



Compassion Fatigue: what doctors tell us

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Managing compassion fatigue: Implications for medical education

Acknowledgments:

Associate Professor Robyn Dixon
School of Nursing, FMHS, University of Auckland

Associate Professor Linda Cameron
Department of Psychology, FoSc, University of Auckland

The 253 Resident Medical Officers who participated in this phase
of the study

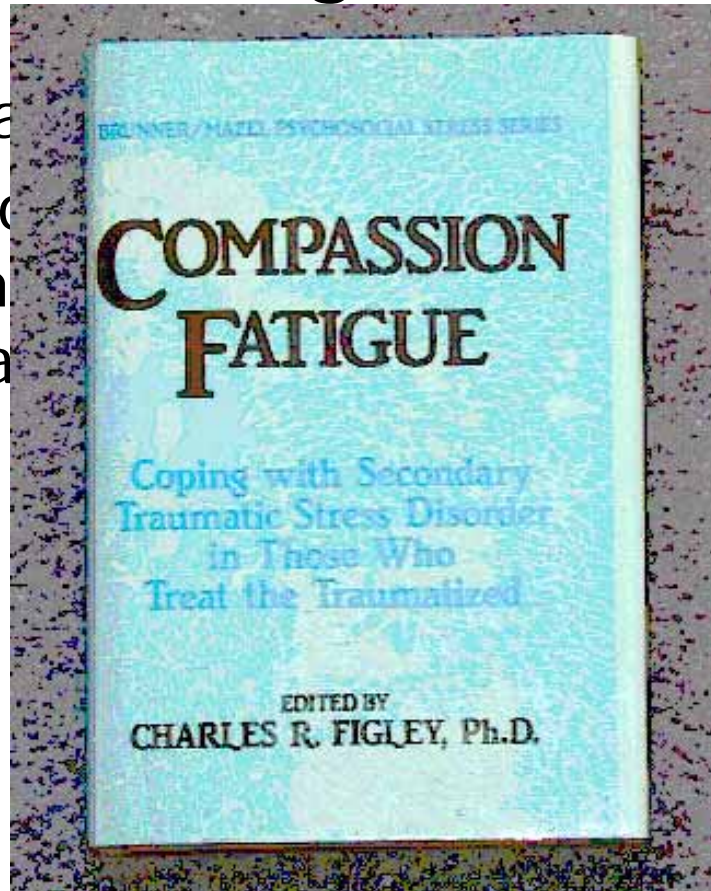
Sometimes, in discussions about burnout, compassion fatigue, and vicarious traumatisation, we call to mind incidents, patients, families, that have been significant in our lives, and at times, the very painful memories of these events



If these memories do re-surface, think about why they have returned, and the significance of them for you – recall to mind the support that you do have in your own personal and professional life

Compassion fatigue

. . . the nature
and emotional
a traumatic
significant



behaviours
knowing about
caused by a
(1995)



Charles Figley

Burnout

Maslach Burnout Inventory

- Emotional exhaustion
- Depersonalisation
- Reduced personal accomplishment

Compassion satisfaction

. . . an expression of the positive aspects of care-giving (Stamm, 2002)

Beth Stamm



CF - PTSD

CF-PTSD

intrusion
avoidance
hypervigilance

The person has been exposed to a traumatic event in which both of the following were present:

- (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
- (2) the person's response involved intense fear, helplessness, or horror

DSM IV-TR (2000)

I don't want to "pathologise" what I'm talking about, however, . . .

You can't wash the tears from someone's face without getting your hands wet

Who cares for the carers?

