Compassion Fatigue

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Learning Objectives

- Define compassion fatigue and the risk factors for developing compassion fatigue.
- Identify the effects of unaddressed compassion fatigue.
- Apply one activity to alleviate compassion fatigue in their practice.

Compassion fatigue

in The Stem Cell transplant Experience

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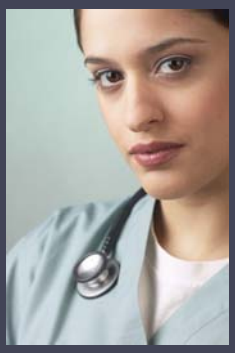
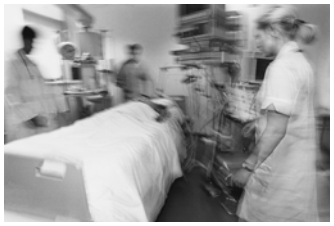
Compassion Fatigue



The cost of caring for others in pain

DIFFERENTIATING BURNOUT FROM COMPASSION FATIGUE



BURNOUT =
Stresses clinicians experience within and related to the work environment

COMPASSION FATIGUE =
Stresses related to the relationships between clinician and patient

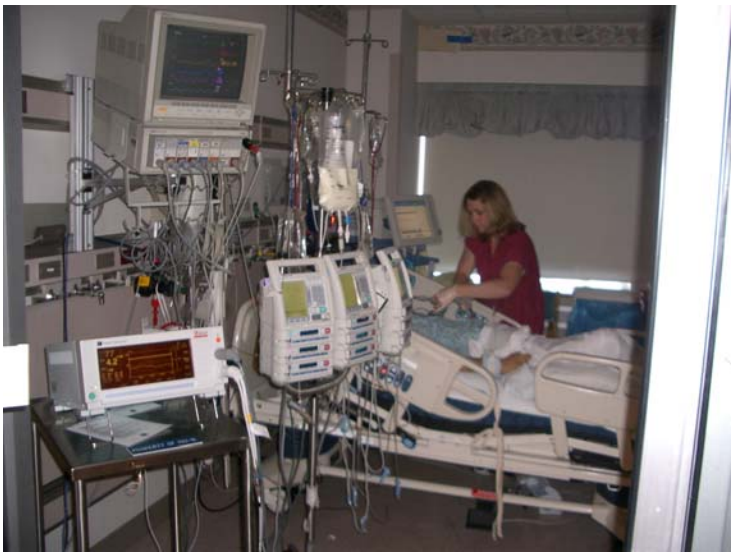
Compassion Fatigue Historically Defined

Compassion fatigue is debilitating weariness brought about by repetitive, empathic responses to the pain and suffering of others.

Unique Corollaries of Compassion Fatigue in Health Professionals

- Education preparation gap
- Need for protracted compassion
  - Sustained intimacy
  - Affective weariness
- Neglected grief
- Vicarious trauma
- **Moral anguish/distress**
- Mourning aversion
  - Isolation
- Lack of self care

Over Time …



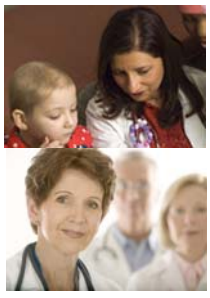
Working Definition

Healthcare professionals' compassion fatigue refers to an emotional state with negative (i.e., psychological, physical, spiritual) consequences that emanate from intense interpersonal stress where patient/family-related traumatizing events are witnessed in the work environment over time. This stress revisits personal unresolved trauma experienced. Yet despite repeated recall, the stress remains neglected. The cumulative effects of compassion fatigue result in personal and professional consequences that impact social and work-related performance.

Boyle & Bush, 2008

Factors Influencing the Risk for Compassion Fatigue

- Age
- Identification
- Personal loss
- Cumulative loss
- Personal stressors
- Experience/tenure



Unique Corollaries of of the Transplant experience

- For many, you don't walk them through their journey, you walk **WITH** them through their experience
- **What you witness …**
  - Isolation/aversion/discriminati
  - Dependency
  - Symptom distress
  - Confusion
  - Family chaos
  - Futility
  - Missed opportunities
  - Premature dying

The expectation that we can be immersed in suffering and loss daily and not be touched by it, is as unrealistic as expecting to be able to walk through water without getting wet. This sort of denial is no small matter.

