



4.16

Burnout, compassion fatigue, and moral distress in palliative care

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Introduction to burnout, compassion fatigue, and moral distress

Work in palliative care and, in particular, end-of-life care is associated with inherent stressors that may impact on the well-being of clinicians working in the field. Work stressors may have diverse impacts on the emotional and professional lives of palliative care and hospice staff; not only to physicians and nurses but to all members of the professional staff and, in some cases, to volunteers as well. Through their impact on professional function, these stressors can adversely affect the effectiveness and quality of care and may compromise the ability to sustain a career in palliative care.

Clinicians involved in the provision of palliative care constantly confront professional, emotional, and organizational challenges. These challenges, especially when workplace support is limited, can make clinicians vulnerable to experiencing one or more of three well-described interrelated syndromes—burnout, compassion fatigue, and moral distress—each of which can lower the threshold for the development of the others (Sundin-Huard and Fahy, 1999; Keidel, 2002; Hamric et al., 2006; Pendry, 2007; Alkema et al., 2008; Newell and MacNeil, 2010; Maiden et al., 2011; Slocum-Gori et al., 2013) (Fig. 4.16.1).

Burnout results from stresses that arise from the clinician's interaction with the work environment (Maslach et al., 2001), compassion fatigue evolves specifically from the relationship between the clinician and the patient (Booth, 1991), and moral distress is related to situation in which clinicians are asked to carry out acts that run contrary to their moral compass. Clinicians who care for dying patients are at risk of all of these (Rohan, 2005) and they can be emotionally, personally, and professionally devastating. It is vital, therefore, that palliative care clinicians are aware of these potential problems and with strategies to mitigate risks and to manage them when they present either in their own individual lives or in the work environment.

Burnout

The burnout syndrome is characterized by losing enthusiasm for work (emotional exhaustion), treating people as if they were objects (depersonalization), and having a sense that work is no longer meaningful (low personal accomplishment). It relates to work (particularly human service work) and it is often present when individuals work under constant pressure. *Emotional exhaustion* refers to feelings of being overextended and depleted

of one's emotional and physical resources. Exhaustion prompts efforts to cope by distancing oneself emotionally and cognitively from work (Maslach and Leiter, 2008). *Depersonalization* refers to negative, callous, cynical, or excessively detached responses to various aspects of the job and is another form of distancing (Maslach and Leiter, 2008). *Lack of personal accomplishment* refers to feelings of being ineffectual and underachieving at work.

These feelings may arise from a lack of resources (e.g. critical information, tools, or time) to get the work done, from overload, or from specific other stressors which may be directly related to emotional exhaustion and depersonalization or be independent of them (Maslach et al., 2001; Maslach and Leiter, 2008). Burnout tends to spread gradually and continuously over time unless circumstances alter or active steps are taken to address the factors contributing to work stress.

Better understanding of burnout can be gained by an understanding of its opposite: job engagement. Job engagement is characterized by energy, involvement, and efficacy in the workplace. Many clinicians working in palliative care express a sense of competence, pleasure, and control in their work (Vachon, 1995, 2008). Factors contributing to this desirable professional/emotional situation include feeling professionally competent and able to cope with challenges, having sustainable workload, feelings of choice and control, appropriate recognition and reward, having a supportive work environment, being treated fairly, and having a strong appreciation of the meaning and value of one's work.

Farber (Farber, 2000; Montero-Marin et al., 2009) proposed three different subtypes of burnout: 'frenetic', 'under-challenged', and 'worn-out'. The *frenetic type* is overinvested and works extremely hard (to the sacrifice of other personal needs) and is frustrated and distressed by the lack of proportionate satisfaction: success, reward, or appreciation. The *under-challenged type* is indifferent as a result of insufficient challenge, stimulation, or meaning from work. The *worn-out type* is neglectful as a result of having been overwhelmed by too much work stress and lack of proportionate satisfaction, success, reward, or appreciation for the stresses that are endured.

Symptoms and signs of burnout

Burnout can affect individuals or, sometimes, whole teams. Some of the common presenting symptoms are described in Box 4.16.1.



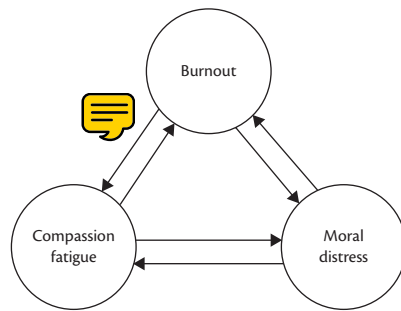


Fig. 4.16.1 The relationship between moral distress, compassion fatigue, and burnout.

Box 4.16.1 Symptoms and signs of burnout

Individual

- ◆ Overwhelming physical and emotional exhaustion
- ◆ Feelings of cynicism and detachment from the job
- ◆ A sense of ineffectiveness and lack of accomplishment
- ◆ Avoidance of emotionally difficult clinical situations
- ◆ Irritability and hypervigilance
- ◆ Interpersonal conflicts: over-identification or over-involvement
- ◆ Perfectionism and rigidity
- ◆ Poor judgement: professional and personal boundary violations
- ◆ Social withdrawal
- ◆ Numbness and detachment
- ◆ Difficulty in concentrating
- ◆ Questioning the meaning of life
- ◆ Questioning prior religious beliefs: sleep problems, intrusive thoughts, and nightmares
- ◆ Addictive behaviours
- ◆ Frequent illness: headaches, gastrointestinal disturbances, immune system impairment.

Team

- ◆ Low morale
- ◆ High job turnover
- ◆ Impaired job performance (decreased empathy, increased absenteeism).

Source: data from Maslach, C., et al., Job burnout. *Annals of the New York Academy of Sciences*, Volume 52, pp. 397–422, Copyright © 2002 and Vachon, M. L., Staff stress in hospice/palliative care: a review, *Palliative Medicine*, Volume 9, Number 2, pp. 91–122, Copyright © 1995.

Factors that contribute to burnout

The actors that contribute to burnout are complex and are often interrelated.

Workload

Workload has been identified as a major stressor for palliative care clinicians (Newton and Waters, 2001; Payne, 2001; Rokach, 2005) especially in settings of staff shortages and financial restraint. Dealing with dying patients and their families, excessive caseload of challenging patients and families, inadequate supports, excessive bureaucracy, and lack of time to talk to patients have all been identified as workload stressors. The greater the mismatch between the person and the work environment, the greater is the likelihood of burnout (Maslach and Leiter, 2008). A clear relationship between nursing shortages, understaffing, and burnout among nurses has been demonstrated (Toh et al., 2012).