Caring for the carers, cares for the cared-for

Current study

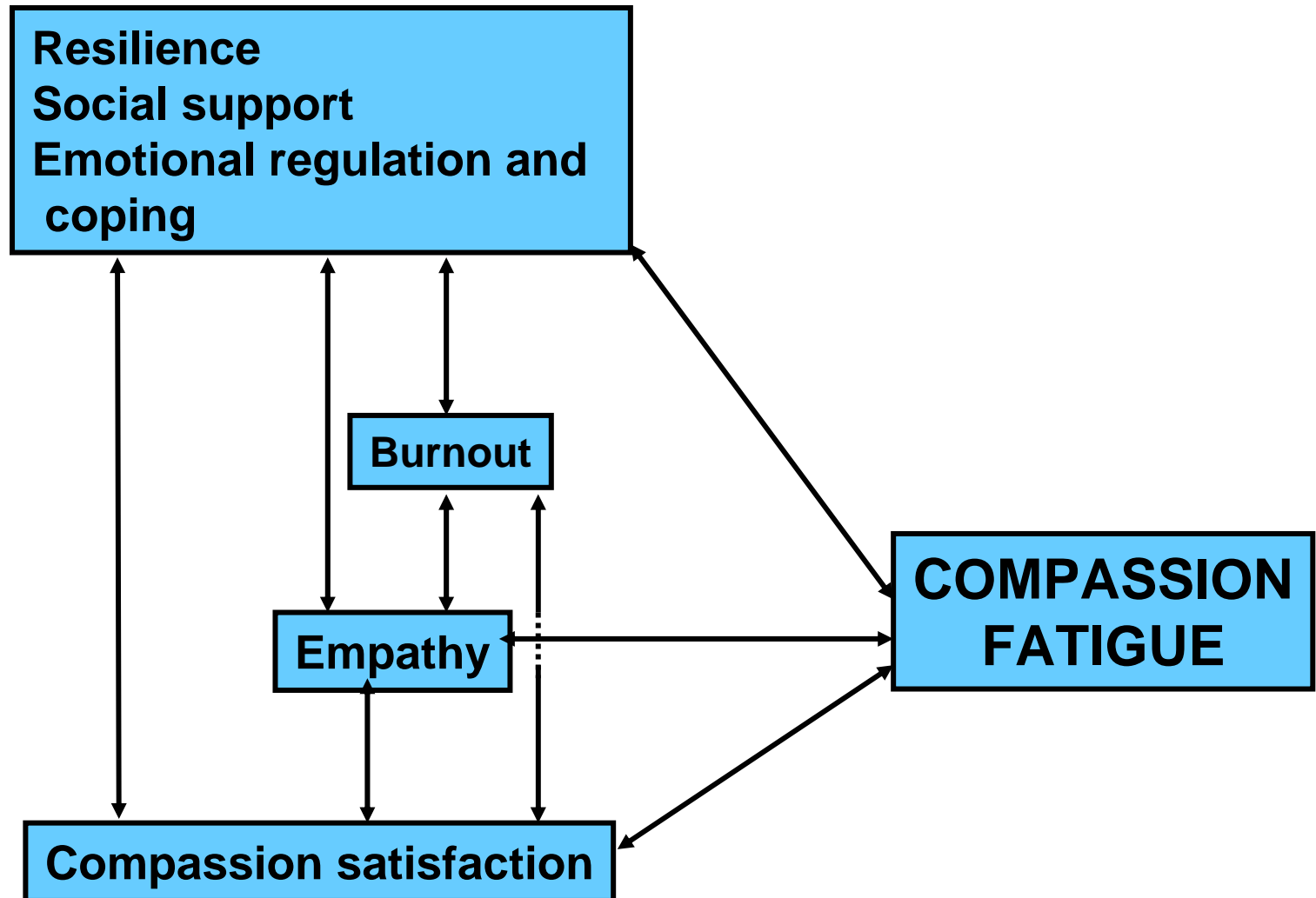
The 3 Ps of compassion fatigue

Prevalence

Predictive factors

Protective factors

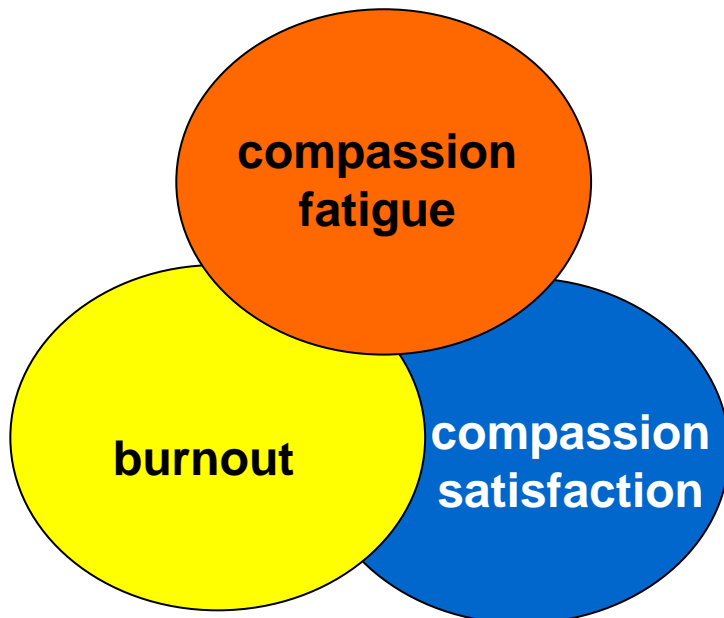




Measures

Prevalence:

Compassion Fatigue, Burnout &
Compassion Satisfaction:
Professional Quality of Life Scale
(Stamm, 2002)



Predictive & Protective Factors:

Resilience:

Connor-Davidson Resilience Scale
(Connor & Davidson, 2003)

Empathy:

Jefferson Scale of Physician Empathy
(Hojat, 2001)

Spirituality:

Ryff's Scales of Psychological Well-being
(van Dierendonck, 2003)

Emotional Regulation & Support Seeking:
(Huggard, 2003)

Methodology & Demographics

Anonymous questionnaire to Registered Medical Officers (n=1100)

Distributed twice

Quantitative measures plus qualitative comments

One-on-one interviews

n=253

Male = 40%, Female = 60%

New Zealand Pakeha = 53%

Mean age = 31 years

Mean time since finishing medical school = 7 years

Results

		Compassion Satisfaction	Burnout	Compassion Fatigue
N	(valid)	230	226	222
Mean		29	24	13
Range		34	38	40
Minimum value		10	3	0
Maximum value		44	41	40
Percentiles:	25	25	20	8
	75	34	28	17
Reference values:	Mean	37	23	13
Percentiles:	25	31	18	7
	75	42	29	18

