (emotional exhaustion), feeling detached from or having negative reactions towards patients (depersonalisation), and feelings of professional inadequacy, ineffectiveness and failure (lack of personal achievement) (Maslach et al., 1997).

Within the medical profession, junior doctors can be at particular risk of burnout, as they have not acquired the resilience and experience that consultants may have (Halliday et al., 2016). However, consultants are not immune to burnout. A cross-sectional questionnaire survey of UK hospital consultants showed stress was associated with emotional exhaustion, leading to poor mental health (Graham, Potts, & Ramirez, 2002). Conversely, job satisfaction protected from burnout and reduced psychiatric morbidity (Graham et al., 2002). We also know that burnout can lead to a reduction in work effort and time at work (Shanafelt et al., 2016), which in our present climate could lead to dangerous levels of staff shortages and impact on patient safety (Welp, Meier, & Manser, 2015).

Oncology and palliative care

The effect of work-related stresses on oncology and palliative care staff members has long been recognised (Huet, 2015; Italia, Favara-Scacco, Di Cataldo, & Russo, 2008; Lyckholm, 2001; Nainis, 2005; Potash, Chan, Ho, Wang, & Cheng, 2015; Whippen & Canellos, 1991). This group are more likely to be delivering bad news, managing complex symptoms and treating those where treatment has failed. Caring for dying patients may also be a significant factor, as hospice staff have been recognised as a high-risk group for burnout (Huet, 2016; Keidel, 2002).

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Surveys have shown that between 60% and 71% of oncologists experienced burnout (Banerjee et al., 2014; Whippen & Canellos, 1991). Depersonalisation was higher in men, and low personal achievement more prevalent in younger oncologists (Banerjee et al., 2014). European region of work, workforce number, patient numbers, commuting time, and relationship or children status were all factors contributing to burnout. Having no access to support, fewer hours for recreation, inadequate work–life balance and inadequate vacation time increased the chance of burnout (Banerjee et al., 2014).

A consistent cause of burnout was treating palliative patients, due to a sense of 'failure' when a patient's disease progressed or led to their death (Creagan, 1993; Whippen & Canellos, 1991). Clinicians can find interactions with patients, carers and families under these circumstances difficult and stressful. Therefore clinicians may avoid empathetic behaviours, such as acknowledging the patient's distress or discussing dying, and rather focus on treatment options (Buckman, Tulsky, & Rodin, 2011). For example, it has been shown that oncologists respond to only 11–22% of empathic opportunities and would instead respond by concentrating on medical care and change in treatment (Buckman et al., 2011). A lack of empathy or compassion fatigue may lead to lower patient satisfaction and more complaints (Buckman et al., 2011), in turn increasing doctors' stress and reducing their sense of personal achievement.

Art therapy to address burnout

There have been studies using arts therapies methods to creatively combat burnout. Music-imagery for nurses (Brooks, Bradt, Eyre, Hunt, & Dileo, 2010) and social art therapy for counsellors (Reim Ifrach & Miller, 2016) have been shown to rejuvenate and re-focus the participants, and reduce burnout respectively. Other techniques such as art viewing and discussions, and psychodynamic-narrative group work have been shown to be helpful in addressing burnout and promoting resilience (Atalia Mosek & Ben-Dori Gilboa, 2016; Huet & Holttum, 2016).

Art therapy techniques, such as art viewing and art making, have been used with doctors and nurses working within oncology and the hospice environment (Huet, 2015; Huet & Holttum, 2016). Other methods, such as creating a 'healing quilt' (Nainis, 2005), clay mask making and symbolic imagery (Belfiore, 1994), or a combination of techniques (Italia et al., 2008), have been shown to build team morale, help process emotions such as grief, and reduce burnout. A model of six weeks of art therapy was used in supervision groups to develop self-reflection, increase emotional awareness and reduce burnout in end-of-life care workers (Potash et al., 2015).