Control (and training)

A sense of personal control helps people maintain emotional stability and cope with challenges in life. Perceived lack of control and actual lack of control over aspects of one's professional life are both associated with burnout (Glass et al., 1993). Lack of control may be intrinsic, related to lack of competence to cope with the challenges of patient care, self-care, or professional team dynamics. Extrinsic lack of control may relate to organizational structure or style within the work environment.

When clinicians are expected to take responsibility with inadequate training they may experience extreme lack of control. Among palliative care clinicians this may occur if they lack knowledge in interpersonal or communication skills or specific management skills in palliative care. Clinicians with inadequate training in skilled communication (Shimizu et al., 2003; Travado et al., 2005; Bragard et al., 2010), stress management (Bragard et al., 2006), recognition and management of compassion fatigue (Slocum-Gori et al., 2013), conflict resolution (Montoro-Rodriguez and Small, 2006), and symptom control all have a higher risk of burnout (Keidel, 2002; Cherny and Catane, 2003; Bar-Sela et al., 2012; Caruso et al., 2012; Fang et al., 2012).

Extrinsic lack of control may relate to any one or a combination of the following factors: work conditions, scheduling of work hours, patient allocation, patient load, clinical decisions, or organization decisions. Nurses, social workers, and other para-medical staff often feel disempowered, especially in the setting of hierarchical (or vertical) team management styles and in particular by authoritarian decision-making by physician partners who ignore or minimize the significance of their input or judgements.

Interprofessional and team issues

Team conflict, particularly between doctors and nurses or among nurses or between other members of the care team all contribute to burnout (Payne, 2001; Garman et al., 2002; San Martin-Rodriguez et al., 2005; Estryn-Behar et al., 2007; Brinkert, 2010; Bowers et al., 2011; Lasebikan and Oyetunde, 2012). Characteristics commonly seen in poorly functioning interdisciplinary care teams include lack of collaborative practice among professionals, strong hierarchical characteristics, lack of a shared philosophy of care, stifled expression of concerns, and strong professional territoriality. Often conflicts are generated by lack of common understandings of the prevailing goals of care, role diffusion issues, or differences of opinion regarding the appropriate clinical management or issues related to management style (San Martin-Rodriguez et al., 2005; Brinkert, 2010).

Values

Attitudes of clinicians towards palliative care and communication impact how care is implemented (Cherny and Catane, 2003; Lloyd-Williams and Dogra, 2003; Schreiner et al., 2004; Addington-Hall and Karlsen, 2005; Cherny, 2010). There is evidence demonstrating that the degree of congruity between personal values and the values central to the work environment predict for feelings of energy, involvement, and efficacy which are essential for job engagement (Leiter, 2008; Leiter et al., 2009). For instance, oncologists who do not highly value the psychosocial aspects of care and investment in the relief of physical, psychological, and spiritual distress report greater burnout (Cherny and Catane, 2003) and describe a greater degree of burnout, a sense of failure at not being able to alter the course of the disease (Jackson et al., 2008) when working with palliative care patients.

Moral distress (see later section) arising from situations in which one is expected to perform duties that run contrary with one's moral compass may be a major stressor contributing to distress and burnout (Sundin-Huard and Fahy, 1999). Indeed, one of the factors contributing to moral distress derives from having difficulty getting up to one's own standards or to an idealized, and often unattainable, vision of palliative care for the provision of a 'good death'.

Reward

Limited or inadequate financial rewards for the extremely challenging work of palliative care can contribute to burnout. Lack of reward may also relate to the lack of institutional reward to support the development of palliative care services or to provide for the psychosocial and supervision requirements of the clinical staff.

Emotion-work variables

Caregivers dealing with patients who die, particularly those who have had long-term relationships with their clients may experience feelings of grief, loss, or chronic grief (Vachon, 1999; Merluzzi et al., 2011). Coping with grief reactions may be challenged when patients or their children are young, when the distress and symptoms of the patient were not well controlled, and when staff feel that they were unable to deliver the best possible care to the patient when the death was contextually inappropriate such as deaths arising from the side effects of treatment. Repeated intense involvement with the distress of patients and their families in the time leading up to and after the death can traumatize health-care providers and contribute to 'the compassion fatigue syndrome' (Keidel, 2002; Rourke, 2007; Slocum-Gori et al., 2013) (see later) with its consequences which may include avoiding contact with patients, a negative self-assessment of performance, and a host of other responses that may adversely impact on personal and professional well-being and function.

Intrinsic to the challenge of providing palliative care is a delicate balance of maintaining warm supportive contact to those facing death while at the same time finding ways of not being overwhelmed by the patient's suffering, and by the challenges and burden of trying to ease that suffering.

Extrinsic factors

Palliative care staff may also have personal sources of pressure outside of the work environment. These include family, financial

health, and societal pressures, limited supports, and problems with interpersonal relationships unrelated to their roles as carers (Keidel, 2002). Professional caregivers with more responsibility for their own children or elderly parents, report more stress (Kash et al., 2000). For both women and men, the greater the number of children at home, the more difficulty with work-life balance and emotional exhaustion (Keeton et al., 2007). Being single, however, is also an independent risk factor for burnout (Ramirez et al., 1996).

Personality factors

Overinvested, highly motivated health professionals with intense investment in their profession are at a greater risk for the development of burnout (Leiter and Maslach, 2005; Anewalt, 2009). They become overinvolved and are constantly exposed to experiences of loss, awareness of their own mortality, and the termination of intense relationships (Keidel, 2002). Clinicians with this trait often display diminished awareness of their own physical and emotional needs, thus contributing to a self-destructive pattern of overwork (Anewalt, 2009). This may express itself in a 'psychology of postponement', in which they repeatedly defer attending to their significant relationships and other sources of personal reward until all the work is done or the next professional challenge is achieved (Spickard et al., 2002). A compulsive triad of an exaggerated sense of responsibility, doubt, and guilt can have an enormous impact on clinicians' professional, personal, and family lives (Spickard et al., 2002; Shanafelt et al., 2006).

Demographic variables associated with burnout

Age

Younger caregivers report more stressors and exhibit more manifestations of stress and fewer coping strategies (Vachon, 1995); they are more prone to burnout and stress reactions (Graham et al., 1996; Ramirez et al., 1995, 1996; Kash et al., 2000; Taylor et al., 2005; Kuerer et al., 2007). In contrast, some studies have found that caregivers with more years of experience are less likely to report stress-related symptoms and burnout (Vachon, 1995; Whippen et al., 2004); this, however, has not been a consistent finding (Allegra et al., 2005).

Gender

The data on gender as a risk factor is conflicted and inconclusive. Although most studies show women to be at higher risk for burnout and mental health problems (Graham et al., 1996; Kash et al., 2000; Kuerer et al., 2007), two surveys on the mental health of UK National Health Service physicians (880 consultants in 1994 compared with 1308 in 2002) found male and middle-aged consultants to be particularly at elevated risk (Taylor et al., 2005).

