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Strong Emotional Reactions for Doctors Working in Palliative Care: Causes, Management and Impact. A Qualitative Study.

Short running title -
Strong Emotions for Doctors in Palliative Care

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Abstract

Objective: Doctors working in palliative care services are exposed to challenging emotional environments almost daily. Strong-emotional reactions experienced in this setting have implications for patient care and doctor wellbeing. Existing research has not focused on doctors working in specialist palliative care. This study aimed to understand what strong emotional reactions are experienced by doctors working in specialist palliative care, the cause of these strong emotional reactions and the impact they have on the lives of palliative care doctors.

Methods: Qualitative descriptive design included grounded theory techniques. Semi-structured, audio-recorded individual interviews explored doctors' memories of strong emotional reactions and challenging aspects in palliative care work, how emotions were managed and affected doctors' lives.

Setting/participants: Twenty doctors were recruited from a specialist palliative care service within a public health network in Melbourne, Australia, comprising of two inpatient units, a consult service and outpatient clinic.

Results: Palliative care doctors experience a myriad of strong emotions in their line of work. Experiences found to elicit strong emotional reactions included patient, family and staff distress and organizational issues. Strong emotional reactions impacted clinical behaviours, patient care and doctors' personal lives. Strategies developed for managing strong emotional reactions included debrief, setting boundaries, avoidance and self-reflection, along with non-work strategies such as time with family.

Conclusions: Whilst emotionally challenging experiences are unavoidable and necessary in a palliative care doctor's development, doctors need to be supported to avoid adversely impacting patient care or their own wellbeing.

1. Background

Doctors providing end of life care are often exposed to significant stress when attending to emotional and spiritual needs of patients and their families,[1,2] especially when caring for young adults or those with young children.[3–5] Experiences which may lead to strong emotional reactions (SER) in physicians from varied speciality areas include identification with patients[3–6] or feeling personally responsible for a patient's death.[3,4,7] The emotionally charged nature of this work leaves doctors at risk of compassion fatigue and burnout.[8,9] The prevalence rate of burnout in palliative care physicians is estimated at 15.1%[10] which whilst alarming, is considerably less than that of oncologists.[11] The reasons for this difference are unclear and call for a better understanding of how palliative care doctors manage challenging work situations.

A study exploring doctors' emotional reactions to clinical work, not specific to end-of-life care, found common emotions experienced were sadness, fear/anxiety, frustration and anger.[12] Intense negative emotions were more frequently reported than positive emotions and, when poorly managed, affected doctor-patient clinical relationships.[12] Other research on doctors experiencing SER has focused largely on responses to difficult patient deaths.[3–5,7,13–18] Coping mechanisms used by doctors working with dying patients across various specialties included dehumanising patients, euphemisms, humour and denial.[19] In Granek and colleagues'[5,15,17] research on oncologists' experiences of patient death, debriefing within and outside work and peer support[5,16] were commonly reported as helpful. Strategies used included exercise[5,16] and meditation,[5] alongside maladaptive behaviours, including compartmentalisation,[16,17] disengagement,[17] alcohol and prescription drugs.[5]

There has been minimal research into the emotional states of palliative care doctors and studies on doctors' emotional responses when working with dying patients have largely been limited to general medical contexts,[3,4,14,19] suggesting a significant gap in the literature. The need to understand doctors' SER when working in specialist palliative care has become increasingly important, especially as early integration palliative care models become increasingly adopted[20] and more patients receive specialist palliative care. This knowledge will then help identify how best to support doctors working in specialist palliative care. Our aims therefore were to understand the SER experienced by doctors working in specialist palliative care including their cause, management and impact.

2. Methods

2.1 Design

The constructivist paradigm informed this study which acknowledges that perceived reality is constructed by individual, social, cultural and historical contexts and that no absolute shared truth can therefore exist.[21] A qualitative descriptive design was used, which enables a comprehensive study of phenomena and can include grounded theory techniques.[22,23] Qualitative description research does not enable theory generation because it does not use theoretical sampling.[22] In this study, grounded theory techniques used included inductive, cyclic and comparative data analysis. A complete grounded theory method, which requires indeterminate time to collect data and reach saturation,[23] was unfeasible in this time-limited study.