Considering that oncology and palliative care doctors, particularly trainees, are at a high risk of burnout (Banerjee et al., 2014; Whippen & Canellos, 1991), the authors felt there was an opportunity to address this issue with art therapy. The studies discussed above used a mixture of different techniques such as mindfulness, relaxation, visualisation, psychodrama and skills based supervision alongside art therapy, and therefore it can be difficult to ascertain which intervention acted as an agent of change. As a result, the authors decided to use purely art therapy methods to address burnout in this cohort.

Method

Design

The pilot study was designed in consultation with the co-author, a trainee doctor, in order to tailor it to the doctors' working context. Following consultation with the first group of participants, we decided on a structure of six sessions lasting 90–120 minutes each. This was the maximum amount of time they could commit to and the minimum intervention the art therapist felt was needed to effect change. The first two courses were conducted in the art therapy room and the third in a meeting room within a Central London hospital. The same art therapist ran each of the three courses.

The course was informed by: Potash's Hong Kong-based studies (Potash et al., 2015; Potash, Ho, Chan, Wang, & Cheng, 2014), Huet's work on art therapy and organisational consultancy (Huet, 2011, 2012) and previous Continual Professional Development (CPD) sessions the art therapist had run for clinical psychologists and clinical nurse specialists within the NHS trust.

The art therapist had worked at the hospital for over 10 years and had an in-depth understanding of the oncology context, organisational stressors and the patient group treated by the trainee doctors. The six sessions were structured and divided into three broad themes pertinent to burnout:

(1) Self-awareness and self-care.
(2) Collegial connection and the organisation.
(3) Reflecting on death, bereavement and finding meaning.

In an opt-in meeting preceding the start of the course, the art therapist explained the remit of the course, particularly in terms of the difference between art and personal therapy and the professional context of the group. The art therapist explained the rationale for offering the course and terms of participation, such as mutual respect and the need to commit to the group through regular attendance. Participants were

asked to be mindful of confidentiality and supportive of each other to enable the group to be a safe and reflective space, free from judgement. If participants agreed to engage they were asked to complete the Maslach Burnout Inventory – Human Services Survey (MBI-HSS).

Through extensive experience of working with staff groups, the art therapist was mindful of keeping participants safe within their professional roles whilst encouraging a certain amount of personal risk in sharing aspects of their broader selves with colleagues. The art therapist has found art therapy to be well placed to facilitate this delicate balance as a result of the way in which metaphor is employed to address and explore issues in a less direct manner (Moon, 2007). Similarly, art making allows strong feelings to be expressed and witnessed without the need for the maker to say very much if they choose not to (Malchiodi, 2013).

Self-awareness and self-care

The first two sessions focused on the self as a way of introduction to the group and in order to bring the fuller identities of the trainee doctors into individual and group awareness. This was felt to be an important starting point from which to build, as trainee doctors can begin to feel like faceless cogs in the healthcare system (General Medical Council, 2017; Nettleton, Burrows, & Watt, 2008). Feeling recognised and respected as an individual is a protective factor against burnout. A lack of this can impact negatively on a sense of personal achievement at work (Maslach et al., 1997; Potash et al., 2015).

The first session included the use of image making within a circle as the focus for an expression of the self (a Mandala). This creative technique has been employed throughout history by a number of cultural and religious subgroups. Jung brought it into the awareness of modern psychology as a tool for individuation (Jung & von Franz, 1964). The second session engaged the trainee doctors in reflective art making in response to an image chosen from a varied selection of art postcards provided by the art therapist.

Collegial connection and the organisation

The third session focused on an explorative and playful use of clay. After individual, guided exploration of the material, the group was invited to create a collaborative sculpture. The art therapist observed the group quietly and facilitated group reflection once the piece was completed. This approach, in which the therapist symbolises a containing, attentive parent in whose presence children feel safe enough to play, is a tenet of art therapy theory and practice (Bion, 1961; Winnicott, 1971).

In the fourth session, the trainee doctors were invited to create light-hearted metaphorical maps of the organisation, after which they made group paintings on the theme: 'What is wrong with the organisation?'. Groups were then invited to transform these paintings in order to rectify the issues. Humour was introduced intentionally in this session to facilitate collegial bonding and further develop a healthy playfulness to ease engagement with organisational issues, an area that can bring up strong feelings of powerlessness and frustration.