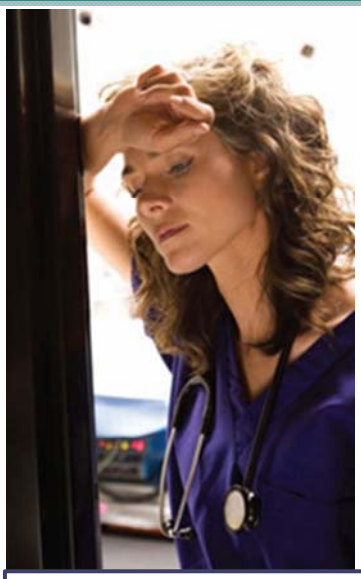
Rachel Naomi Remen M.D.
Kitchen Table Wisdom: Stories That Heal

The capacity for compassion and empathy seems to be at the core of our ability to do our work and at the core of our ability to be wounded by the work.

How Much Work-Related Unattended Sorrow Have You Experienced?

Unattended Sorrow Inventory

- Years in your health profession ____
- Monthly estimate of distress episodes ____
- Yearly # these situations ____
- Cumulative estimate of exposure ____



What do you do with your feelings?

How good are you at recognizing compassion fatigue in yourself and others?

Characteristics of Compassion Fatigue

- Feelings of depression, responses of negativity
- Lethargy, little energy
- Sadness, emotional lability or response out of context to situation severity
- Sustained effort to subdue mounting melancholy
- Boundary issues/overextension
- Lack of attention to self (i.e., diet, exercise, personal enjoyment)
- Reward substitution (i.e., food, ETOH)

How Do I Know If I Have Compassion Fatigue?

- **Difficulty accepting feedback (+ or -)**
- **Job transfer, turnover**
- **Impatience with family or issues not deemed 'life threatening'**
- **Frustration with partner insensitivity to needs**

Undertaking a Personal Inventory

- **Current stressors:**
  - Work
  - Family (nuclear & extended)
  - Roles
- **Strengths**
- **Reactions to death & dying**
- **Self-care intervention audit**

Balanced Wellness Wheel

Out-of-Balance Wellness Wheel

In traditional Native American teaching, it is said that each time you heal someone, you give away a piece of yourself until at some point, you will require healing.

Source: Mark Stebnicki (2008). *Empathy Fatigue.* Springer Publishing: New York.

Moral Distress in Stem Cell Transplantation Care

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Moral Distress Healthcare Provider

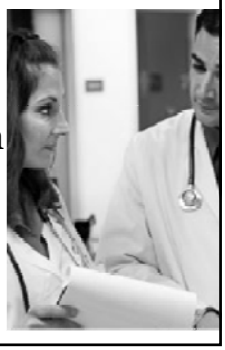
- Painful feelings or state of psychological disequilibrium that results from recognizing the ethically appropriate action, yet not taking it because of such obstacles as lack of time, supervisory reluctance, an inhibiting medical power structure, institutional policies or legal considerations (Corley, Nursing Ethics, 1995; Erlan & Sereika, 1997; Livingston & Livingston, 1984; Sorlie, et al. 2005)

Moral Distress/Compassion Fatigue – Incidence and Impact

- Moral distress and compassion fatigue experienced by 60% HSCT nurses - NMDP System Capacity Initiative nurse survey
- Rated very high importance (2.54, 0-3 scale) content survey included for ONS/ONCC HSCT certification
- Major potential for impacting recruitment and retention not just nurses but all disciplines

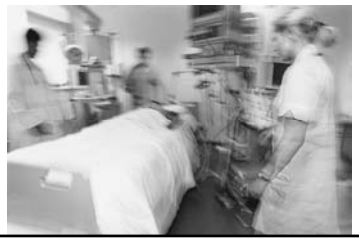
Factors leading to Moral Distress and/or Compassion Fatigue

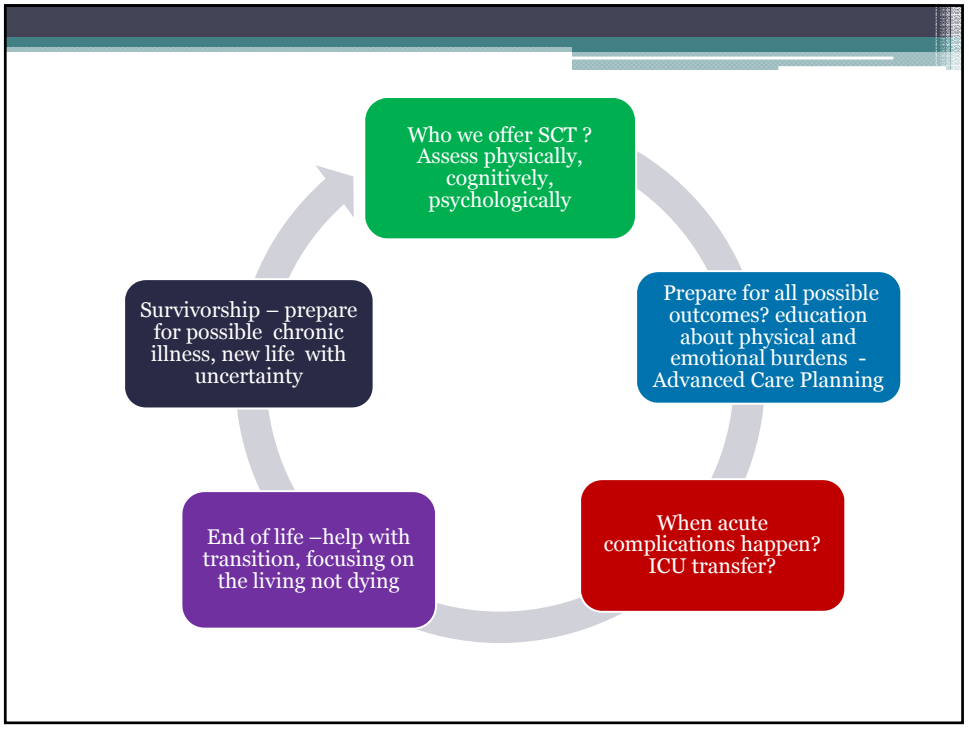
- Unrealistic expectations (patient/ family/provider) what we CAN do
- By not tell patient/family likely outcome denying the opportunity to decide how they will spent the rest of their life (however long)
- Not having a voice to share observation and concern
- Not understanding and accepting each others perspective