2.2 Setting and participants

The study setting was a specialist palliative care service within a public health network in Melbourne, Australia, comprising an 8-bed inpatient unit, consult service and outpatient clinic within a 504-bed acute hospital, and freestanding 20-bed inpatient and day hospice facility. The palliative care service's doctors included consultant specialists (trained solely in palliative care or dual trained in specialties including geriatrics or general practice) and junior medical staff rotating within the hospital. Junior (FY1) doctors worked between 5-11 weeks in palliative care and those in residency/registrar training spent 3 months or greater. Participants included doctors who were currently working or had previously worked within the palliative service between October 2016 to October 2017 and remained employed at the heath network.

Sampling was initially convenience. The study's purpose was explained at the service's regular doctors' meeting and a group email invitation was sent to all eligible (n=38). One reminder email invitation was sent to those who had not responded to the initial invitation. Purposive sampling ensued whereby JD reminded selected staff about the study who had not responded to initial invitations and who had more diverse backgrounds and experience levels compared to those already willing to participate. Informed written consent was obtained from participants. Participants underwent individual interviews with DH, a male psychiatry trainee within the same service, trained in qualitative research methods and without any managerial relationship with participants. Interviews were conducted with all doctors who accepted an invitation to participate between September and October 2017.

2.3 Measurement

Semi-structured, audio-recorded interviews collected data. The interview schedule (Appendix A) was piloted with a palliative care doctor not involved in the study and subsequently refined. Interviews explored participants' characteristics, memories of SER and challenging aspects in palliative care work and how emotions were managed and affected their lives (if at all). Participants were told that SER were whatever they perceived them to be. Concurrent data collection and analysis proceeded, with interview questions added to explore novel ideas.

2.4 Data analysis

Interviews were transcribed verbatim. Analysis involved coding line-by-line coding (researcher examined each line of data and created labels to represent textual segments which were relevant to research aims), category development (labels created to represent comparable code groups) and thematic development (labels created to represent comparable groups of categories and codes). DH conducted the initial analysis. To achieve rigour, an interrater reliability procedure[24] was conducted: JD and COC, both experienced qualitative researchers, examined all data and analysis and regularly met with DH to discuss and rework the findings until agreement was reached. Qualitative data management software ATLAS.ti 8 for Windows was used.

Consolidated Criteria for Reporting Qualitative Research (COREQ) was followed, although participants did not provide feedback on study findings, which COREQ guidelines suggest. Such member checks create additional intrusion for participants, require additional resources and no evidence indicates that they improve research quality.[25]

2.5 Ethics

Ethics approval was provided by St Vincent's Hospital Melbourne (number LNR/17/SVHM/203).

3. Results

Twenty doctors (14 female) participated in interviews with mean length 38 min (SD=11 min). Participant characteristics are in Table 1. Four themes and 12 category findings became apparent. Thematic descriptions follow.

Table 1. Participant characteristics (n=20)

Characteristic	n (%)
Sex	
Female	14 (70)
Male	6 (30)
Age group	
Under 35 years	10 (50)
35 years and over	10 (50)
Years of experience in palliative care	
<1 year	8 (40)
1-5 years	4 (20)
5-10 years	4 (20)
10+ years	4 (20)
Position	
Intern (Foundation Year 1)	3 (15)
Residency/Registrar training	7 (35)
Consultant Specialist	10 (50)
Currently working in palliative care	
Yes	16 (80)
No	4 (20)

3.1 Myriad of strong emotions experienced

Wide-ranging emotions regularly described by palliative care doctors included sadness, frustration, anger, distress and hopelessness. Emotions often fluctuated during clinical work:

> *I'd fluctuate between being feel really, really sorry for him and get really angry at him… that is the only time I think I've ever got angry at a dying patient… (ID18)*

Less commonly mentioned emotions included shock, embarrassment, guilt, anxiety, resentment and fear.

Only four doctors spoke of positive emotions, all of whom mentioned satisfaction. Happiness and joy were also mentioned.