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Resilience

Empathy

Spirituality

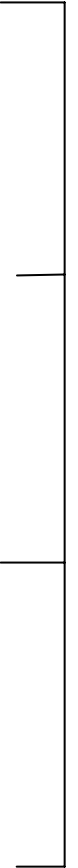
Emotional Regulation

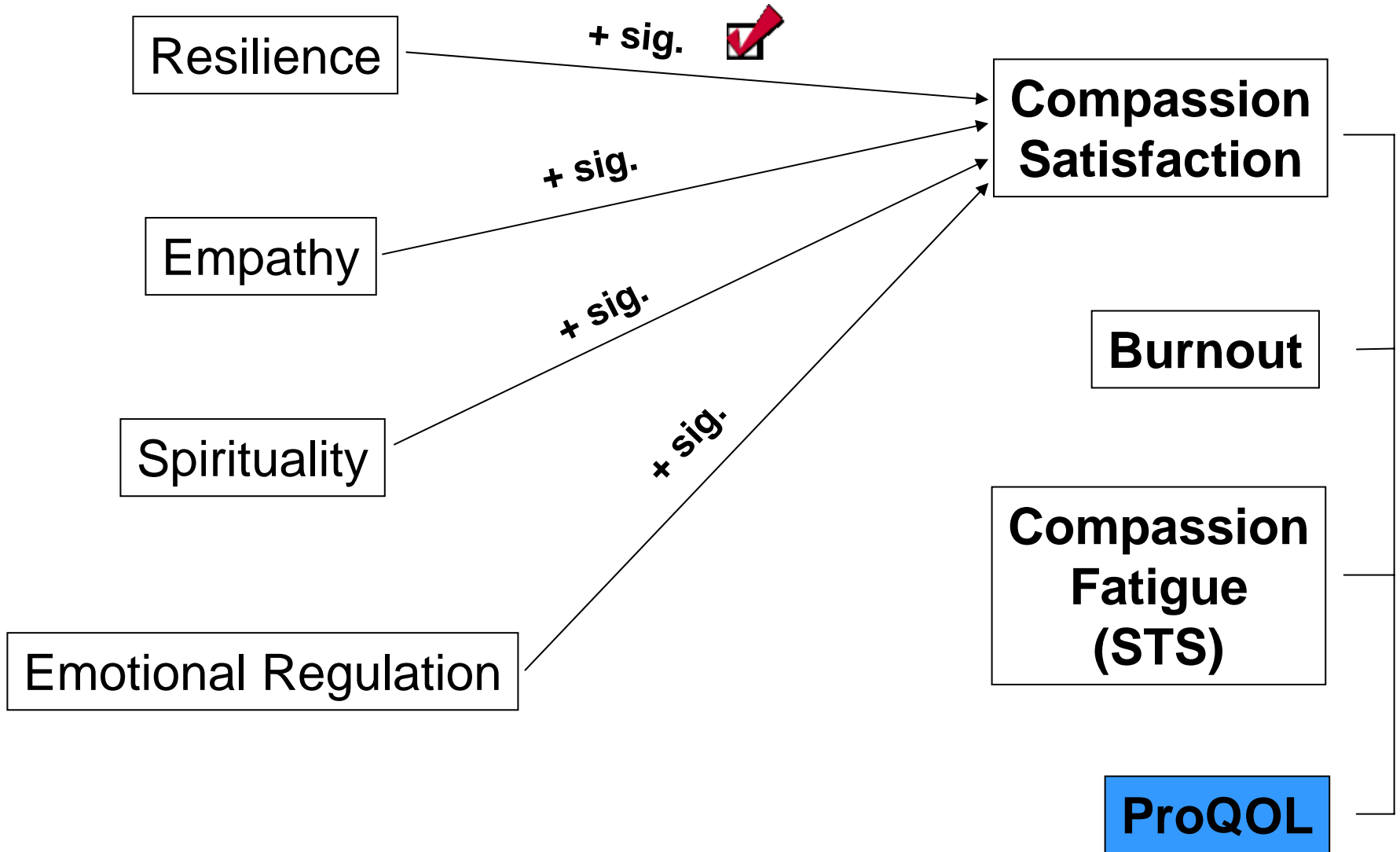
**Compassion
Satisfaction**

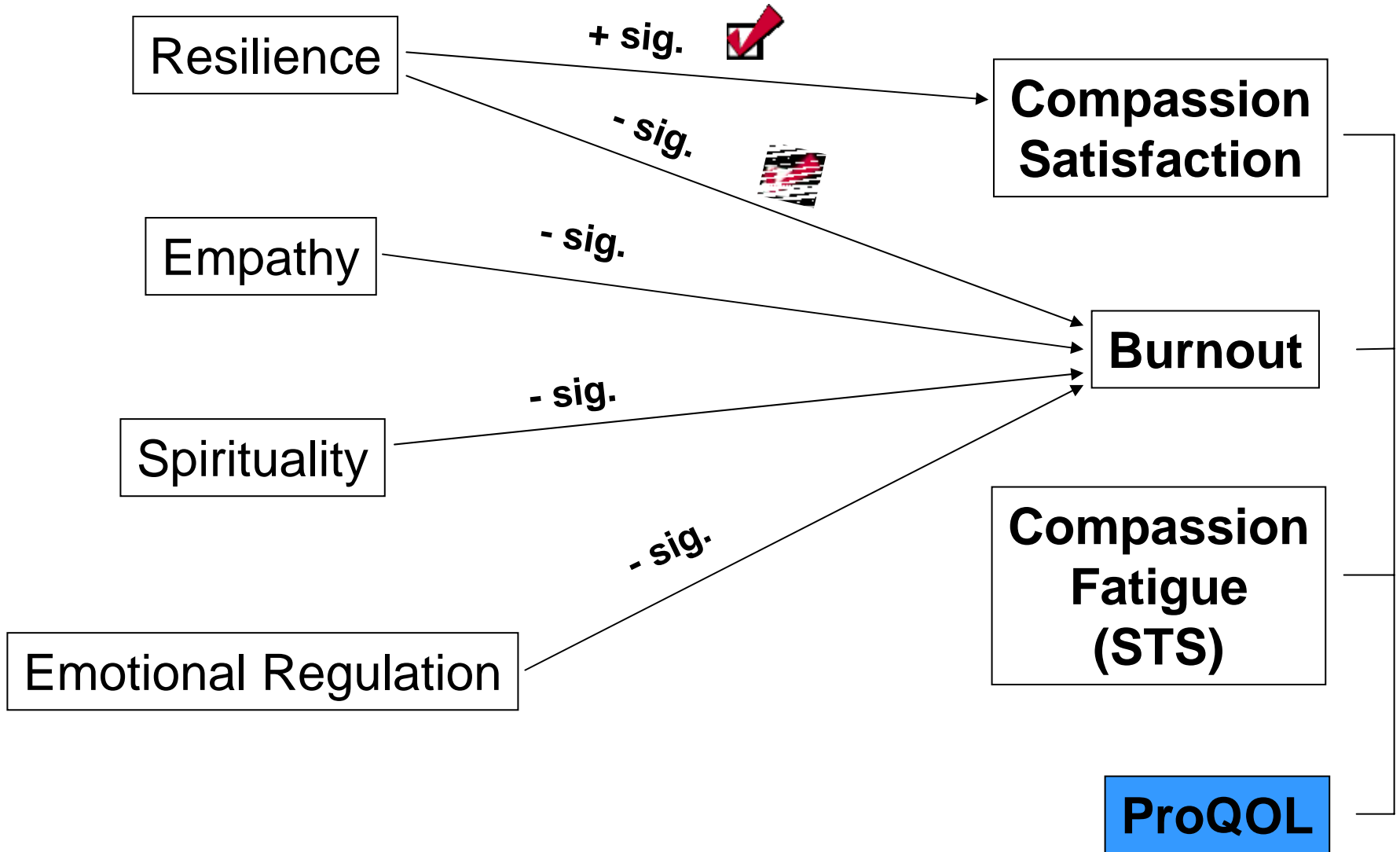
