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Supporting Cancer Care Clinicians to 'hold' their patients during and beyond the COVID-19 pandemic: A role for reflective ethics discussions

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Introduction.

The COVID-19 pandemic has placed an overwhelming burden on healthcare delivery globally. This paper examines how COVID-19 has affected cancer care clinicians' capacity to deliver cancer care in the Australian context. We use the lens of 'holding patients' (drawing from attachment theory, psychology and from Australian Indigenous knowledge) to conceptualise cancer clinicians' processes of care and therapeutic relationships with patients. We consider the disruptive effects of COVID-19 on care delivery and on clinicians themselves. We then show how models of clinical ethics and other similar reflective discussion approaches are a relevant support mechanism to assist clinicians to process and make sense of COVID-19's disruptions to their professional role during and beyond the pandemic.

Cancer Care and the concept of ‘holding’

Cancer care is characterized by high quality research and targeted evidence-based treatment protocols together with collaborative and integrated models of biopsychosocial care which acknowledge and address the life altering impact a cancer diagnosis has for a person¹. Patients with cancer require clinicians to engage with their needs both cognitively and emotionally, to assist them to be autonomous and to feel safe^{2,3}. Salmon and Young (2017)² characterize this therapeutic relationship as a type of attachment, where patients are able to rely on their clinician to hold and protect them through a combination of clinical expertise and empathy. Originally applied to parent-infant relationships, in clinical and adult relationships, attachment theory explains the emotional bonds a person may form with someone who has power to protect them. Importantly, clinicians’ power to protect their patients is not grounded in paternalism. It is grounded in their commitment to and expertise in meeting patients’ needs, not in a paternalistic authority to decide on what those needs are.²

Another characterization of this relationship is through the lens of ‘holding another’. The idea of holding is grounded in psychoanalytic constructs: holding and containment are sometimes used instead of analysis or interpretation as ways for a therapist to meet the psychotherapy needs of a patient.⁴ This conception of holding emphasizes the importance of clinicians sometimes bearing witness to a patient’s needs rather than actively interpreting and addressing them.

A third conception of holding is from Australian Indigenous knowledge, where ‘holding’ is a deeply embedded cultural and socially inclusive value, linking authority with nurturing. The concept of ‘karnyirninpa’ is used in languages from the Western Desert people, including Kukatja and Pitjantjatjara, to describe older generations caring for and looking after their society’s young people through their connections and relationships.⁵ This relational and sociocultural notion of holding assists young men in particular to feel secure in the notion of their place, sense of self and their relationships with elders and others, within their societal and kinship groups⁵. In cancer care, patients have similarly reported placing great value on ‘being known’ as an awareness of how they fit into the clinical care team and treatment protocols.⁶ The feeling of ‘being known’ for a patient is characterised by experiencing a level of genuine human connection from their clinicians, a connection that intrinsically values their individuality as they progress through their cancer journey.

Clinicians’ capacities to ‘hold’ their patients are internalized and virtue-based ethical practices, which animate ethical duties to benefit, to avoid harm and to respect each patient.³ Although absorbed within their professional identity and role, the ethical work of ‘holding’ is nevertheless energy intensive³ and COVID-19 has both disrupted and amplified this work.

COVID-19 Disruptions to Holding Patients

Australia has had far fewer patients infected with COVID-19 than most other countries, however the delivery of cancer care has been severely disrupted so as to prevent patients from being exposed to COVID-19 and to avoid further compromising their immunity.⁷ In the height of the initial wave of COVID-19, clinicians, especially in the state of Victoria, not only had to consider the specific clinical needs of their patients, they also had to consider whether the treatment protocol was safe for the patient, themselves, their colleagues and the wider population.⁷ Communication via telehealth, telephone and in PPE distorts communication and makes meaningful engagement with patients and their needs much more difficult. It disrupts treatment protocols, and particularly hinders communication for patients who do not speak English or have hearing impairments.