Epidemiology of burnout in oncology and palliative care

There has been considerable research into the epidemiology of burnout in palliative care (Masterson-Allen et al., 1985; Bram and Katz, 1989; Nash, 1989; Mallett et al., 1991; Ramirez et al., 1995; Vachon, 1995, 1999; Keidel, 2002; Swetz et al., 2009; Ostacoli et al., 2010; Pereira et al., 2011; Huynh et al., 2012; Slocum-Gori et al., 2013) and in oncology (Costantini et al., 1997; Kash et al., 2000; Lyckholm, 2001; Whippen et al., 2004; Allegra et al., 2005; Asai et al., 2006; Sherman et al., 2006; Balch and Copeland, 2007;

Kuerer et al., 2007; Arigoni et al., 2008; Liakopoulou et al., 2008; Alacacioglu et al., 2009; Mukherjee et al., 2009; Ostacoli et al., 2010; Shanafelt and Dyrbye, 2012).

A number of studies have reported that clinicians involved in palliative care had neither more nor less stress and burnout than other health professionals (Vachon, 1995, 2008; Pereira et al., 2011). Some studies seem to indicate that palliative care clinicians have lower burnout levels (in all three dimensions), particularly when compared with physicians practising in other fields such as oncology (Ramirez et al., 1995; Schraub and Marx, 2004; Asai et al., 2006; Fanos, 2007). These results may derive, in part, from the self-selection of people with congruent personal and professional values who chose to work in palliative care and the support palliative care team members give to one another (Vachon, 1995; Pierce et al., 2007).

Consequences of burnout

Dissatisfaction and distress caused by burnout have significant costs for clinicians and their families, their patients, and the health-care settings in which they work. Burnout alters both the physician–patient relationship and the quality of care clinicians provide (West et al., 2006). High levels of burnout are associated with diminished empathy and compassion, lack of professionalism, and increased risk of making medical errors (West et al., 2006; Halbesleben et al., 2008; Sharp and Clancy, 2008; Ida et al., 2009). Clinicians who manifest burnout are more likely to endorse euthanasia or assisted suicide as appropriate end-of-life options (Portenoy et al., 1997). Given the potential human costs of medical mistakes, the emotional impact of actual or perceived errors can be devastating for clinicians. Burnout also appears to influence the degree of trust and confidence patients have in their treating clinicians and patients' satisfaction with their medical care (Halbesleben and Rathert, 2008).

In addition to these professional repercussions, burnout can have profound personal consequences for clinicians, including depression, substance abuse, intent to leave clinical practice, and even suicide (Vachon, 1995, 1999; Kuerer et al., 2007). Rates of psychiatric disturbances, including depressive symptoms, anxiety, and sleep disturbances (Grunfeld et al., 2000; Kash et al., 2000; Asai et al., 2006), in clinicians working in end-of-life care ranged from 12% in a study of palliative care physicians (Asai et al., 2006) to between one-quarter and one-third of oncologists in other studies (Grunfeld et al., 2000; Kash et al., 2000; Asai et al., 2006).

Factors mitigating burnout

Some researchers have focused on factors that promote a sense of well-being and which mitigate against the effects of stress. Among the factors identified were self-awareness, hardiness (resilience), promoting a sense of control, and good team function (Ablett and Jones, 2007).

Attitudes and values

Clinicians who strongly identify with the values central to palliative care are more likely to experience and to express feelings of energy, involvement, and efficacy which are essential for job engagement (Leiter, 2008; Leiter et al., 2009). Engaged palliative care clinicians often relate to their commitment to making the most out of life and out of relationships, they derive meaning

from their contributions to the well-being of the patients and families they care for, they have realistic expectations as to what they can achieve, they are forgiving of themselves and of their colleagues when outcomes are less than optimal and they recognize that flexibility and compromise is often necessary in order to maintain coping.

Good team work

There is a substantial and growing body of evidence that well-functioning interdisciplinary team work characterized by shared philosophy of care, respectful interdisciplinary relationships, mutual trust and support, and strong culture of communication can mitigate the risk of



Box 4.16.2 Measures that may help prevent burnout and compassion fatigue

Personal wellness strategies

These include strategies that attend to personal, familial, emotional, and spiritual needs while attending to the needs and demands of patients. Suggestions for developing a good self-care plan that can minimize the impact of compassion fatigue include (Rourke, 2007):

1. Getting adequate sleep, good nutrition, and regular exercise (Jones, 2005; Wallace et al., 2009; Swetz et al., 2009; Newell and MacNeil, 2010).
2. Building relaxation into most daily activities including the regular use of tools such as meditation, deep breathing, visual imagery, and massage (Swetz et al., 2009; Wallace et al., 2009).
3. Engaging regularly in a non-work-related activity to rejuvenate and restore energy, commitment, and focus (Jones, 2005; Lovell et al., 2009; Swetz et al., 2009; Wallace et al., 2009).
4. Develop your supportive and enjoyable relationships with family and friends outside of work (Keidel, 2002).
5. Maintaining a good balance between work, family, and pleasurable activities to defuse work-related tensions (Lovell et al., 2009; Swetz et al., 2009; Wallace et al., 2009; Newell and MacNeil, 2010).
6. Monitor oneself for tendency to being over involved (Keidel, 2002).
7. Finding and allowing adequate personal time to grieve losses that come with losing a patient with whom one has a special bond (Wallace et al., 2009).
8. Self-awareness techniques including mindful communication (Jones, 2005; Shanafelt et al., 2005b; Harrison and Westwood, 2009; Rushton et al., 2009; Goodman and Schorling, 2012) and/or reflective writing (Bernardi et al., 2005; Fearon and Nicol, 2011; Meier et al., 2001, Coulehan and Granek, 2012, Wald et al., 2010).
9. Developing a specific set of coping skills, stress management, organization, time management, communication, and cognitive restructuring, to ease the challenges of day-to-day issues (Jones, 2005; Perry, 2008; Lovell et al., 2009; Newell and MacNeil, 2010).
10. Relying on psychotherapy or spiritual care, particularly for staff who are experiencing very strong emotional reactions to their work, staff who are strongly reminded of their own personal losses frequently, and those with no clear confidante in their daily lives (Holland and Neimeyer, 2005; Sinclair and Hamill, 2007; Newell and MacNeil, 2010).
11. Attending to one's spiritual needs and developing a philosophy of care that provides personal meaning and a sense of purpose in the delivery of palliative care (Holland and Neimeyer, 2005; Sinclair and Hamill, 2007; Swetz et al., 2009; Newell and MacNeil, 2010).