> *If we've had…a good death… especially after…challenging circumstances, one could sort of feel quite happy … I have certainly experienced that, it was a good outcome for the patient and the family and (I) had that sort of positive emotional experience. (ID20)*

3.2 Patient, family and staff distress and system issues can elicit SER

Patient and family circumstances

SER could be elicited by identification with patient or family situations, particularly young patients who died or those with young children. Many reported sadness, powerlessness or shock when caring for those with unexpected, traumatic or prolonged deaths, who refused treatment, had language barriers, died by suicide or suffered from intractable symptoms.

> *The thing that I found most difficult I guess is watching suffering of the patient or the family… I guess not knowing how to alleviate that suffering… I know I have a very low threshold for pain and suffering myself. (ID4)*

Strong emotions were also more likely when doctors cared for patients for long periods or believed that they had hastened a death. Doctors experienced positive emotions when patients advocated for themselves or had comfortable deaths.

Patients and families who are aggressive or disagree with medical recommendations

Junior doctors in particular (but not exclusively) often became 'caught up' in anger and frustration expressed by families. Patients or family members who refused symptomatic treatments or opted for natural over conventional treatments often elicited frustration or anger. Lack of patient and family gratitude could also elicit resentment and make caring difficult.

> *You felt like every attempt was thwarted, so it was very difficult to even assess her, let alone actually talk to her to make, so she could make an informed decision… I actually had a lot of frustration. (ID19)*

Staff distress and disagreements within medical teams

Clinical disagreements were identified by many as a source of SER, including when late palliative care referrals were received or a patient's dying status was not recognised. Disagreements often blurred patient care goals, split teams and invoked feelings of hopelessness and frustration. One participant experienced difficulty when other doctors were judgemental towards vulnerable patients and some junior doctors experienced frustration when they disagreed with senior management plans. Witnessing colleagues' distress could also be distressing:

> *When I see our medical and nursing colleagues struggling with the day-to-day clinical work and the pressures it puts them under or the distress it causes, that's when I find I get most distressed. (ID11)*

Stretched resources and organizational pressures

Doctors felt prone to strong emotions during periods of unexpected staff absences or high workflow and, in the case of junior doctors, when approaching challenging clinical situations without availability of senior staff. Pressures from hospital management, including need for patient turnover and stringent resource allocation, elicited considerable distress and professional doubts amongst some senior doctors:

> *We've been under a lot of pressure… you feel that you are being challenged because they feel that you're not doing a good enough job. You may feel a bit angry… and you don't feel that you're being appreciated. (ID7)*

3.3 Various strategies developed for managing SER

Self-awareness

While many doctors were aware of their SER, several only became aware of them when a colleague commented, a patient reacted negatively, during the research interview, or after several stressful experiences:

> *I didn't really have the sort of awareness at that stage of my career and my training to really recognise how much of an impact that had had on me… you have a patient die or somebody's discharged then what happens is that bed gets filled and you've got a new patient who comes in. (ID12)*

Several doctors named self-reflection as a strategy to create awareness of triggers for SER.

Debrief and other reflective practices

Almost all doctors identified debrief, both within and outside work, as the main way SER were managed. Informal debrief at work was considered to helpfully reframe and validate experiences, and to illuminate shared feelings. Some senior doctors, however, considered that "inappropriate" informal debriefing may exacerbate distress and anxiety.

> *if you sort of talk about stuff too much and you do it in a sort of scatter-gun approach you know, just to try and make yourself feel better, that's not constructive. (ID6)*

Access to psychiatry, psychology and pastoral care support on wards was regularly identified as an informal way to debrief. Formal debrief opportunities were rare but many recommended that it be offered. Some doctors were reluctant to debrief if they had low self-confidence or wanted privacy.

> *I was a very private individual back then, I wasn't as confident and I wasn't as outspoken so it was actually quite difficult for me to reach out and ask for that support but when I did, it was provided and it was very adequate. (ID1)*

Outside work, doctors accessed external supervision, undertook personal psychotherapy or debriefed with partners, extended family or friends. Debriefing with people with medical knowledge was preferred as it was felt non-medical people often did not "get it" or would be burdened.