Clinicians have witnessed patient and family distress created by visitor restrictions (particularly near the end of life), knowing patients were fearful of coming to hospitals, and at the same time, having less community supports available.⁸ This awareness and inability to act as clinicians would wish has been psychologically and morally distressing.⁹ Moral distress typically occurs when a clinician has to implement a decision made by somebody else, and which goes against their professional moral beliefs and duties. Moral distress is different to “ordinary” distress about a tragic situation, such as the death of a patient despite everyone’s best efforts.¹⁰

Anxiety about being able to safely practise coupled with moral distress associated with having to offer non-standard treatments necessarily reduces clinicians’ freedom and opportunity to ‘hold’ their patients as they normally would. It is hard for clinicians to reassure patients that they are safe, when clinicians themselves may not feel safe based on health-care worker infections, fatigue, and worry about infecting their families and managing other pressures that flow from COVID-19 related constraints such home schooling and other household members working from home.

Because of COVID-19, professional work in cancer care has become and will likely remain more cognitively and emotionally labour intensive. Having to constantly negotiate barriers to usual practice, may lead clinicians to feel less clinically effective, and less able to act authentically in their professional role, both of which are triggers for burnout¹⁰ This working environment also raises the important question of how to support clinicians’ capacity to renew their sense of professional identity and their capacity to hold others during and beyond the COVID-19 pandemic?

A role for reflective ethics based support

COVID-19 burdens on frontline health workers are well recognised, with many authors calling for more institutional supports¹¹ and priority for clinicians when allocating resources including vaccination. Our thesis in this paper is to argue for the importance of also addressing the

cognitive and emotional labour required of cancer care clinicians. We suggest that facilitated reflective discussions to enable clinicians to have the opportunity to share the complexity and uncertainty of their clinical role within a COVID-19 environment, and to make sense of and thoughtfully and creatively respond are relevant responses. Reflective discussions may take a practical and technical focus and an example of this has been the establishment of the Victorian COVID-19 Cancer Network (VCCN) bringing cancer care clinicians together to troubleshoot issues raised by COVID-19 in a collaborative fashion.⁷ A second type of reflective discussion supports clinicians to review the process and meaning of their clinical work experiences¹². Clinical ethics discussions represent one of these latter types, and others include ‘supervision,’ ‘critical incident stress de-briefs’ and ‘mortality and morbidity’ meetings.

In the ordinary course of their work, clinicians do not need an ethicist to provide epistemic access to norms that guide their holding work. However in ethically complex situations, clinicians may need extra support to unpack and process their ethical dilemmas, moral distress and underlying emotional responses. The questions in Table 2 provide an example of the types of questions which can support clinicians to stand back from moral distress or anxiety; review ethical decision points, and values that may need to be balanced or traded off.¹³

Table 2: Clinical ethics questions to support reflection on ‘holding’ patients

<ol style="list-style-type: none"> 1. What feels difficult about this situation? 2. What is ethically complex about holding/caring for this patient? <ol style="list-style-type: none"> a. what values are at stake? b. which ethical ideals/values are important or in conflict? 3. Is there a key ethical concern? 4. What are the available options to respond to this concern? 5. What are the pros and cons of each option; what values are being promoted or sacrificed in each? 6. Considering all of this, what do I need to do to hold this patient at this time?

Supported ethics discussions conducted by a clinical ethicist or clinician with bioethics training are effective because they take moral issues seriously, validate clinicians’ experiences and authority, and assist them to distinguish between moral distress which can lead to burn out and erosion of their health and wellbeing, and moral regret at the inevitable tragedies and losses associated with COVID-19. Such discussions can promote a type of philosophical healing by supporting clinicians to name and process ethical dimensions of their work experiences using ethics language and concepts.¹⁴ The goal of such consultations is to assist clinicians to move from feelings of moral distress or unresolved moral tension towards greater moral clarity about what should or could be done given the circumstances. This ultimately supports clinicians to find new ways of holding their patients. It is likely that such supports will prove relevant for some time to come, well beyond the peaks of COVID-19 infection waves, for the cancer care community.

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