Professional development strategies

These approaches must recognize the realities of working in palliative care: many people die from their diseases and health-care providers are limited in their ability to relieve a patient's and family's suffering.

1. Remember who owns the problem: be interested in and challenged by your patient's physical, emotional and spiritual problems but don't make them your own.
2. Learning to handle conflict effectively (Jones, 2005).
3. Training in communication skills (Fallowfield et al., 2002; Fallowfield et al., 2003; Armstrong and Holland, 2004; Jones, 2005; Bragard et al., 2006; Shanafelt and Dyrbye, 2012; Shanafelt et al., 2012).
4. Maintaining a high level of clinical knowledge and familiarity with established clinical guidelines for management of common problems (Holland and Neimeyer, 2005; Rushton et al., 2009).
5. Engaging in peer consultation (most helpful if it occurs in a safe, confidential, and non-judgemental environment with conscious avoidance of catastrophization) (Perry, 2008; Swetz et al., 2009).
6. Developing assertiveness skills including learning to set limits, to say 'no', and to ask for what you need (Keidel, 2002).
7. Being clear and consistent with oneself and others about boundaries and personal limit-setting including taking vacations and limiting overtime and time on-call (Jones, 2005; Perry, 2008; Swetz et al., 2009; Newell and MacNeil, 2010) and maintaining a sustainable workload (Maslach et al., 2001; Jones, 2005; Kuerer et al., 2007; Maslach and Leiter, 2008).
8. Diversifying one's workload, so that not all professional time involves providing care to the most distressed patients. Examples include adding research, teaching, or other activities to round out clinical service (Quill and Williamson, 1990; Levine et al., 2005; Kuerer et al., 2007; Le Blanc et al., 2007).
9. Continuing educational activities (Robinson et al., 2004; Kuerer et al., 2007).



Box 4.16.2 Continued

10. Identifying the one or two scenarios that are most difficult and exhausting for a professional, and identifying and reviewing potential responses to use when these situations arise.
11. Finding and focusing on the positive features of one's own and one's patients' experiences (Jones, 2005; Perry, 2008; Swetz et al., 2009).
12. Connecting regularly with a respectful team of professionals that meets regularly and shares a common goal or mission (Jones, 2005; Sinclair and Hamill, 2007; Swetz et al., 2009).
13. Develop an approach/philosophy to dealing with death/end-of-life care (Jones, 2005; Shanafelt et al., 2005a).

Organizational strategies

The organization within which any palliative care provider works sets the stage for how stressful the work is, and for how effectively the provider is able to defuse that stress. It is essential that health-care organizations allocate adequate resources necessary to do the job well and provide structures for addressing compassion fatigue (Pisanti et al., 2011).

Organizations can be the focus for important interventions to prevent or reduce burnout and compassion fatigue. Some strategies that may move organizations closer to these goals include:

1. Providing adequate resources for the job, including regular and supportive supervision, continuing education opportunities, days off without undue hassle, appropriate benefits, and an overall positive work climate (Jones, 2005; Sinclair and Hamill, 2007; Newell and MacNeil, 2010; Pisanti et al., 2011).
2. Ensure schedules that accommodate work–life balance for providers as much as possible (Jones, 2005; Sinclair and Hamill, 2007; Perry, 2008; Swetz et al., 2009).
3. Providing clinical staff with physical settings that are comforting or soothing and offering meeting spaces that are appropriately furnished and private (Pisanti et al., 2011).
4. Encouraging and supporting choice and control (Shanafelt et al., 2006) and promoting fairness and justice in the workplace (Maslach et al., 2001; Maslach, 2003; Jones, 2005).
5. Appropriate recognition and reward (Maslach et al., 2001).
6. Developing a supportive work community (Maslach et al., 2001; Maslach and Leiter, 2008).
7. Adequate supervision and mentoring (Graham and Ramirez, 2002; Jones, 2005; Mackereth et al., 2005; Balch and Copeland, 2007).
8. Providing space for personal items that anchor clinicians to their lives outside of work (Pisanti et al., 2011).
9. Developing an atmosphere of respect for the work performed by palliative care clinicians (Jones, 2005; Pisanti et al., 2011).
10. Open acknowledgement, in routine and in education programmes, that compassion fatigue is an expected occupational hazard, not a weakness (Sinclair and Hamill, 2007; Newell and MacNeil, 2010).
11. Developing an interdisciplinary care team with an ethos of collaborative practice among professionals that values participation, fairness, freedom of expression, and interdependence (Jones, 2005; Sinclair and Hamill, 2007; Swetz et al., 2009).
12. Regular discussions of challenging cases, in which all team members, regardless of role, are encouraged to contribute, in an atmosphere that is safe supportive and which avoids catastrophization.
13. Mindfulness-based stress reduction for team (Cohen-Katz et al., 2004, 2005a, 2005b).
14. Meaning-centred intervention for team (Fillion et al., 2009).

Strategies particularly focused in improving self-awareness are discussed later in the section on 'Self-awareness (mindfulness) strategies'.

Spirituality and meaning

Studies of caregivers in end-of-life care have highlighted the importance of spirituality and meaning in preventing burnout (Holland and Neimeyer, 2005; Boston and Mount, 2006; Harrison and Westwood, 2009). Caregivers in oncology who rated themselves as being religious had a decreased risk of burnout (Kash et al., 2000). Huggard (2008) studied 230 New Zealand physicians and found an inverse correlation between burnout and spirituality.

Reducing burnout

Reducing burnout and promoting job engagement must include three dimensions: personal care, professional development, and infrastructural initiatives. Practical measures that may be used to reduce burnout and promote job engagement are outlined in Box 4.16.2. If distress persists despite use of these practices, and particularly if any objective impairment in functioning occurs, the clinician should seek psychiatric evaluation and treatment.

Administrators and clinical leaders have a major role in preventing or intervening in burnout (Medland et al., 2004; Estry-Behar et al., 2007; Williams et al., 2007; Sprinks, 2012).



Clinical leaders have a responsibility to monitor staff conflicts and to promote positive staff relations through the use of support and discussion groups. Palliative care services must help prepare staff members to deal with the emotional needs of the patient and family through the development of counselling skills. Stress inoculation training may be useful for teaching appropriate coping skills (Admi, 1997; Medland et al., 2004). Workshops on job stress followed by small group discussions of concerned personnel may also be useful. One-to-one discussions to discuss mutual concerns between employees experiencing a conflict are sometimes necessary. If this is not comfortable for either party, an outside professional counsellor could be used (Keidel, 2002). These organizational interventions to reduce burnout can have additional flow-on benefits of increased staff retention and satisfaction, reduced absenteeism and staff conflicts, and improved patient and family satisfaction.