Other management strategies

Many doctors remarked how difficult early clinical experiences had revealed the importance of empathising rather than sympathising and not becoming overinvolved with patients and families. Whilst several senior doctors described the need to set boundaries and challenge family members' aggressive behaviours, junior doctors mostly tried to tolerate or "give in" to these behaviours, fearing that they may upset families further. Others described becoming detached from challenging work experiences or "bottling things up".

Some participants spoke about "sharing the clinical load" with colleagues.

> *Being able to tag team a little bit is a good thing with the clinical work especially when there's a really challenging patient. That it's not a crisis to ask the colleague to see a patient… (ID19)*

More experienced doctors were better aware of triggers, able to acknowledge their SER and manage their impact. Less common strategies were to speak with a unit director or work fewer hours. Busy work-lives, however, could reduce opportunities to reflect and share clinical loads.

Management strategies outside work included exercise, time with family, socialising and maintaining outside interests. Only one participant stated that they had inadequate strategies for managing SER.

> *I realise that I used to have lots of strategies but I haven't actually been using any of them probably because of time constraints... I'm very much aware that it's something that I need to work on. [ID16]*

3.4 SER can impact clinical behaviours, professional development, and personal lives

Overattentive or avoidant interactions with patients and families

Doctors who strongly identified with their patients often felt compelled to spend more time with them and their families. Conversely, when doctors were angry and 'worn out' by patients and their families, they would often avoid them.

> *I think probably the times where I felt really sorry for him I probably spent like way more time and then other times if I was like really, like feeling particularly angry at*

> *him or his mum I probably would be like, 'Oh I don't want to go see that patient' even if they had a legit (sic) question. (ID18)*

Impact on treatment decision-making and patient care

Doctors spoke about SER occasionally causing deviations from normal clinical practice such as treating patients more aggressively. Many reported that distressed patients or families could be exhausting and reduce capacity to care for others:

> *He took up so much of my emotional energy and mental energy every day, I felt that I couldn't give 100% to other patients. (ID14)*

Impact on professional development

Doctors believed that exposure to unpleasant emotions uncovered by challenging clinical experiences was an important and necessary step in the development of better coping strategies and professional resilience. With experience, work triggers commonly changed, or intensity of reactions lessened. Junior doctors mostly felt challenged by complex patient and family situations whereas senior doctors were more likely tested by health system or staff conflict issues.

> *The experiences that I've had were quite difficult particularly as an intern and once I was able to come to terms with it, I feel it did make me a better doctor… it was just one of these hurdles that I feel I would need to cross. (ID1)*

Impact on personal life

While many doctors found palliative care work personally rewarding it also sometimes left them feeling depleted, flat, angry and irritable outside of work. Some ruminated or dreamt about work at home. Others acknowledged its adverse effects on personal relationships, including with their children. One doctor's partner refused to discuss medicine at all.

> *I felt flat when I came home... I think that has an effect, like had an impact on my relationship, not like a long-lasting impact but it certainly had, you know, little intermittent impacts, you know, negative impacts on my relationship. (ID13)*

4. Discussion

4.1 Main findings

Palliative care doctors in this study described a range of strong emotions experienced across all aspects of work. Recollections of so-called ‘negative’ emotions, including anger, sadness or frustration greatly outnumbered more ‘positive’ emotional recollections like happiness. There was a recall bias towards negative emotions, which is consistent with previous studies on emotions in doctors.[12] Positive emotions are typically well-received and reinforce that a doctor is doing a good job. Conversely, negative emotions are more likely to be remembered as they challenge a doctor’s confidence and cause them to question their clinical acumen. The unpleasant nature of negative emotions can elicit changes in clinical behaviour as the doctor seeks to avoid these feelings.