Reflecting on death, bereavement and finding meaning

Like the approach of Potash et al. (Potash et al., 2015), the six-week course was intentionally designed for sessions with most difficult emotional content to be towards the end when the group had had a chance to develop familiarity and trust. The final two sessions embraced in-depth reflection on memorable, upsetting and meaningful patient encounters. Participants were asked to create an image in response to a patient of theirs who had died. They used their images as a starting point for reflection on their memories. The art therapist supported them through her full attention throughout the session, reflective listening, normalising their feelings and making links between individual participants' experiences and images.

In the final session, they produced art work relating to a meaningful encounter with a patient. The art therapist validated individual experiences, whilst encouraging linking and the recognition of shared experiences in the group. Participants were asked to complete anonymous feedback forms and to complete the post-intervention MBI-HSS.

Participants

The art therapy courses were advertised locally within a large teaching hospital in Central London, to medical oncology, clinical oncology and palliative care trainee doctors via email.

Inclusion criteria: (i) qualified doctor in training registered with the General Medical Council (ii) medical oncology, clinical oncology or palliative care trainee, or currently working within the speciality as a senior house officer (iii) responsible for the care of oncology patients (iv) given permission by their clinical supervisor to be released from clinical commitments in order to attend (v) attended three or more sessions within a course (vi) completed the pre- and post-intervention MBI-HSS. Exclusion criteria: (i) failure to attend three (50%) or more sessions within a course (ii) attendance at previous art therapy courses.

The participants were a self-selecting non-randomised sample, opting in to join the art therapy courses. All participants consented for the use of their art work, MBI-HSS scores and written feedback for research purposes.

Quantitative measures

The MBI-HSS (Maslach et al., 1997) was used to assess pre- and post-intervention burnout in the participants. The questionnaire consists of 22 statements of job-related feelings that measure three subscales of emotional exhaustion, depersonalisation and personal achievement. Frequency of occurrence to each statement ('never', 'once or twice during the year', 'once a month or less', 'once or twice a month', 'once or twice a week', 'every day') correlates to a point (one to six) scale from which a total for each subscale was calculated. The authors ran a paired sample t-test on the results.

Qualitative measures

A feedback questionnaire created by the art therapist was completed at the end of both courses. The questionnaire included questions regarding experienced helpfulness and specific outcomes of the sessions as well as a chance for comments. Content analysis of the feedback was performed by both authors.

Results

Sample characteristics

There were three groups: the first group of eight participants commenced on 13 January 2015, and following regular weekly sessions, finished on 17 February 2015. The second group of two participants commenced the course on 13 June 2016, and due to delays, completed on 21 August 2016. The third group of six participants commenced the course on 16 May 2017 and completed on 18 July 2017. Each group ran roughly a year apart. As trainee doctors regularly rotate, this timeframe allowed for a new cohort of rotating doctors to participate in each course. The authors feel the uneven spread of participants on the different courses was proportionate to the enthusiasm of the supervising clinicians. In 2015 and 2017, the senior supervising clinicians encouraged and facilitated attendance. In 2016, this level of encouragement was not present and may explain the lower numbers.

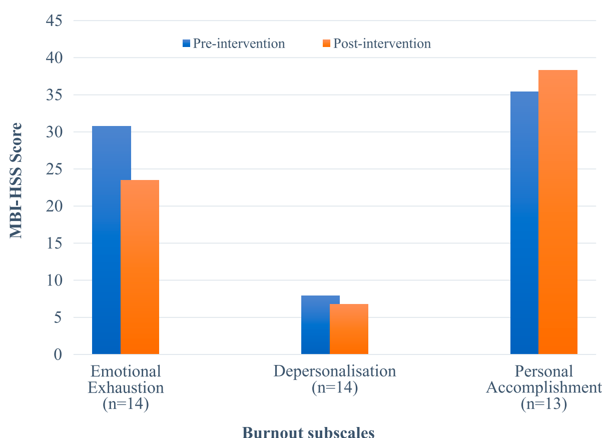


Figure 1. Mean scores for Maslach Burnout Inventory subscales.