Compassion fatigue

Palliative care clinicians navigate situations of severe distress and they do this challenging work in the face of the intense emotions of the incurably ill patients and their families (Alkema et al., 2008). Many of the family members may demand time and attention that is simultaneously required to be directed towards helping the patient die peacefully and without pain or distress. Since most palliative care clinicians consider attentiveness to such distress to be part of their mandate, it is near impossible for them not to be affected in some way by these interactions.

Compassion fatigue refers to the emotional impact of working with people involved in traumatic life events such as terminal illness; it has been referred to as the ‘cost of caring’, that comes from continuous compassion directed towards people in crisis (Booth, 1991). Some consider compassion fatigue to be a form of post-traumatic stress disorder (PTSD) in professional carers (Booth, 1991). Compassion fatigue is also known as secondary or vicarious traumatization (Tabor, 2011).

Clinicians may be more vulnerable to compassion fatigue in some situations than others. This is particularly true of the care of young people, be they patients or the children of patients (Robins et al., 2009), and when they are exhausted, stressed, or overworked. The intense relationships that often occur between palliative care providers and patients and their families can themselves be sources of compassion fatigue. Sometimes intense exposure to multiple deaths can lead to a feeling of ‘grief overload’ (Vachon, 1995).

The effects of compassion fatigue may endure or worsen over time, developing into serious reactions that compromise a health-care provider’s ability to interact in positive and helpful ways with patients and families (Firth-Cozens, 2001)

Regarding the relationship between compassion fatigue and burnout, while compassion fatigue may be one of the factors contributing to burnout, it is important to appreciate one can have compassion fatigue whilst at the same time maintaining engagement and enthusiasm for one’s work and with no sign of burnout (Booth, 1991; Keidel, 2002; Slocum-Gori et al., 2013).

Symptoms of compassion fatigue

Symptoms of compassion fatigue are similar to the three classic features of PTSD: hyperarousal, disturbed sleep, or outbursts of

anger, and hypervigilance; avoidance, ‘not wanting to go there again’, and the desire to avoid thoughts, feelings, and conversations associated with the patient’s pain and suffering (Wright, 2004). Compassion fatigue can have a profound impact on personal well-being and function and express itself across psychological, cognitive, and interpersonal domains (Box 4.16.3). Clinicians with compassion fatigue often have intrusive thoughts or dreams, and psychological or physiological distress in response

Box 4.16.3 Impact of compassion fatigue

Psychological

- ◆ Strong emotions (sadness, anger, guilt, worry)
- ◆ Intrusive thoughts or images/nightmares
- ◆ Feeling numb or frozen
- ◆ Avoiding the patient/family or situation
- ◆ Somatic complaints (gastrointestinal distress, headaches, fatigue)
- ◆ Anxiety or agitation
- ◆ Compulsive or addictive behaviours (drinking, smoking, shopping sprees)
- ◆ Feeling isolated or personally responsible, with no back-up
- ◆ Inability to make self-protective measures leading to maladaptive or harmful behaviours such as overworking, decision-making difficulties and a loss of sensitivity to one’s own needs.

Cognitive

- ◆ Mistrust of others (family, patient, other staff)
- ◆ Increased personal vulnerability or lack of safety
- ◆ Belief that others aren’t competent to handle the problem
- ◆ Increased or decreased sense of power or control
- ◆ Increased cynicism
- ◆ Increased sense of personal responsibility or blame
- ◆ Belief that others don’t understand the work that you do.

Interpersonal

- ◆ Withdrawal from the larger treatment team
- ◆ Withdrawal from personal relationships (because people ‘don’t understand’)
- ◆ Difficulty trusting others personally and professionally
- ◆ Over-identifying with the distress of others leading to skewed boundaries in relationships
- ◆ Detachment from emotional situations or experiences (including the patient/family)
- ◆ Becoming easily irritated with others.

Adapted from *Pediatric Clinics of North America*, Volume 54, Issue 5, Rourke, M. T., Compassion fatigue in pediatric palliative care providers, pp.631–644, Copyright © 2007, with permission from Elsevier, <<http://www.sciencedirect.com/science/journal/00313955>>.



to reminders of work with the dying (Valent, 2002; Showalter, 2010). They may manifest as either over-involvement or detachment and these can impact on clinicians' relationships with their patients, colleagues, and family members.

Among the complications of compassion fatigue are several syndromic behaviour patterns: splitting, the so-called saviour syndrome, and detachment.

Splitting

Splitting is form of good–bad polarization. It involves perceiving oneself or other members of the care team as entirely good and helpful, and others as entirely bad and extremely unhelpful. It produces intra-team conflicts and tensions that compromise team work and the cohesiveness of the care team. Additionally, caregivers may demonstrate splitting between their 'good patients' and their 'bad patients'.

The saviour (in contrast to helper) syndrome

The ultimate denial of the traumatic tragedy of terminal illness is to avoid the tragedy by rescuing the patient. Taking on the role of the saviour is one of the manifestations of compassion fatigue. It avoids the role of helping (which just feels too hard) by devoting energies to rescuing the situation. Among oncologists with compassion fatigue the saviour syndrome is often manifested as a 'counterphobic determination to treat'.

Becoming detached

Clinicians with compassion fatigue may gradually or abruptly withdraw as the emotional intensity increases. This occurs most commonly when clinicians are working alone or not being part of a supportive and collaborative team when providing end-of-life care.

Strategies to mitigate compassion fatigue

Empathic engagement between clinician and patient is at the heart of palliative care. It is hard to imagine a palliative care clinician who is not occasionally emotionally impacted by their work. The challenge is how to prevent these normal responses developing in strongly negative and destructive ways. The usual recommendation for mitigating compassion fatigue is 'good professional boundaries' (Anewalt, 2009; Hall, 2011). While professional boundaries are important, exclusive reliance on this as the main self-care strategy to prevent secondary traumatization may result in objectification, detachment, and reduced empathy. Hence, the need to consider other ways. As with burnout there has been increasing focus on factors that mitigate against the effects of compassion fatigue.

Exquisite empathy

Qualitative research on outstanding therapists who were thriving in their work with traumatized clients, including palliative care patients and their families, has identified a variety of protective practices that enhance caregivers' professional satisfaction and help prevent or mitigate compassion fatigue (Harrison and Westwood, 2009). In particular, trauma therapists who engaged in *exquisite empathy*, defined as 'highly present, sensitively attuned, well-boundaried, heartfelt empathic engagement', were 'invigorated rather than depleted by their intimate professional connections with traumatized clients' and protected against compassion fatigue and burnout (Harrison and Westwood, 2009).

