Compassion fatigue

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C.R., a family physician for 6 years, had been caring for P.A., a 34-year-old woman diagnosed with advanced cervical cancer. At the time of diagnosis the cancer was locally advanced despite normal Papanicolaou test results in the past. Over time P.A. experienced increasing pelvic pain, lymphedema, and renal failure. Despite chemotherapy and surgery, the disease advanced and she developed increasing pain. She could no longer care for her 2 children, who were 6 and 9 years old. C.R. made home visits, but she was unable to control the pain and subsequently admitted P.A. to the hospital where the palliative care team was able to get the pain under control with multiple medications, including ketamine and opioids via infusion.

P.A. was transferred to the local hospice where C.R. could visit her. However, C.R. seldom visited, and when she did she never stayed longer than a few minutes with P.A. and her family. She also did not talk to the staff or the attending physician at the hospice. One day while visiting, P.A. thanked C.R. for her ongoing support and care. C.R. felt distressed to hear these words, and she suppressed tears and only nodded in response.

After P.A.'s death, C.R. continued to care for P.A.'s spouse and children; however, she dreaded these appointments. She found herself shortening the visits and being unable to mention P.A. by name to either the children or their father. C.R. began to wonder whether she was able to care for patients who were dying. Sometimes she felt anxious looking at her own children, and her husband noted that she was distant and irritable at times.

One day when C.R.'s medical office assistant asked her about taking on another patient with advanced disease, C.R. was surprised at her immediate "gut reaction" of distress and fear.

Death of a patient

Physicians do experience reactions to the deaths of their patients, although it is not a topic often talked about or researched. A quantitative and qualitative study identified that physicians early in their training and career found deaths more shocking and disturbing than more experienced physicians did.[1] The same article noted that physicians' emotional responses were influenced by their own personal experiences with losses, the degree to which they identified or felt close to the patients, and the degree to which they felt responsible for the patients' deaths.

Another study done in the United States found that the longer a physician had been caring for a patient, the more satisfying but also the more emotionally distressing the patient's death could be.[2] This is certainly the case for family physicians who might have known their patients for many years before their deaths.

What both articles noted was the lack of discussion of these emotional responses among physicians, particularly between trainees and their teachers. Although trainees tended to be more emotionally affected by the deaths of patients, they were not more likely to discuss this with senior physicians. This might highlight a cultural focus in medicine on the biomedical rather than the psychological or emotional aspects of care.

Later that day when C.R. had some time to herself, her thoughts returned to her gut reaction against taking on more patients with serious illness. She replayed the key events again in her mind, realizing that she had a sense of failure and guilt associated with the care of P.A. and her family. She also felt a deep sadness, for she had enjoyed seeing P.A. with her children during well-baby visits and had admired P.A.'s strength in learning a new language and culture after coming to Canada.

She reflected on how little energy she seemed to have for her own family when she felt weighed down by a case like P.A.'s. C.R. wondered if she was experiencing burnout.

Burnout versus compassion fatigue

Burnout results from the stresses of the clinician's interactions with his or her environment. Compassion fatigue results more from the relationship between clinician and patient. People who care for dying patients are at risk of both.

The main symptoms and signs of burnout[3] are emotional exhaustion, a sense of ineffectiveness, or dissatisfaction with work, all of which can result in cynicism and detachment from work. There can be poor sleep, difficulty in concentrating, social withdrawal, which can lead to interpersonal conflicts, poor judgment, and addictive behaviour. Physicians with burnout are more likely to make errors, and their patients are less satisfied with the quality of their care.[4] Younger physicians and those responsible for dependants at

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home (children or parents) might experience more difficulties with life-work balance and emotional exhaustion but not dissatisfaction with work.[5]

Compassion fatigue (also called *secondary* or *vicarious trauma*) compromises clinicians in their ability to care for patients because of symptoms that parallel posttraumatic stress disorder.[6] There might be an avoidance of situations in which patient suffering is involved, and intrusive thoughts or dreams of distressing symptoms. Physiologic distress can occur in response to reminders of work with dying patients. If these symptoms persist, additional stress in the environment of home or work might result in burnout.