In total 18 candidates were recruited but four were excluded from our analysis as: two candidates withdrew prior to the first session, and two candidates did not complete the post-intervention MBI-HSS survey (one attended only two out of the six sessions). Excluded candidates were comprised of two medical oncology registrars, one haematology registrar and one senior house officer.

Fourteen participants completed both MBI-HSS surveys and were included in the analysis (Table 1). Four participants were from medical oncology, four from palliative care, three from clinical oncology and three from haematology. Seven participants were included from the first course, two candidates from the second course, and five candidates from the third course. There was a preponderance of female participants (11 female versus 3 male). This may reflect the higher number of female trainees in these specialities and the self-selection of the participants. This is similar to the groups recruited by Brooks et al. (24 females versus 2 males within the intervention group) (Brooks et al., 2010).

Of the 14 participants included in the analysis, two attended every session. All participants attended the sixth session. The mean attendance was 71.4%.

Quantitative data

The data from the 14 participants was encouraging, showing a positive and significant change in two of the three subscales (Table 1, Figure 1).

Based on nine questionnaire items, the mean pre-intervention emotional exhaustion score was 30.79. According to Maslach, this score is within the 'high' range for burnout (score >27). Post-intervention, this reduced to 23.5, which was a statistically significant response ($p = < 0.001$), and put the group in a 'moderate' range (score 17–26).

Based on five items, the mean pre-intervention depersonalisation score was 7.93. This is on the lower end of the 'moderate-risk' category (score 7–12). Post-intervention this reduced to 6.79, though this was not statistically significant ($p = 0.212$), this dropped the mean score into the 'low-risk' category.

Based on eight items, the mean pre-intervention personal accomplishment score was 35.79. This score is within the 'moderate' category (score 32–38). Noting that this scale is inverse to the other two subscales, post-intervention the score increased to 37.71, which was not a statistically significant increase ($p = 0.175$). However, removing one outlying participant's pre- and post-intervention scores reveals a statistically significant result ($p = 0.011$) (with mean pre-

Table 1. Mean scores for Maslach Burnout Inventory subscales.

Subscale	Pre-Intervention (SD)	Post-Intervention (SD)	Change (SD)	Significance (*P*)
Emotional Exhaustion (*N* = *14*)	30.79 (8.31)	23.5 (7.61)	−7.29 (4.39)	<0.001
Depersonalisation (*N* = *14*)	7.93 (5.05)	6.79 (4.68)	−1.14 (3.26)	0.212
Personal Accomplishment (*N* = *13**)	35.38 (6.51)	38.31 (5.31)	2.92 (3.52)	0.011

*1 outlier participant data excluded.

intervention personal accomplishment score of 35.38, and a post-intervention mean score of 38.31).

Qualitative data

We received 11 completed feedback questionnaires. All respondents found the sessions helpful or very helpful (scale: 'very helpful', 'helpful', 'made no difference', 'unhelpful'). They particularly liked working as a group and sharing common good and bad experiences. They also appreciated a safe environment for expression:

> [I liked] the chance/space to reflect on difficult situations at work and shared experience with other doctors – we wouldn't naturally share this stuff at work; no time/space/forum in which to and also not part of the culture.

When asked what changes may have made the course more useful, most respondents wanted more sessions and were disappointed to miss sessions. They also felt that if the time was protected from work commitments take-up and attendance may have been better:

> More sessions would have been helpful as I felt that we had got into a good habit or practice and routine in breaking up the work week.

All but one of the respondents found the sessions either helpful or very helpful in addressing feelings of burnout ('very helpful' $n = 6$, 'helpful' $n = 4$). In particular, they valued reflecting on patients and their experiences with colleagues. They felt the sessions helped recognise the symptoms of burnout:

> It has allowed time to reflect on patients or experiences with other people from the same background. Talking about these have been incredibly helpful, allowing me at times to offload and share. This has been extremely helpful as a coping mechanism.