This idea, which has also been referred to as bidirectionality (Katz, 2006), refutes the commonly held notion that being

empathic to dying patients must lead to emotional depletion (Pearlman, 1995; Figley, 2002) and it challenges the characterization of empathy as 'emotional liability'.

The practice of exquisite empathy is facilitated by clinician self-awareness and mindful communication skills (discussed later) which were identified in another study as the most important factor in psychologists' functioning well in the face of personal and professional stressors (Coster and Schwebel, 1997).

Resilience (hardiness) and coherence

Personal and professional resilience predicate the capacity for positive outcomes from caring even in the most challenging of circumstances. These positive outcomes have been referred to as compassion satisfaction and post-traumatic growth.

Compassion satisfaction is pleasure derived from the work of helping others. Acknowledging the risks of work-related secondary exposure to trauma, Stamm (2002) identified compassion satisfaction as a possible factor that counterbalances the risks of compassion fatigue and suggested that this may partially account for the remarkable resiliency of the human spirit.

Post-traumatic growth (Tedeschi and Calhoun, 2004) is characterized by positive changes in interpersonal relationships, sense of self, and philosophy of life subsequent to direct experience of a traumatic event that shakes the foundation of an individual's worldview (Tedeschi and Calhoun, 2004). Post-traumatic growth is not uncommon and may occur concurrently with negative sequelae of trauma (Tedeschi and Calhoun, 2004). The term describes the phenomenon of clinician growth and inspiration that results from witnessing positive sequelae of other people's experiences of trauma. This may include the clinician's feelings that his or her own life has been enriched, deepened, or empowered by witnessing the patient's or family's post-traumatic growth (Harrison and Westwood, 2009; Splevins et al., 2010). When patients experience meaning and peacefulness in relation to their approaching death, this enriches the lives of the clinicians involved. This phenomenon appears similar to the 'healing connections' identified by Mount and colleagues (Mount et al., 2007).

Research has provided empirical evidence for the construct of vicarious post-traumatic growth (Linley et al., 2005; Harrison and Westwood, 2009). Exemplary therapists who were thriving in their work with traumatized clients experienced positive shifts in their sense of meaning or spirituality. Therapists enrolled in a study (Harrison and Westwood, 2009) described having gained an expanded worldview, even paradoxically feeling enriched, as a result of witnessing the sequelae of other people's experiences of trauma. Research on exemplary oncology nurses has focused on feelings of personal growth and development derived from moments of connection, making moments matter, and energizing moments with their patients and their families (Perry, 2008).

Grieving strategies

Approaches that facilitate grieving may be useful particularly for clinicians who are exposed to frequent and multiple deaths. Approaches that have been suggested include departmental memorial services, journaling, attending a funeral, or participating in a post-bereavement family visit (Vachon, 1998).

Use of mindfulness strategies

Mindfulness strategies, which will be described in greater detail later in the chapter, focus on enhancing intrapersonal



and interpersonal self-awareness and can assist practitioners in becoming more attentive to the presence of stress, to their relationship with the sources of stress, and to their own personal capacity to self-monitor and be less emotionally reactive in stressful situations.

Use of wellness strategies

Wellness approaches have been strongly advocated as a means to mitigate against compassion fatigue (Mulligan, 2004; Benson and Magraith, 2005; Aycock and Boyle, 2009; Slatten et al., 2011) (see Box 4.16.2).

Moral distress

Clinicians working in palliative care are confronted with many ethically challenging situations. Sometimes the chosen course of clinical action runs contrary to what individual clinicians would see as the most ethically appropriate approach and yet they are expected to go along with the committed action plan that they ethically disagree with (Weissman, 2009). This is the scenario that creates moral distress.

Moral distress is a stress reaction characterized by feelings of frustration, anger, and anxiety. It occurs when an individual has a conviction of what is ethically correct but is constrained from acting in accordance with their convictions and often expected to act against their convictions (Andre, 2002; Rushton, 2006). External constraints that contribute to moral distress include power imbalances between members of the health-care team (the doctor has decided), patient or family preferences, poor communication between team members, pressure to reduce costs, fear of legal action, lack of administrative support, or hospital policies that may conflict with patient care needs. Although the phenomenon was initially described in nurses it has been identified among nearly all health-care professionals, including physicians.

Sources of moral distress in palliative care

While research has identified common sources of moral distress (Kalvemark et al., 2004; Cohen and Erickson, 2006; Ferrell, 2006; Rushton, 2006; Schluter et al., 2008), not every clinician will experience distress when faced with these situations, and some clinicians will experience distress from other circumstances.

- ◆ *Clinical decisions*: continued life support even though it is not in the best interest of the patient; inappropriate use of health-care resources, overaggressive care, nihilistic care, requests for cardiopulmonary resuscitation by terminally ill patients or their family members, inadequate pain relief, sedation at the end of life.
- ◆ *Communication issues*: inadequate communication about end-of-life care between providers and patients and families, false hope given to patients and families.
- ◆ *Resources*: when the interests of the organization override the interests of a particular patient because of limited resources or when working in situations in which appropriate medications, equipment, or staff are not available to provide optimal care.
- ◆ *Lack of staff time*: such as the distress of professional staff caused by the proportion of time devoted to administrative tasks rather than attending to the physical and psychological needs of patients and their families.

- ◆ *Rules and regulations*: this occurs when there is a conflict between the regulations and what the clinicians regard as the best for the patient. Moral distress can arise in situations in which clinicians break rules or when they are constrained by the rules against their better judgement.

Consequences of moral distress

Moral distress can commonly produce feelings of frustration, anger, and anxiety and of having been devalued and marginalized. Moral distress can be devastating, leading to nightmares, headaches, and depression (Schluter et al., 2008). Affected staff often feel disenfranchised and may be reluctant to divulge their distress and feelings of impotence. This can contribute to feelings of isolation, which is an additional threat to their self-worth. The issue of isolation is further confounded by the fact that in any given situation, not all of the involved clinicians will disagree with morality of the approach taken.

Moral distress can certainly be a factor contributing to burnout and, among nurses, it has been identified as a major risk factor for leaving either a department or the field of nursing entirely (Ferrell, 2006; Repenshek, 2009; Piers et al., 2011).

Moral distress, and the feeling that one has seriously compromised oneself or allowed oneself to be compromised tend to linger and, especially if repeated frequently, can impact adversely on self-worth. This has been called 'moral residue' (Hardingham, 2004; Epstein and Hamric, 2009).

Management of moral distress

Approaches to the management of moral distress should be developed at both an organizational level and at an individual level.