Personal growth

C.R. was part of a team of 4 physicians who also covered for one another. After a staff meeting, one of the older physicians asked C.R. about how P.A.'s death had gone. C.R. found herself sharing her feelings of having failed P.A. and her family, and expressing her reluctance to take on more patients like this. The other physician was empathetic, and after listening to C.R. she offered her several suggestions, which C.R. decided to follow.

C.R. reviewed P.A.'s chart and noted that she and the office staff members had asked P.A. to come in for regular Pap tests after she had been treated for grade 2 cervical intraepithelial neoplasia. The results of her last Pap test 2 years before her cancer had been normal, but she did not attend for another Pap test despite multiple requests from the office. C.R. reviewed recent guidelines and noted that office procedures were up to date. She planned to attend a course on cultural competency to see how she might improve the uptake of regular health screening for immigrants.

C.R. also reviewed articles about communication during end-of-life situations and times of grief, so that she could better support P.A.'s family members when they next visited. Now she felt better able to listen and to support them, and she realized that they expected no more of her than that. She was able to accept their gratefulness for her support during the illness of their loved one. She then found herself feeling even a little energized by their visits.

C.R. decided that she needed to resume her regular exercise—something she had given up when her children were born.

Many clinicians have described their own personal growth through witnessing patient or family growth from serious illness or other traumatic events.[7] Clinicians who were able to achieve this also demonstrated self-awareness—meaning they were able to simultaneously monitor the needs and emotions of patients and families and their own subjective experiences.[8] Reflecting on one's own experience of dealing with emotionally draining circumstances, learning new skills, and finding meaning in this work seems to allow clinicians to be highly present and empathetic to the experience of suffering, as well as to feel energized rather than drained by it.[9]

A healthy physician employs multiple strategies to manage the stress of being involved in emotionally demanding patient and family situations. **Box 1**[7] suggests several strategies.

Several weeks later, C.R. discussed the strategies that she was implementing with her physician colleague. The older physician said to her, "I use a quote from the poet Kahlil Gibran to remind me why I do this work. 'The deeper that sorrow carves into your being, the more joy you can contain.' Be sure to look for the joy and allow it to fill you up. It leads to a rich life."

Box 1. Strategies for managing the stress of being involved in emotionally demanding patient or family situations

1. Practice mindfulness in the moments you have (eg, while hand-washing before seeing a patient, take slow deep breaths, think of a loved one, recite a favourite line, say a prayer, or imagine you are in a favourite place)
2. Stop to look out a window, or as you walk outside take time to notice something in nature or in your environment; fully attend to it for even a few moments
3. Make connections with patients, family members, or colleagues; this can be through humour or by noticing something about the other person or his or her environment
4. Reward yourself after completing tasks or resolving situations
5. Deliberately shed your role when you leave work and do not take it home with you
6. Use community resources and other professionals to help meet the needs of complex end-of-life situations, as one person cannot meet the needs of a whole family. With a "team approach," members can be supportive of one another
7. Know your limits. This involves not only medical limits (ie, when to refer), but also with difficult end-of-life situations with family dysfunction, mental illness, or refractory symptoms—cases in which it is challenging to achieve good outcomes no matter how hard you try
8. Learn from your experiences. Use challenging situations to motivate yourself to acquire new knowledge, skills, or attitudes
9. Do what relieves stress (eg, exercise, visit with friends, play sports)
10. Practise reflective writing or keep a diary
11. Learn and practise mindfulness meditation
12. Have a special place you like to visit as a "getaway"

Adapted from Tedeschi and Calhoun.[7]

BOTTOM LINE

- Although physicians' emotional responses to the deaths of their patients is not a topic often talked about or researched, physicians do experience reactions to the deaths of their patients.
- Burnout results from the stresses of the clinician's interactions with his or her environment. Compassion fatigue results more from the relationship between clinician and patient. Physicians who care for dying patients are at risk of both.
- With personal growth and self-awareness, clinicians are able to simultaneously monitor the needs and emotions of patients and families and their own subjective experiences. Reflecting on one's own experience of dealing with emotionally draining circumstances, learning new skills, and finding meaning in this work allows clinicians to be highly present and empathetic to the experience of suffering, as well as to feel energized rather than drained by it.

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Competing interests
None declared

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