The majority of respondents found the sessions influential on their work with patients ('definitely' $n = 3$, 'yes' $n = 4$, 'maybe' $n = 3$, 'no' $n = 1$) (scale: 'definitely', 'yes', 'maybe', 'no'). They felt the sessions helped to relieve stress and had a positive and empowering effect on them at work:

> The sessions were a way of relieving stress. This helped me to relax in a busy working environment which I felt contributed in me being a more patient and empathetic doctor.

> I think I felt more resilient again and felt I was making an important difference to people's lives.

Most respondents found the sessions influential on their work with colleagues ('definitely' $n = 1$, 'yes' $n = 6$, 'maybe' $n = 3$, 'no' $n = 1$) (scale: 'definitely', 'yes', 'maybe', 'no'). Team bonding and communication were highlighted:

> The sessions helped me become more mindful and recognise the signs of burnout and communicate this to colleagues.

All respondents would recommend the sessions to other colleagues ($n = 11$). They were grateful for the opportunity, even those who were sceptical at first:

> It has been so enjoyable … It has been great to acknowledge and get first-hand experience of art therapy and to work through some of the emotional impact of our work.

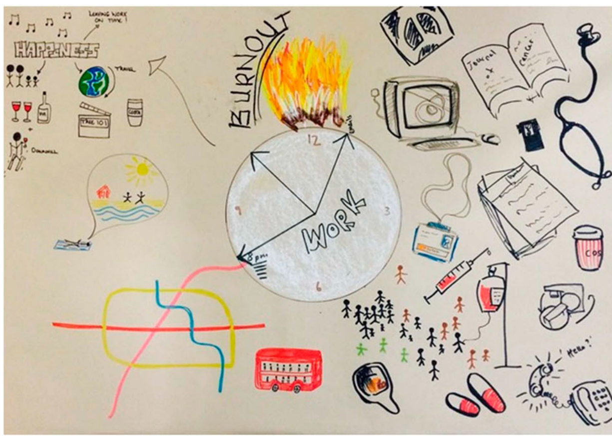
> I wasn't sure what to expect, really wasn't sure if it would help. Amazed – I have actually painted at home after a bad day at work, using my son's paints, and it helped. I would definitely recommend art therapy. Especially to doubters like me.

The qualitative feedback was very positive and the participants felt that the course helped identify and combat symptoms of burnout. The course was an enjoyable, novel experience for the participants whilst having a positive impact on their working lives.

Example artwork

Some of the key themes described are also evident in the artwork produced. Figures 2(a) and (b) are collaborative pieces, made in session 4. They were made with humour and show collegial connection and developing a shared awareness about burnout. Figure 2(c), also made in session 4, is another group painting about shared experiences of what is wrong with the organisation. This piece is a combined clock and compass that have lost their use and make no sense. It reflects a sense of chaos, lack of direction and impossible pressure. The process of collaborative art making in sessions that focused on organisational issues helped participants to achieve a very real sense of being in and working on something together. It facilitated a realisation that they were not alone in their difficulties as well as the sense of being able to address these together.

Figure 2(d) is a group piece made in the third session. Clay was introduced in order to facilitate connection with feelings and the body (Hass-Cohen & Carr, 2008). The art therapist intended the use of clay



(a)

(b)

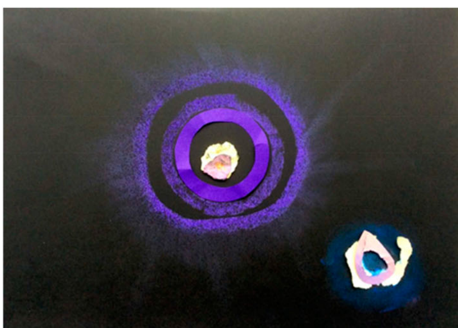
(c)

(d)

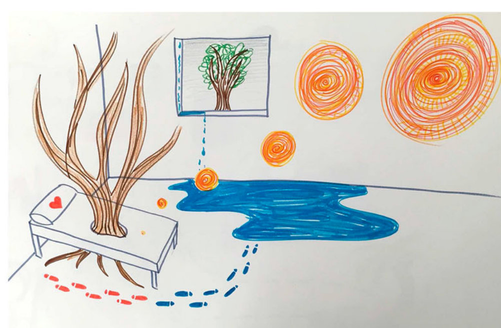
Figure 2. Collaborative pieces from sessions 3 and 4.

to support a kinaesthetic, bottom-up processing of material that the doctors may feel stuck with and had tried but failed to shift using their well-practised reasoning (top-down processing) skills. In this particular group piece, the participants commented on the unplanned emergence of an 'under the sea' theme and the prevalence of signs of death (bones) but also new life (pearls and eggs). This allowed an oblique but meaningful consideration of previously unconscious material regarding the felt experience of working within the life and death context of an acute cancer setting.