Burnout

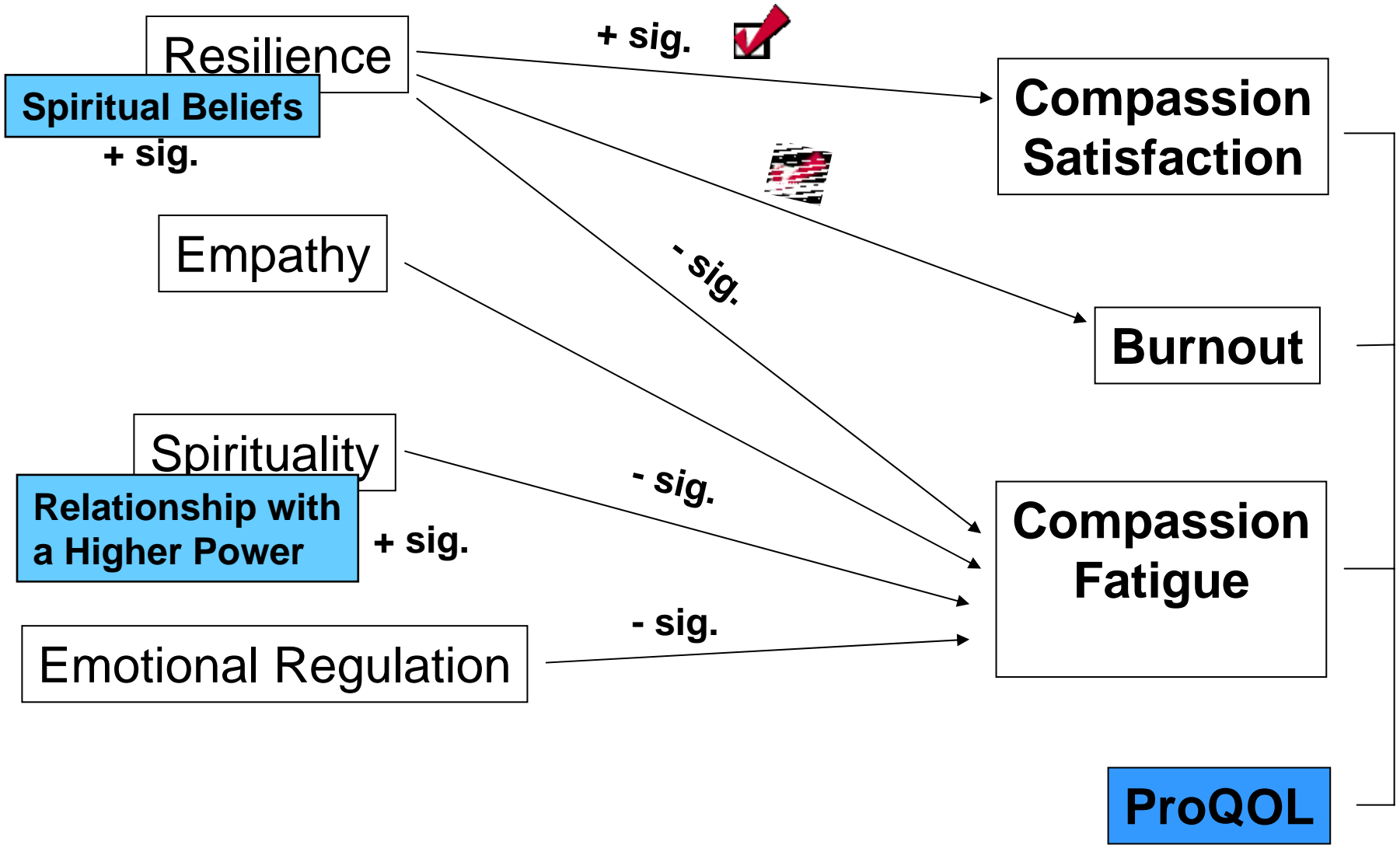
**Compassion
Fatigue
(STS)**

ProQOL

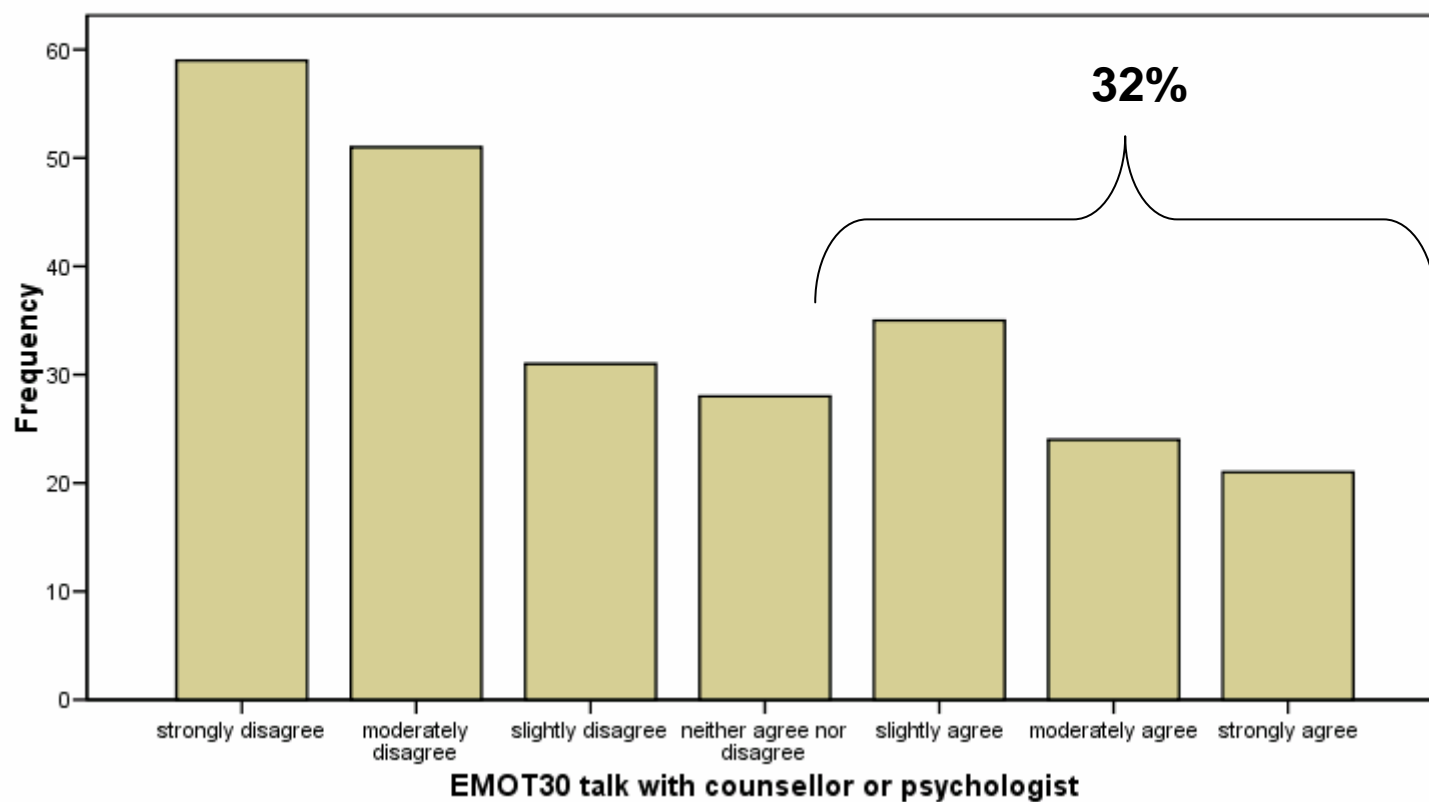






