

Compassionate Care: How Close Is Too Close?

Carolyn Gibson, Richard T. Penson, MD MRCP

"If I get too close to my patients and allow myself to become emotionally entangled in their suffering ... I risk becoming paralyzed in grief."

In 2007 an estimated 145,000 new cancer cases were diagnosed and 560,000 patients died from cancer. This ledger of human loss takes an emotional toll on clinicians who treat cancer patients and understandably may lead to feelings of failure and a desire to create distance from patients to avoid personal harm. These reactions can affect patient care and the clinician's sense of well-being, resulting in a lower quality of care and clinician burnout.

Coping with Loss

Empathy communicates compassion and understanding of an illness's emotional impact on a patient. Clinicians' strengths have inherent weaknesses, such as compassion fatigue, a form of burnout that manifests as physical, emotional, and spiritual exhaustion.^{2,3} *Closeness*, in the context of this article, describes a personal connection constructed of multiple layers that contributes to a trusting and therapeutic professional relationship between clinician and patient. The ways clinicians engage in compassionate care can equip them with resilience in the face of discouraging circumstances. However, this strength is not inexhaustible.

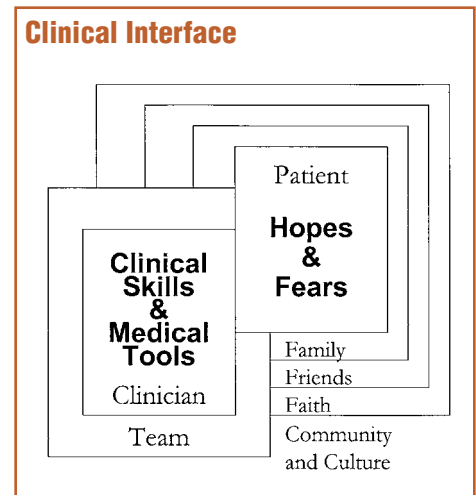
Clinicians may avoid the adverse effects of loss by proactively learning communication skills, coping methods, and strategies for personal reflection in a functional team approach. In intense situations, formalized mentorship can safeguard accountability in the face of transference and countertransference. In a traditional model of a patient-centered relationship, the patient is at the center of a circle with the patient's family and physicians on the periphery. A more accurate model involves multiple

bidirectional arrows between the patient and the care team, including physicians, nurses, social workers, family members, and friends. The broader context of culture and community interface with prior experiences and future expectations.³ A model that attempts to summarize this is presented in the figure to the right.

Burnout

The benefits of longitudinal care have been demonstrated in a variety of clinical settings, most extensively in oncology and general internal medicine.⁴⁻⁸ Studies have demonstrated that better communication and more compassionate care reduce patient anxiety and depression, increase patients' ability to adjust psychologically to their diagnosis, and improve quality of life.⁹⁻¹⁴ Furthermore, longer durations of care and less physician experience correlated with greater emotional reactions in one study of randomly selected recent in-hospital patient deaths.¹⁵ Strong identification with the patient, recent significant deaths of other patients, personal distress or family dysfunction, and feelings of failure or inadequacy hasten the erosion of emotional reserves.^{3,16} Inevitably, the way in which a clinician copes with issues of death and dying is influenced by the emotional baggage brought to the workplace.¹⁷

Professional burnout is a syndrome of emotional exhaustion, depersonalization, and sense of low personal accomplishment that results in decreased quality of work.¹⁸ Burnout has been investigated in multiple specialties, including oncology. Several studies of oncologists have demonstrated that emotional difficulties that result from



carrying for very sick and dying patients add significantly to the risk of burnout. In addition, multiple studies have demonstrated that physicians in training are at a particularly high risk for burnout, often secondary to issues surrounding end-of-life care. The development of effective healthcare teams, good relationships with patients, and positive coping mechanisms appear to help prevent burnout. Hale and Hudson have perhaps best described the evolution of negative defense mechanisms in junior doctors. These included denial, chronic hypomania, intellectualism, counterphobic behavior, acting out, and self-destructive behavior.¹⁹

A survey by the American Society of Clinical Oncology (ASCO) found that the majority of oncologists still do not receive the training necessary for competence in end-of-life care.²⁰ Multiple studies have confirmed the inadequacy of training in this area.²¹ Several initiatives have been developed to meet this challenge, including the Project to Educate Physicians in End-of-life Care (EPEC), which has developed a col-

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laborative program with ASCO and the National Cancer Institute, EPEC-Oncology, specifically for the field of oncology, which is based at several medical schools and cancer centers. These initiatives further the education of physicians and oncologists in the care of very sick and dying patients.

Objective data demonstrating benefit in terms of coping strategies are more difficult to obtain, but there is a strong belief that a more developed exploration of the issues inherent in palliative oncology leads to better adjustment during traumatic events. Qualitatively, this appears to be the case and has been reported in several forums developed for oncology fellows.^{22,23}

Establishing Closeness

Dealing with the death of patients is an emotionally laden experience for physicians, particularly physicians in training, and can deeply affect their overall outlook on life and their practice of medicine. At the core of this problem is determining the appropriate degree of closeness between patient and physician; physicians should be able to inhabit the role of empathic healer without losing a sense of self or objective clinical judgment. Pusari described eight caring elements for care in terminally ill patients: clinical competence, confidence, conscience, commitment, courage, culture, communication, and competent compassion.²⁴ Caregivers should not allow aloof disinterest or dispassion to mark their medical care of patients who are helplessly troubled by an existential and emotional crisis.

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