Figures 3(a) and (b), made in session 5, address death and bereavement, using metaphor to describe the emotional impact of working with dying patients. Figure 3(c) is a multi-media image which describes a



(a)



(b)

(c)

Figure 3. Individual pieces from sessions 5 and 6.

difficult but ultimately meaningful journey with a young bowel cancer patient. The patient is represented by the glittery gem in the centre and is described as unique and precious. It was by holding on to the individual identity of this patient that the doctor was able to create and maintain a sense of meaning and purpose during this challenging and sad case. Most participants reported not having previously spoken about the patients they reflected on in these final sessions. Some had been holding on to unresolved feelings and thoughts for years. Using image making as a starting point allowed a more oblique approach than talking alone and eased the difficulty of engaging with the emotive material. Quiet time making images also facilitated a slowing down and a clearing (Rappaport, 2014) which allowed and supported this rare and unfamiliar opportunity to reflect. As well as easing the verbal reflection and sharing that followed, this process also added depth and nuance. The act of remembering and creating artwork in response to the memory of past patients also had a ritualistic element. Some doctors reported relief and a sense of resolution at finally being able to mark their patient's death in this way.

Discussion

Burnout in healthcare professionals is a serious and topical issue that urgently needs to be addressed to avoid deterioration of healthcare services and patient care. The first step to combating burnout is to recognise the symptoms, followed by the ability to accept support. Doctors can find it difficult to accept and access help. Oncology and palliative care doctors have been identified as a group who are at a higher risk of burnout due to the nature of their working lives. We have shown that using art therapy can help reduce some of the burden of these symptoms, confirming the evidence from supporting literature (Belfiore, 1994; Italia et al., 2008; Nainis, 2005; Potash et al., 2015).

The first of the three Maslach subscales, emotional exhaustion, showed that the mean pre-intervention scores of our cohort were within the high-risk category for burnout (Maslach et al., 1997). The majority of the participants were unaware of this. Following the art therapy sessions, there was a statistically significant reduction in emotional exhaustion, with the scores being in line with a moderate-risk categorisation (Maslach et al., 1997).

We demonstrated a positive change in the depersonalisation scores, although this was not statistically significant. This correlates with the findings of Potash et al. (2015) who found a moderate, but not significant decrease in depersonalisation after six sessions of art therapy based supervision. However, Italia et al. (2008) measured a significant shift across all three subscales including depersonalisation after 13 sessions including art therapy alongside other methods such as psychodrama. This supports the authors' sense that a lengthier intervention may be necessary to effect significant change in depersonalisation. Of note, the pre-intervention burnout rates of the participants in this study were a lot lower than in our cohort. Potash et al.'s study (Potash et al., 2014) baseline rates are also lower, but as the Maslach Burnout Inventory – General Survey (MBI-GS) was used, it is difficult to draw a direct comparison.

The third subscale of personal achievement showed that our participants were not at high risk pre-intervention, but we managed to demonstrate a positive change in the scores following art therapy. One of the participants expressed having 'a bad day' prior to the sixth session, prior to completing the post-intervention MBI-HSS, which may have reflected on their scores. This is quite clear, as the scores are very different from those of the rest of the group. Therefore, when this outlying participant's personal achievement scores are excluded from the statistical analysis, we see a statistically significant improvement in the mean personal achievement score. It is worth noting that generally younger oncologists were shown to have lower personal achievement scores (Banerjee et al., 2014), and all our participants were under the age of 40.