Factors specific to HSCT contributing to Moral Distress

- Patient/donor selection
- Preparing patient
- Life-threatening complications
- End-of-life care





Who should be offered transplantation?

Case responses= do NOT proceed	Ethicist (n=22)	Nurse (n=260)	MD (n=250)	SW (n=60)	P value
Current suicidal ideations	82%	85%	89%	85%	0.45
Current use of addictive/illecit drugs	86%	80%	82%	84%	0.80
History of non-compliance	68%	83%	79%	75%	0.20
Living far away, no caregiver	64%	67%	71%	68%	0.71
Patient told he is alcoholic	64%	66%	65%	60%	0.87
Mild dementia (early Alzheimer's)	27.3%	68%	63.5%	52%	<0.001

Foster, McLellan, Rybicki, Tyler, & Bolwell (2009) Ethical reasoning about pt. eligibility in allogeneic BMT based on psychosocial criteria. BMT 44, 607-612.

Patient/donor selection

Potential Issue	Moral dilemma
Potential SCT patient with relapse or less than optimal condition(co-morbidity) No reliable caregiver for recipient identified pre-SCT Lack of compliance by recipient pre-SCT Current or excessive drug/tobacco/alcohol use/abuse Donor not cleared by unbiased provider	Benefit vs. burden Do no harm Dilemma: feeling the need to proceed despite indicators to the contrary, obligation dilemmas Interpersonal moral conflict between team members Limited resources – good stewards.

Methods to address

- Team decision and promotion of transparency:
  - Provide opportunities for input from team members in a patient-review forum
  - Provide opportunity for team to witness discussions and consent sessions of patient/donor's preparation
- Presence of inpatient/outpatient team at care conference discussed risks have been reviewed w/subject prior to proceeding with poor prognosis, no reliable caregiver
- Compliance 'trial' to determine improvement pre-SCT
- Donor evaluation by MD not caring for recipient to review risks/benefits

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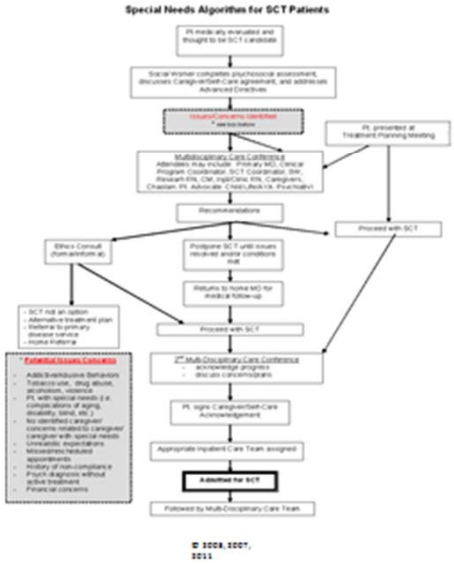
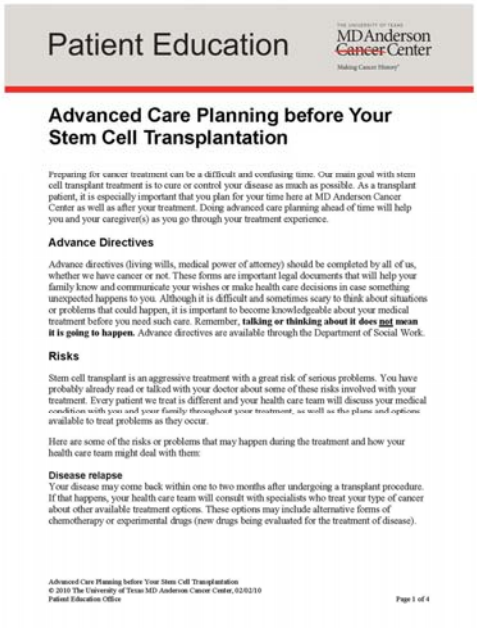