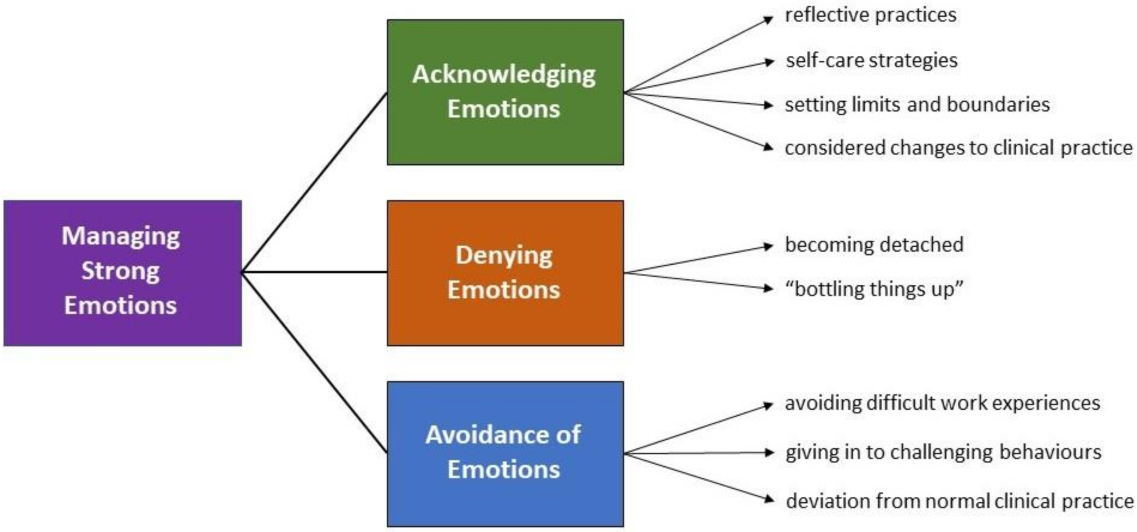
The situations for doctors in this study which led to SER were not just limited to distressing patient deaths. Doctors revealed that they often experienced SER when their usual way of working was disrupted, or when they felt unable to provide what they perceived as ideal care. This included situations such as feeling helpless when attending to a patient with a language barrier or anger when a patient’s family refused symptomatic treatment. In some instances, particularly stressful events only became apparent when explored during the research interview. Non-clinical reasons for SER, relating to organizational or managerial stressors, were most prevalent amongst senior doctors. Whilst senior doctors also experienced SER in clinical work, when compared to junior doctors they usually felt better equipped to identify situations or triggers which led to SER which enabled them to then respond appropriately. No substantive differences were noted in the experience of SER specific to doctors’ gender.

There were a number of different coping strategies mentioned by palliative care doctors as a way of managing strongly-held emotions. These can be best understood as falling into one of three categories: acknowledgement, denial or avoidance of strong emotional states (Figure 1). When doctors acknowledged SER, they were able to reflect and then implement necessary changes to better manage these emotions. Denying or avoiding emotions, which is often an unconscious process,[26] has capacity to do harm[27], particularly if a doctor has limited appreciation of their internal emotional state. Denial of emotions blocks the opportunity to reflect and then address the cause of difficult emotions. Strategies such as detachment or ‘bottling things up’ can lead to burnout, leaving doctors blind to the need to seek help and to activate their support networks. Avoidance of emotions through behaviours such as ‘giving in' to inappropriate demands or spending less time with 'difficult' families can negatively impact patient care if it causes doctors to deviate from routine clinical practice.

A variety of strategies to process difficult experiences and unpack strong emotions were described by palliative care doctors in this study including debrief (formal and informal), self-reflection, personal psychotherapy and supervision. Debrief was frequently mentioned as a means of developing awareness of strong emotions which may not be immediately evident. Reflective practices such as debrief can also help identify problematic behaviours and maladaptive coping strategies[5,17,19].

All doctors spoke about the benefit of in-the-moment informal debrief with colleagues or allied health staff to unpack and process challenging work experiences. Several doctors spoke about formal debrief as a helpful strategy however noted that time and organizational pressures usually limited their ability to attend these. Various models of clinical debrief for doctors have been trialled, including Balint groups[28] and Schwartz rounds[29] however their evidence base is limited.[29] Formal debriefing opportunities which are not compulsory may also not capture the most vulnerable doctors who routinely manage emotions through denial or avoidance.

