Burnout and Resilience Among Clinicians Treating Chronic Pelvic Pain: *Implications for systems of care*

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BACKGROUND

Chronic pelvic pain requiers complex, longitudinal, and coordinated care. Diagnostic uncertainty, overlapping pain syndromes, psychosocial factors, and limited access to multidisciplinary treatment may place substantial emotional demands on both patients and their clinicians. Healthcare providers who care for patients with chronic pain may be particularly vulnerable to burnout, professional isolation, and work extending into personal time. However, burnout and resilience among clinicians treating chronic pelvic pain have not been well characterized.

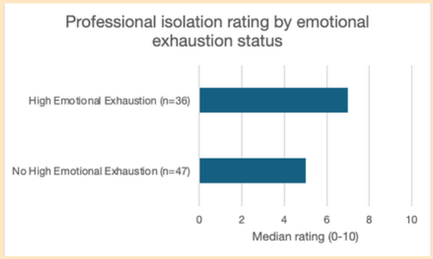
OBJECTIVE

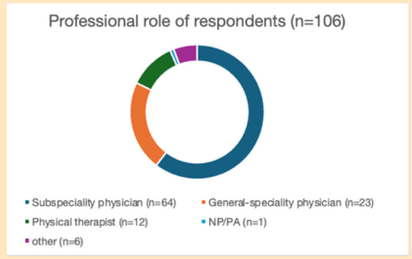
To measure rates of burnout and resilience among health care providers treating chronic pelvic pain and practice- related factors associated with emotional exhaustion and depersonalization.

METHODS

- **Design** : Cross-sectional, anonymous IRB approved online survey
- **Participants:** 106 of 193 invited members of the ICS Chronic Pelvic Pain Working Group and St. Louis University email list, from 19 countries.
- **Measurement tool:** Emotional exhaustion and depersonalization were assessed using the two-item Maslach Burnout Inventory; scores >3 were indicative of high levels. Resilince levels were measured using the two item Connor-Davidson Resilience Scale. Mann-Whitney U test, Kruskal Wallis test and Spearmans P where used where appropriate.

DATA





Mann- Whitney U=490.5, p<.001

Measure	Result
High emotional exhaustion	40/106 (37.7%)
High depersonalization	15/106 (14.2%)
Median resilience	6/8 (IQR 6–8)

The Survey



*Data analyzed using R-based Jamovi software. Jamovi V2.5, 2024, www.jamovi.org.

RESULTS

Burnout Overall: 38.7 % of clinicians met the studies definition of burnout (high emotional exhaustion and/or high depersonalization). 37.7% of participants reported high emotional exhaustion while 14.2% reported high depersonalization.

Professional isolation: Clinicians who reported high emotional exhaustion rated professional isolation as more damaging compared to their collegues with low emotional exhaustion levels (median 7 vs 5/10; p<0.001)

POLICY IMPLICATIONS

1. **Build multidisciplinary support:** Develop referral networks, reimbursed case conferences, e-consultations, or Telehealth models in areas of practice where full multidisciplinary programs are not feasible .
2. **Strengthen professional support:** Establish mentorship and multidisciplinary case discussion forums to combat rates of professional isolation.
3. **Protect clinicians' time and patient care:** Provide care professionals with shared after-hour coverage and protect documentation time that does not overlap with their personal time, while providing continuity of care for their patients.

Key take away: Burnout tracked the work environment (isolation, appreciation, pay, after-hours work), not anything clinicians did for themselves.