Organizational

Palliative care and hospice services must provide support resources and structures to decrease moral distress including a forum for discussing ethically troubling situations experienced in the daily practice. The development of an institutional and/or departmental culture of moral sensibility and commitment is probably the most important step that can be undertaken to relieve the burden of moral distress. Development of a strong moral culture and the provision of support structures for ethical discussions can help reduce moral distress and moral residue (Kalvemark et al., 2004). An open and interactive approach to moral conflicts can assist care providers to cope better with ethical conflicts that will always occur in their day-to-day practice. Teamwork is important since interdisciplinary issues, particularly a lack of opportunity to discuss and achieve wide consensus regarding ethically sensitive clinical decisions, often contributes to moral distress. This work can be facilitated by the development of an ethics infrastructure including the availability of ethics consultations (Schneiderman et al., 2000; Schneiderman, 2006; Pfafflin et al., 2009; Romano et al., 2009).

When similar problems tend to recur in a work setting, this often signals that there are issues in the workplace or organizational dynamic that may be contributing. Consequently, remedial approaches should focus on the work environment and organizational issues. All involved parties must engage together to evaluate the work environment or team dynamic factors that may be generating these dilemmas. Generating factors need to be evaluated to distinguish between those which are amenable to change and



those which are not. Those which are amenable to change need to be targeted. The participation of a skilled ethics consultant in such situations has been shown to help resolve underlying structural issues that sometime contribute to moral distress (Schneiderman et al., 2000; Pfafflin et al., 2009).

Individual

Palliative care staff should be trained and encouraged to recognize moral distress in their professional lives and to discuss their concerns with their peers. Managing a situation of moral distress starts with a careful evaluation of one's own position and then of the constraining issues of the other involved stakeholders. A key question is whether the constraining factors are amenable to change.

Many sources of moral distress are caused by constraints that are potentially amenable to change; for instance, the orders of a doctor, the opinion of a consultant, a family member, or a religious advisor to a patient. When constraints are potentially amenable to change, clinicians are encouraged to articulate their concerns and to possibly relieve the constraints through discussion, negotiation of the issues, or persuasion. This approach requires moral courage (Gallagher, 2011). Situations when clinicians fail to act on their concerns in the face of potentially resolvable obstacles (moral cowardice) may contribute to reactive distress or feelings of guilt for not having spoken out (Jameton, 1993).

Some sources of moral distress are caused by constraints that are rigid and which are not amenable to change. Examples may include constraints caused by rationing of limited clinical resources, and patients who demand life-prolonging interventions on the basis of inflexible vitalist religious considerations. In these situations, the primary strategy relates to coping with the challenge of providing care and trying to understand the moral reasoning that has led other stakeholders to conclusion that vary with one's own. This requires personal flexibility and adaptability. Coping theory suggests that when the preferred ethical approach cannot be achieved, flexible people can maintain a sense of control by finding an alternative satisfying way to conceptualize the situation (Thompson, 2009). This is personally and ethically challenging and it requires a different form of moral courage that incorporates the ability to see the problem from the perspective of someone else rather than one's own to be able to function and care without feeling compromised or violated. There is indeed enhanced control in the 'capacity for choice', rather than reflex, as to how one sees the differing moral perspectives.

Clinicians need to develop an appreciation that there are different ways of reasoning in ethical dilemmas, a better understanding of their own process of ethical decision-making, and create a readiness to cope with situation when other critical stakeholders come to different conclusion to their own. Team and personal strategies need to be developed to cope with situations being generated by factors that cannot be changed. Coping and flexibility are vital skills and often there is more than one right way. Clinicians need to develop an understanding that circumstances may render their best moral option unworkable in prevailing circumstances and that sometimes the best we can do is a compromise. Learning to compromise, and the insight that compromise often comes from strength rather than weakness, is an important part of 'self-compassion'.

In the face of situations contributing to moral distress there is great healing wisdom in the Serenity Prayer: 'God grant me

the serenity to accept the things I cannot change, the courage to change the things that I can, the wisdom to know the difference.' This approach, though soothing, can contribute to complacency. Betty Cherny (1932–2000) championed an inspirational version that challenges the reader to push the boundaries to render obstacles one considered fixed, as changeable: 'God grant me the serenity to accept the things I cannot change, the courage to change the things that I can, the wisdom to know the difference and the chutzpah [audacity in Yiddish] to push the boundaries.'

Self-awareness (mindfulness) strategies for prevention of burnout, compassion fatigue, and moral distress

Traditionally self-care strategies have emphasized the value of 'good professional boundaries' and 'effective self-care strategies outside the workplace.' These alone, however, can lead to emotional detachment by the clinician, leading to less job satisfaction, less patient-centred care, and less satisfied patients (Jackson et al., 2008).

Another approach to addressing loss of meaning and lack of control in life is developing greater self-awareness or mindfulness which includes four cardinal skills (Epstein et al., 2007):

1. The ability to notice and observe sensations, thoughts, and feelings even though they might be unpleasant
2. The ability to lower one's tendency to respond reactively to emotionally charged experiences
3. An enhanced ability to react with awareness and intention rather than being on reactive 'auto-pilot'
4. Focusing on experience, not the labels or judgements we apply to them (e.g. feeling an emotion rather than wondering if it is okay to feel that emotion).

It is proposed that by enhancing intrapersonal and interpersonal self-awareness practitioners can become more attentive to the presence of stress, to their relationship with the sources of stress, and to their own personal capacity to 'to self-monitor, to be less emotionally reactive in stressful situations, and to respond more skillfully to patient and family's needs' (Novack et al., 1999). This approach reduces burnout and compassion fatigue and it enhances the potential for job engagement and compassion satisfaction.

Kearney et al. have suggested that 'clinicians working in end of life care who are experiencing distress related to burnout, compassion fatigue or moral distress who use self-care strategies alone may feel as though they are drowning and barely able to come up for air, whereas self-care with self-awareness is like learning to breathe underwater' (Kearney et al., 2009).

There are a number of practical ways of enhancing self-awareness and mindfulness. These include initiatives such as participation in educational projects (Robinson et al., 2004; Le Blanc et al., 2007), and peer-support (Balint) groups (Rabinowitz et al., 1996; Benson and Magraith, 2005; Kjeldmand and Holmstrom, 2008; Bar-Sela et al., 2012). Two methods of enhancing self-awareness that have empirical data to support their effectiveness are mindful practice training (Epstein, 1999; Kabat-Zinn, 2003; Grossman et al., 2004; Shanafelt et al., 2005b; Krasner et al., 2009) and reflective writing (Frisina et al., 2004, Harris, 2006).