Figure 1 – Managing Strong Emotions



4.2 *Clinical implications*

In comparison to other areas of medicine, doctors in palliative care work in an area where death and dying are everyday events and emotionally-charged encounters with patients and families are a common occurrence. In this challenging area of medicine, doctors need to be aware of their own emotional states and endeavour to engage in routine reflective practices. When a doctor is unaware of their emotional state or does not listen to their emotional cues then this has the potential to negatively impact on decision making[27], adversely affect patient care[30,31] and affect personal wellbeing.[1,30]

SER can signal the risk of potential harm to patients, signal risk of doctor burnout and herald a need for doctors to engage personal networks and supports however this is only possible if doctors have reasonable awareness of their own emotional state. Junior palliative care doctors, particularly interns (foundation year 1) are vulnerable[32] as they have had limited exposure to challenging clinical experiences and often have not yet developed appropriate coping strategies. Junior palliative care doctors are thus in the unenviable position of needing to be exposed to challenging clinical experiences, which can be distressing and destabilising, in order to build resilience and develop appropriate coping strategies. When navigated successfully, this is transformative.[8,33] Palliative care services need to therefore provide an environment where supportive, reflective practices are encouraged, especially for vulnerable junior doctors, who if not supported may develop lifelong maladaptive coping strategies.

Workplaces should also aim to create a culture that fosters the development of informal networks between clinicians to allow in-the-moment support after challenging experiences. Junior doctors would likely benefit from education on how to form these support networks.

Whilst it is common for doctors to attend workshops to learn how to better communicate with patients,[34] the value of doctor-to-doctor communication is often overlooked.[35] Our findings suggest that many doctors would benefit from training in how to recognise when debriefing moments are happening and provide opportunities for it. This should not just happen when there is a ‘sentinel event’.

4.3 Study limitations

Semi-structured interviews allowed for novel ideas, meaningful to research participants, to emerge in this qualitative study. Findings were not saturated; however the pool of potential interviewees was exhausted and limited resources precluded further data collection.

Doctors who were more vulnerable or with limited supports and thus experience stronger emotional reactions, may have chosen not to partake in this study. All except one participant felt they were supported.

Some participants may have felt uncomfortable speaking openly about their emotions or coping strategies perceived as maladaptive to the doctor interviewer who worked in the same hospital. This may explain why the use of drugs or alcohol as a coping strategy was not found, contrary to findings in a similar study[5] which used an anonymous survey.

Recall bias may have occurred among participants' who had not recently worked in palliative care. Studying doctors who had previously worked in palliative care but subsequently left the field may have also uncovered additional insights.

This was a single-centre study, so findings are only representative of palliative care doctors at one site. Future research could expand to include different palliative care workplaces and environments.

5. Conclusions

This study provides important insights into the experiences that lead palliative care doctors to experience strong emotional reactions and how they are subsequently managed. If not acknowledged and managed appropriately, strong emotions can adversely impact patient care as well as lead to burnout and compassion fatigue. Whilst exposure to challenging experiences is necessary for palliative care doctors to develop strategies to deal with subsequent stressful experiences, they need to be supported through this process to avoid inadvertent harm to themselves or others.

Declarations

Authorship

DH and JD conceptualised the study. DH undertook the interviews and initial analysis. JD and COC assisted with data analysis. The final manuscript was produced by DH, JD and COC.

Declaration of conflicts of interest

The authors declare there is no conflict of interest.

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Research ethics and patient consent

Ethics approval for this study was provided by St Vincent's Hospital Melbourne (LNR/17/SVHM/203). Informed participant consent was obtained.

Data availability statement

We do not have permission from St Vincent's Hospital Melbourne's Ethics Committee nor research participants to release collected data.

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Appendix A

INTERVIEW SCHEDULE

Main questions:

- Can you remember a time working in palliative care where you felt a particular experience brought up strong emotions? What was the situation and what were the emotions?
- What would you say has been the most challenging aspect of your clinical work in palliative care?
- Could you please reflect on some of the more difficult times for you in working in palliative care – why do you think that was?
- How did you manage these emotions, if at all?
- Why do you think these experiences brought out strong emotions in you?
- Ideally, what’s a support that would have been helpful or useful during these times?
- How do you feel that these experiences have affected the way you work in palliative care, if at all?
- Did you feel that some of these experiences affected your life away from work? In what way?