Preparing the patient

Potential Issue	Moral dilemma
Informed consent-process Continual patient education Patient autonomous: decision-do they really understand risk Do they have choices?	Veracity Autonomy – Advanced Care Planning/Advance Directives

Methods to address

- Educate and discuss advanced care planning with patient before treatment starts, suggested guides include:
  - Center for Practical Bioethics' Caring Conversations(http://practicalbioethics.org/about/model-and-methodology/making-your-wishesknown-for-end-of-life-care/)
  - Respecting Your Choices developed at Gunderson Lutheran in La Crosse, Wisconsin (http://respectingchoices.org)
  - Five Wishes provided by Aging with Dignity (http://www.agingwithdignity.org/fivewishes.php)
- Patient education about complication
- Documentation in medical record



Patient Education

MD Anderson Cancer Center

Advanced Care Planning before Your Stem Cell Transplantation

Preparing for cancer treatment can be a difficult and confusing time. Our main goal with stem cell transplant treatment is to cure or control your disease as much as possible. As a transplant patient, it is especially important that you plan for your time here at MD Anderson Cancer Center as well as after your treatment. Doing advanced care planning ahead of time will help you and your caregiver(s) as you go through your treatment experience.

Advance Directives

Advance directives (living wills, medical power of attorney) should be completed by all of us, whether we have cancer or not. These forms are important legal documents that will help your family know and communicate your wishes or make health care decisions in case something unexpected happens to you. Although it is difficult and sometimes scary to think about situations or problems that could happen, it is important to become knowledgeable about your medical treatment before you need such care. Remember, **talking or thinking about it does not mean it is going to happen.** Advance directives are available through the Department of Social Work.

Risks

Stem cell transplant is an aggressive treatment with a great risk of serious problems. You have probably already read or talked with your doctor about some of these risks involved with your treatment. Every patient we treat is different and your health care team will discuss your medical condition with you and your family throughout your treatment, as well as the plans and options available to treat problems as they occur.

Here are some of the risks or problems that may happen during the treatment and how your health care team might deal with them:

Disease relapse

Your disease may come back within one to two months after undergoing a transplant procedure. If that happens, your health care team will consult with specialists who treat your type of cancer about other available treatment options. These options may include alternative forms of chemotherapy or experimental drugs (new drugs being evaluated for the treatment of disease).

Advanced Care Planning before Your Stem Cell Transplantation
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Patient Education Office

Page 1 of 4

MDACC SCT patients completion of AD

	7/03 (100 pt)	7/09(50 pt)	8/11 (64 pt)	3/13 (72 pt)
Have AD	39%	42%	50%	47%
Copy at time of admission	30%	32%	35%	—
Copy in chart (hard copy or scanned)	15%	32%	35%	40%
Both LW and MPA	19%	34%	21%	31%
Requesting continued treatment-terminal or irreversible condition	1%	1%	1%	1%

When Life-threatening Complications Occur

Potential Issue	Moral dilemma
Potential dilemma between needing to fill "cheerleader" role vs. providing realistic information/expectations (patient/family ask, will I get better? What do you think I should do?) Patient/family/ICU staff (ICU staff is different from usual HSCT staff)	Veracity – truth telling vs. support hope Autonomy : let patient say enough 

Methods to address

- Ensure consistent communication with patient/family with HSCT and ICU teams present in order to provide more seamless info/expectation for patients and providers
- Palliative care consult, if not done earlier
- Utilize models such as : Physician Orders for Life-Sustaining Therapies (POLST)

End of Life Care

Potential Issue	Moral dilemma
Team members ability to share ideas/ opinions about care situation Mutual care goals (curative vs. comfort) Shared decision making, appropriateness of orders activated (i.e. DNR/AND)? Patients' symptoms being adequately managed (i.e. pain control, delirium) Family supported to focus on the patient vs. machines/numbers	Level of appropriate care (futility) orders Care congruent with goal Veracity (truth telling) Dignity of patient/provider Autonomy – opportunity for patient to decide what is important Good stewards of limited resources

Methods to address

- Care conference with patient family interdisciplinary team
- Established goal of care and communicate clearly
- Palliative /hospice care continued involvement
- Debriefing/counseling service
- Formal, structured, scheduled (monthly, bi-monthly, quarterly) rounds/conferences to allow discussion as described above (models such as Schwartz rounds).

Suzanne Ezzone, editor
ONS publisher