Mindful practice and mindful communication training

Mindful practice describes four qualities that are inherent in the behaviour of exemplary clinicians: *attenti eness* refers to the capacity to observe without making judgements that would otherwise distort or diminish one's capacity to understand. This involves monitoring one's own biases, thoughts, and emotions: observing the observer observing the observed. *Critical c riosit* refers to the ability to open up to possibilities, rather than premature closure and discarding new information or insights. *Informed e, ibilit* (sometimes referred to as having a 'beginner's mind') refers to the ability to be able to adopt a fresh perspective or to consider more than one perspective simultaneously rather than taking only a single fixed perspective on a problem. Finally *presence* which involves being there physically, mentally, and emotionally for patients, and accurately communicating an understanding of the patient's concerns and feelings back to the patient (empathy) (Epstein et al., 2007). This approach is predicated on the characteristics of mindfulness described earlier.

Mindful communication brings this approach to the situation of challenging communication encounters between clinicians

and their patients (and family members of patients) and between professional colleagues in their professional deliberations and interdisciplinary discussions. The aim of mindful practice and communication training is to contribute to the ability of clinicians to respond to challenging situations with more flexibility, greater sensitivity, and less reactivity (Shapiro et al., 2007) and enhance their capacity to be more appreciative and forgiving of themselves (self-compassion) as well as to have greater empathy for others (Shapiro and Izett, 2008).

Researchers and educators from Rochester University School of Medicine, New York, United States, reported the results of an intensive course in 'mindful communication' which included a variety of self-awareness and body-awareness exercises, narratives about meaningful clinical experiences, appreciative interviews, didactic material, and discussion. The 70 participating physicians not only reported lower burnout and lower psychological distress, but also greater empathy and psychosocial orientation in care (Krasner et al., 2009; Beckman et al., 2012).

Strategies to teach mindful practice have been developed and initiated at a number of sites including the Stress Reduction

Box 4.16.4 Some suggested self-care and self-awareness practices in the workplace

- ◆ As you walk from your car to your workplace or through the corridors of your workplace, attend carefully to the sensation of contact between your feet and the ground.
- ◆ Set your watch or telephone alarm for midday each day. Use this as a prompt to perform some simple act of centring, for example, take four deep, slow breaths; think of a loved one; recite a favourite line of poetry or a prayer; imagine weights around your waist and the words 'ground, down'.
- ◆ Reward yourself after the completion of a task, for example, an early coffee break.
- ◆ Call a 'time out' (usually just a few minutes) as way of dealing with emotional flooding after a traumatic event; call a colleague saying, 'I need a walk' or take a break.
- ◆ Stop at a window in your workplace and notice something in nature; consciously give it your full attention for a few moments.
- ◆ Take half a minute of silence or take turns to choose and read a poem at the beginning of weekly interdisciplinary team meetings.
- ◆ Before going into the next patient's room, pause and bring your attention to the sensation of your breathing for two to five breaths.
- ◆ Take a snack before the end of clinic to prevent neuroglycopenia.
- ◆ Stay connected to the outside world during the day, for example, check in with loved ones.
- ◆ Multitask self-care, for example, dictate or meditate while using the treadmill in your office.
- ◆ Use the suggested 20 seconds of hand washing in creative ways, for example, pay attention to the sensation of the water on your skin and allow yourself to sink into this experience; make this an act of conscious receiving by acknowledging to yourself 'I am worthy of my own time'; or repeat a favourite line from a poem or prayer; or sing yourself 'Happy Birthday!'
- ◆ Don't be afraid to ask the question 'Is it time for a break?'
- ◆ Deliberately make connections during the day with colleagues and with patients, for example, use humour; look for something particular or unusual in the patient's room; or notice patient's birth date or age.
- ◆ Keep a notebook and write 'field notes' on traumatic or meaningful encounters and events; occasionally take time at interdisciplinary team meetings to share this material.
- ◆ Deliberately develop a 'role-shedding ritual' at the end of the day, for example, pay attention to putting away your stethoscope or hanging up your white coat; use the drive home from work deliberately, for example, take the longer, more interesting route; listen attentively to the news, music, or books-on-tape.

Adapted with permission from Kearney MK et al, Self-care of physicians caring for patients at the end of life: 'Being connected . . . a key to my survival', *Journal of American Medication Association*, Volume 301, Issue 11, pp. 1155–64, Copyright © 2009.



and Relaxation Program of the University of Massachusetts Medical Center (<<http://www.umassmed.edu/cfm/index.aspx>>) (Kabat-Zinn, 2003), the American Academy on Communication in Healthcare (<<http://www.aachonline.org>>), the Northwest Center for Physician Well Being (<<http://www.tfme.org>>), and the Mindful Practice Programs at the University of Rochester (Epstein et al., 2007). The Mindful Practice Program at the University of Rochester has published a curriculum which is also available online (Epstein et al., 2007).

Reflective writing

Writing in a reflective and emotionally expressive way is another form of self-care that enhances self-awareness. Physical and psychological benefits of expressive writing have been demonstrated in patients (Smyth et al., 1999; Stanton et al., 2002; Petrie et al., 2004; Cepeda et al., 2008; Morgan et al., 2008; O’Cleirigh et al., 2008) and this practice has been promoted as a tool to develop reflection and empathic engagement in clinicians (Charon, 2001; Brady et al., 2002).

In this approach, clinicians are encouraged to diarize challenging and/or rewarding clinical encounters, recording personal thoughts and along with the objective clinical data of the narrative (Pennebaker, 1997; DeSalvo, 1999; Charon, 2001; Spann, 2004). Narratives can be shared and explored in small group discussions or in one-on-one supervision or debriefing. The aims of the discussion are to facilitate a reflective/evaluative approach to understanding one’s thoughts, thought processes, feelings, and responses. This approach aims to help foster better self-understanding, and the mindfulness skills described in the previous section.

Practising self-care

Although clinician self-care may happen through some of the formal practices and methods discussed earlier, it may also happen in countless informal ways as an everyday part of a physician’s working life. Many experienced clinicians have evolved what are sometimes unique yet time-tested methods of self-care. A collection of suggested self-care and self-awareness practices in the workplace are listed in Box 4.16.4.

Conclusion: ongoing tasks

There remains abundant scope for research to address the prevention and management of burnout, compassion fatigue, and moral distress in palliative care. Specifically, there remains relatively little data on the frequency and specific nature and impact of compassion fatigue and moral distress among palliative care clinicians and the knowledge base regarding strategies for management remains largely anecdotal with only a very limited evidence base to inform practice beyond expert opinion. Researchers will be aided by the well-validated tools that are available to measure burnout (Maslach et al., 1996), compassion fatigue (Bride et al., 2007), and moral distress (Eizenberg et al., 2009). We look forward to being able to revise our next edition with additional knowledge you may have generated.

Online materials

Complete references for this chapter are available online at <<http://www.oxfordmedicine.com>>.

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