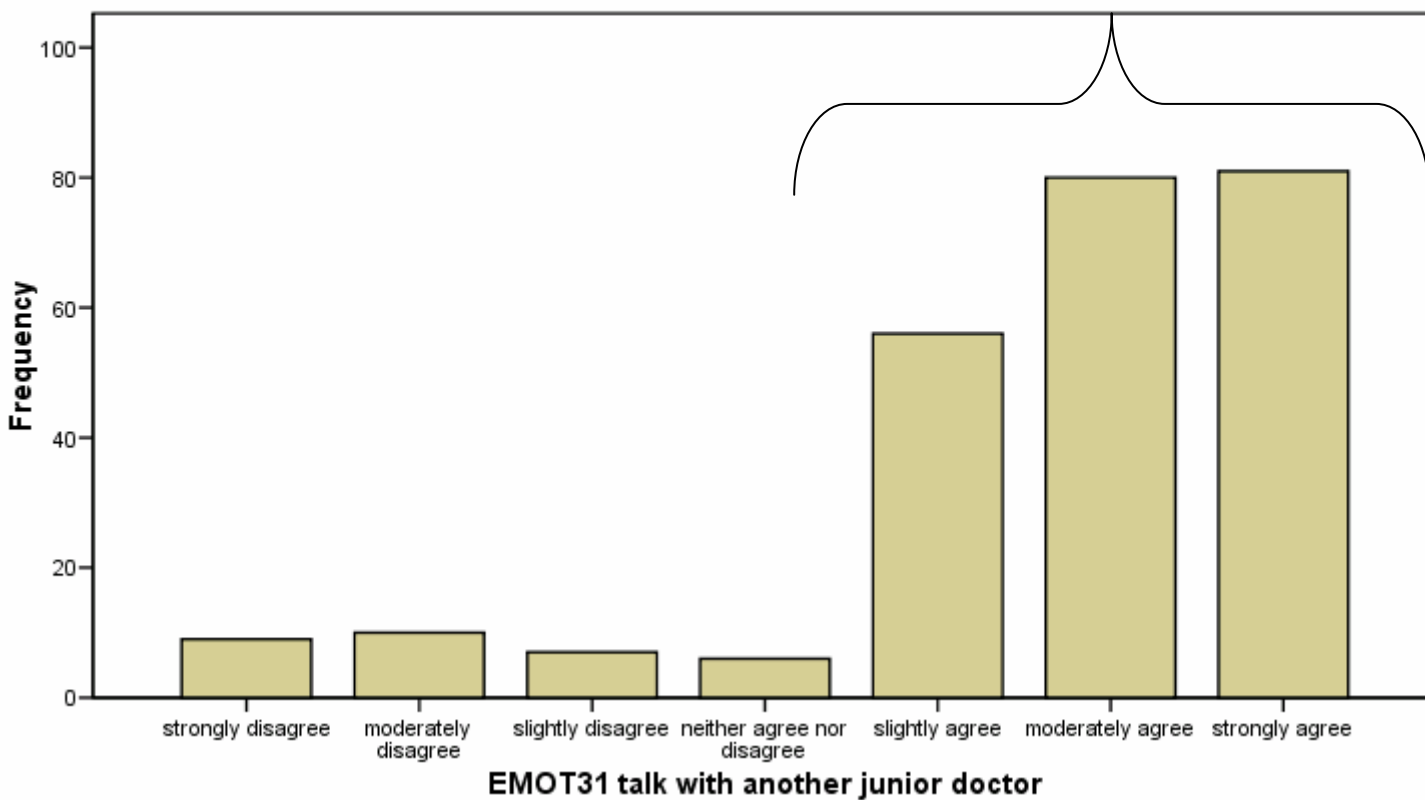


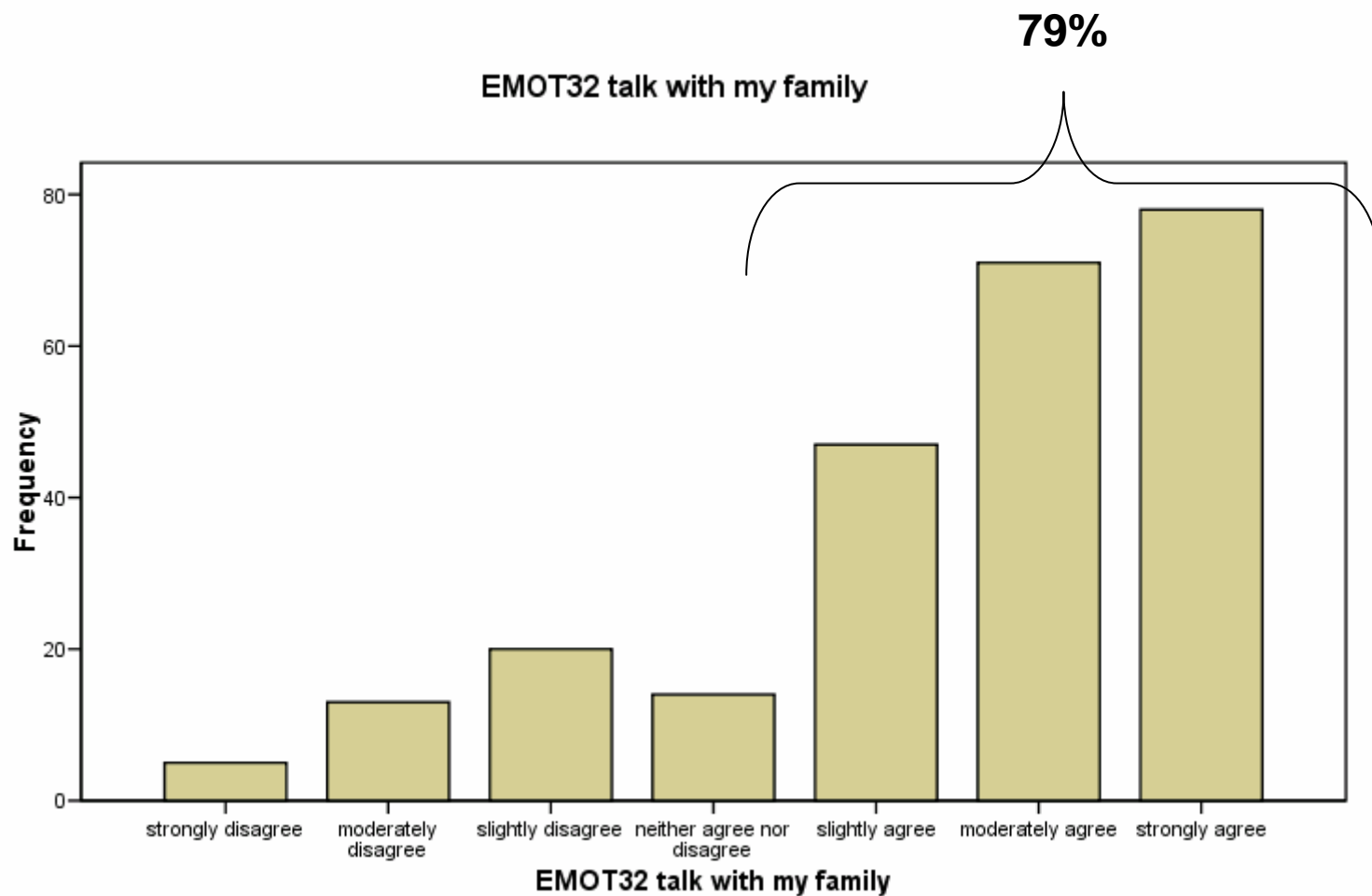
EMOT30 talk with counsellor or psychologist