Feedback from participants showed that art therapy was beneficial to develop awareness of the symptoms of burnout, to recognise the symptoms not only in themselves but also in colleagues who may need help. Participants felt more resilient and better placed to manage their stress following art therapy. Having a trusting group environment for the sessions helped participants reflect on common difficulties and realise that they were not alone in facing and managing these problems.

Study limitations

The same art therapist ran the groups; however, following the completion of the first course, more effective techniques learned through the first experience may have been used in the second and third groups. In addition to this, the two doctors in the second group had more time for discussion and reflection with the art therapist, but less input from colleagues. Whilst this does not appear to have impacted on the results it is difficult to evaluate due to the small sample size.

The group was self-selecting and therefore may not be an accurate representation of the burnout rate within their fields. The authors feel that a reluctance for some to join the course may be a reflection of the stigma surrounding burnout and seeking help within the medical profession. Data was not collected from those who chose not to respond to the opportunity. The authors also recognise that a few trainee doctors

who expressed a desire to attend did not feel able to leave their clinical commitments, despite the sessions taking place after working hours, as leaving early may be frowned upon by colleagues.

Clinical implications

This study found that a six-week course of art therapy sessions significantly reduced burnout symptoms in a cohort of oncology and palliative care doctors, whose feedback was that this impacted positively on patient care. The results could be extrapolated to other medical specialities and healthcare professionals, and supports the current evidence (Atalia Mosek & Ben-Dori Gilboa, 2016; Brooks et al., 2010; Huet & Holttum, 2016; Reim Ifrach & Miller, 2016).

Art therapy offers an inexpensive means of addressing burnout in medical professionals and, in doing so, improving patient safety. This type of intervention could be built into medical education curriculums, such as those for newly qualified or speciality training doctors. We envisage that positioning this work at a curriculum level will reduce the stigma of participation and allow for a cultural shift whereby doctors become more aware of and able to address the signs of burnout in themselves and each other. This could lead to a more stable and effective workforce who are better able to provide the quality of care patients seek.

Further research

Further research would be required to increase the sample size if studies such as this were to influence curriculum and policy. To develop the evidence base, it is important to find ways to engage male doctors, as they are under-represented in both our study and previous studies (Brooks et al., 2010). Male doctors may feel less willing to access support despite being shown to be at higher risk on the depersonalisation subscale. Further to this, it would also be helpful to collect data from those choosing not to attend. This would develop a better understanding of the full cohort's levels of burnout and also potential barriers to engagement with the course. It would be useful to ascertain whether a lengthier intervention could impact on results. It may also be helpful to measure follow-up scores, possibly after six months, in order to ascertain the longer-term effects of the intervention.

Conclusion

The issue of burnout in healthcare professionals is an acute problem, which if unaddressed can have serious consequences for the workforce and patients. Having taken a particularly at-risk group of trainee doctors in oncology and palliative care working in a large London hospital, we have found six weeks of art therapy based sessions to significantly improve their symptoms of burnout. Our study builds on a modest but growing body of evidence that shows significant promise for art therapy as an effective means of addressing burnout in healthcare professionals.

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Disclosure statement

No potential conflict of interest was reported by the authors.

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Megan Tjasink is Lead Art Psychotherapist in Cancer Psychological Services, Barts Health NHS Trust. Megan is also a lecturer and admissions tutor on the MA Art Therapy at the University of Hertfordshire. Megan studied Fine Art and Psychology at the University of Cape Town in South Africa before undertaking an MA in Art Therapy at the University of Hertfordshire. Having worked in hospice and hospital settings for nearly 20 years, Megan has formed a strong and abiding interest in art therapy not only with patients facing life threatening illness, but with the medical professionals caring for them too.

Gehan Soosaipillai is a Medical Oncology Speciality Doctor at Barts Health NHS Trust, currently taking time out of the training programme as a Clinical Research Fellow at Imperial College London. Gehan's research interests include using innovative training tools to empower clinicians to break bad news, ensure patient-centred care and facilitate advance care planning, particularly for those at the end of life. As a trainee doctor, he has seen the effects of burnout in colleagues and has worked to find solutions for this.

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