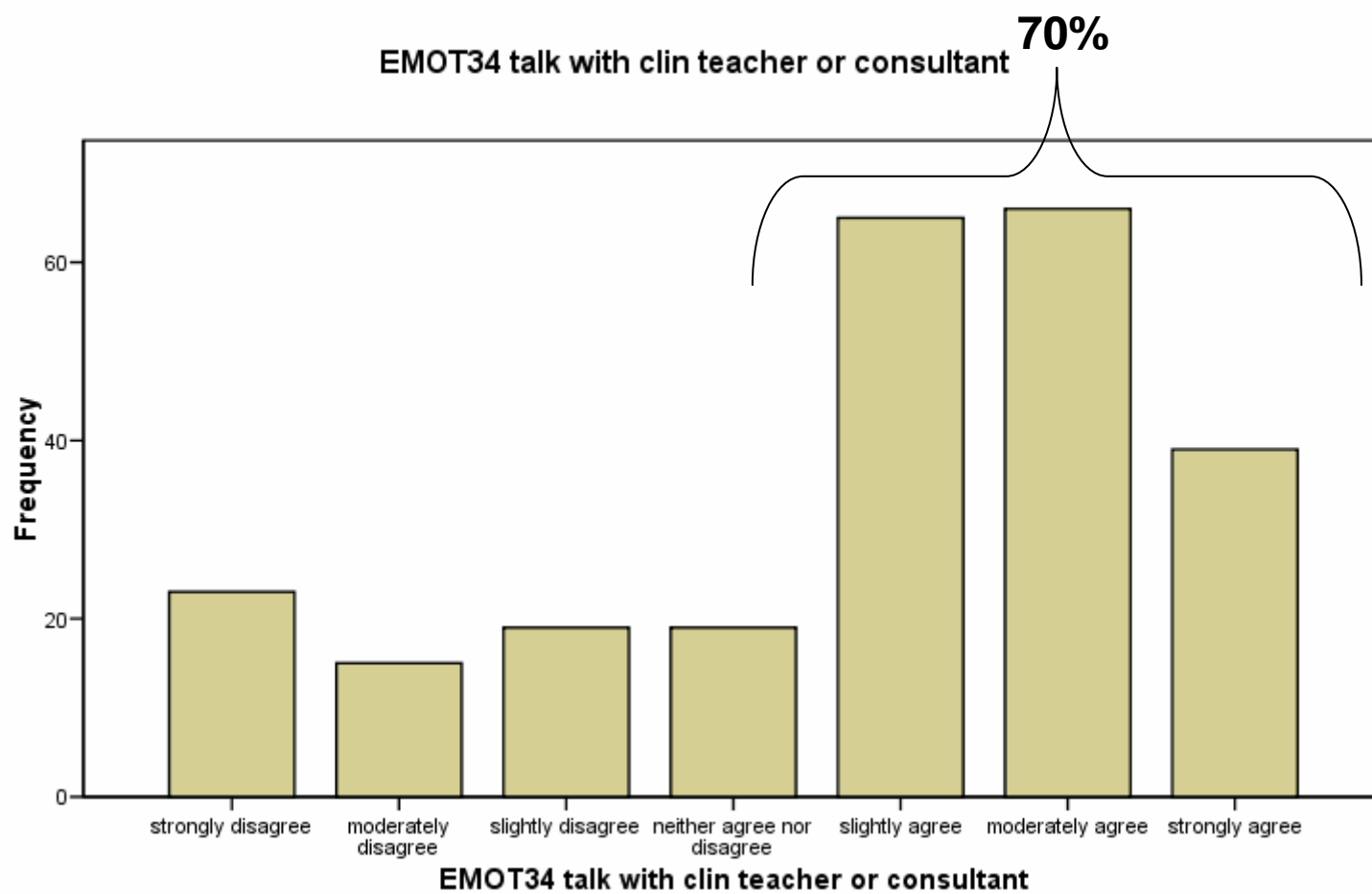


EMOT31 talk with another junior doctor

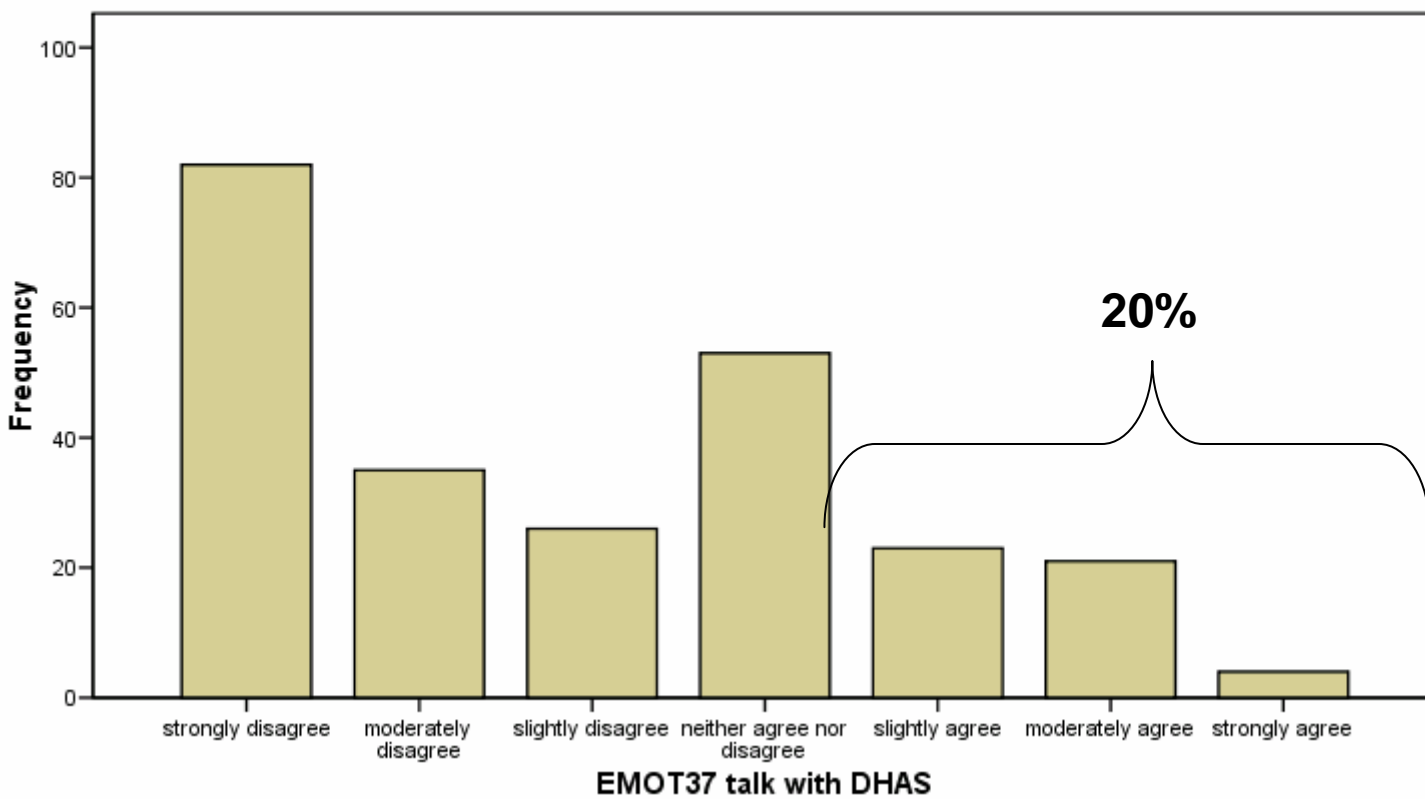
88%







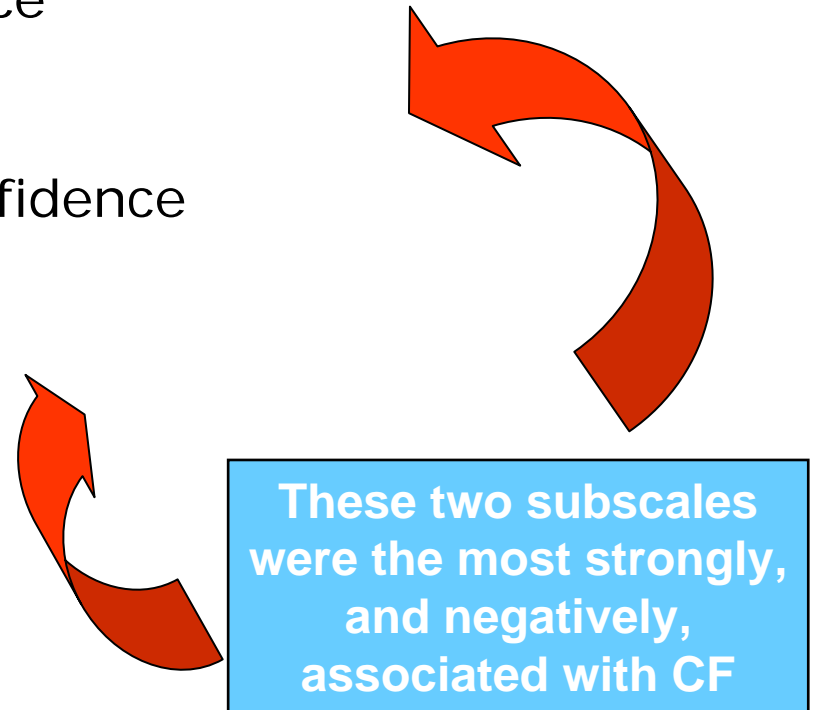
EMOT37 talk with DHAS



Prediction of compassion fatigue

Personal Strengths and Resilience

Emotional Competence and Confidence



Personal Strengths and Resilience

- I can deal with whatever comes up
- I believe that past success gives confidence for new challenge
- I see the humour side of things
- I believe that coping with stress strengthens
- I tend to bounce back after illness or hardship
- I believe I give my best effort no matter what
- I believe I should act on a hunch

Emotional Competence and Confidence

- I feel confident in my ability to care for patients exhibiting strong emotional distress
- I am aware of my emotions as I experience them
- I feel confident in my ability to understand my own emotional responses to my patients' distress
- I feel competent in my ability to understand the reasons for my patient's strong emotional distress
- I feel confident in my ability to care for the emotional as well as the physical needs of my patients
- I feel able to initiate access to additional support, if required, to help me to understand and manage my emotions in relation to my patients

Qualitative comments

Five themes emerged:

- Time demands
- Support
- Undergraduate training
- Confidence
- Coping



Time demands

Often too busy to have time to engage in emotional issues

I find that empathy and being involved with patients is a fine goal - but when you work long hours with minimal breaks, with minimal support, with patients who have high expectations, on the background of a somewhat hostile and non-medical management, you have no time.

Time demands

Although empathy for, and understanding of patients feelings and their families feelings is very important for patient well being, I feel doctors often don't have the time to pay a lot of attention to them. Perhaps this is why the nursing / physio / OT / social workers roles are so important as they have more of an opportunity to consider the patient and their families as a whole.

Support

Management and senior clinicians can be unhelpful

The medical system is not well designed to facilitate, nor support “emotional competence”

People pay “lip-service” to support for junior doctors - there really is very little

Support

Most doctors know how to act and practice but the crap system we work in doesn't allow this practice and more, the only people that can change that are the manager/CEO's of the hospitals - and it will cost money!

It is actually very hard to ask for help from colleagues

Support

Who looks after doctors???

Management and hospitals certainly don't.

At times it seems that no-one cares how the doctor is feeling

A doctor can best empathise and have capacity to be open to patient's emotions if they in turn work in a supportive environment where the staff that influence their working day can empathise with them

Support

There needs to be better understanding of the emotional traumas that junior medical (and nursing) staff go through, a wider recognition from senior staff and managers that these traumas do exist, and more education on coping strategies for doctors struggling to come to terms with the difficult emotions they experience every day

Undergraduate training

How to deal with feelings of professional inadequacy and fear of looking stupid in front of colleagues is an important area usually missed out in communication skills/emotional competence training

Unfortunately a lot of the topics mentioned are not really able to be taught at med school – med students focus on “grades” and what is “examinable”

Undergraduate training

At Otago Medical School we had a mentoring system which was very effective. However, when you become a house surgeon and most need this mentoring, it is much harder to access.

Emotional competence is poorly taught in Med School - at least in my day

Undergraduate training

At med school, psychiatry and palliative care departments gave very good guidance on communication and empathy and self awareness of own responses.

Expectations are for us to provide a service at a high level but very few senior staff seem to have any interest in ensuring we have a balanced life / coping with the stresses of the job / generally doing OK.

Undergraduate training

Learning to deal with these situations and to cope with one's own response to them is very difficult and yet there is little formal education for this

Confidence

If a doctor has poor interpersonal relationships with patients but especially also with colleagues the most likely cause is that “they’re scared”.

Lack of confidence in your own abilities and an ability to deal with the fact you make mistakes is in my experience, the factor which stops most people being effective carers/helpers

Coping

I have seen many junior doctors in pieces trying to strike the correct balance

I think we get very hardened and cynical to cope with it all

Junior doctors tend to debrief with each other a lot

Coping

After traumatic events senior staff often ask “are you OK?” but only two or three times have they taken me away, sat me down and checked that in fact I am OK. When you get asked – knee jerk reaction is to say “I’m fine / I’ll be OK” and so it’s not discussed further.

Another import factor is workload: - Increased workload = decreased compassion

Coping

I now know very clearly when I have become / am becoming burnt out – and this is when I am no longer able to feel for my patients. I know I should care (intellectually) but I don't feel anything.

Coping

I think junior doctors are simply expected to 'get tough' through dealing with other people's emotional problems and being involved with horrific situations that members of the public outside the medical community would simply not comprehend.

Coping

Your survey doesn't take into account the role medication such as antidepressants, play in coping – they are commonly in use by junior medical staff to help cope (I believe). My answers reflect partially the calming ability of these medications! Prior to them my quality of life was approaching zero because of the JOB

Coping

There is little confidentiality in the medical profession so I imagine there would be reluctance to seek help as well as most of us being high achievers / goal setting individual who don't like to admit we are not coping. The only way around this is compulsory regular "debriefing" sessions e.g. at 3/12/y.

An interesting question to ask of us would be –
“How many of you would do medicine again?”

