

*From Compassion Fatigue to Compassion Satisfaction: A Research Among Physicians
Specialising in Oncology at the University of Padua*

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Abstract

Context: The quality of health workers' professional life includes some expressed or latent metacognition skills related to psycho-emotional stress management, especially in settings where there is constant contact with suffering or dying patients. The purpose of this study was to ascertain the quality and quantity of *self-care* strategies among oncology residents. **Method:** A professional educator administered the Professional Quality of Life Scale (ProQOL), which measures *compassion fatigue*, *burnout*, and *compassion satisfaction*, and an ad hoc questionnaire. The ProQOL is a questionnaire developed and validated explicitly to detect the emotional experience and perceived work quality of professionals engaged in high-exposure settings due to the onset of vicarious disorders. The ad hoc questionnaire proposed simple questions through which to get a picture of everyday life outside of work and to try to understand the self-care strategies that these residents implement. **Results:** Most of the residents involved were at risk of burnout and had low scores on the subscale of the test measuring satisfaction related to the pleasure of helping others. The study on oncology residents, known to be exposed daily to the risk of incurring vicarious disorders (Cheli, et al., 2017; IsHak et al., 2013; Rotenstein et al., 2016; Sinclair et al., 2016), confirmed the trend highlighted by a recent review of the literature (Panagioti et al., 2016).

Keywords: Compassion Fatigue, Oncology, Self-care Strategy

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1. Introduction¹

The experience of a suffering person affected by an illness can also create suffering among the people who know them, who are close to them or who listen to their story. The term Compassion Fatigue refers to the emotional and psychological state of suffering that results from continuous and prolonged exposure to the pain of others. The most likely and at the same time most visible consequences with which this state of secondary and indirect suffering manifests itself concern dysfunctional behaviors on a cognitive and psychological level with important effects also on professional performance.

Secondary Traumatic Stress is increasingly recognized as a possible occupational consequence of any caring and helping profession (Huggard, Dixon, 2011), and with respect to primary care physicians, surgeons, and oncologists, studies have shown that there are significant challenges with respect to the emotional scope of their work (Balch et.al, 2009; Huggard & Dixon, 2011). In particular, all those who carry out the health profession in the oncological area are exposed to these outcomes (Cheli, et al., 2017; Tartas, 2016).

Another relevant aspect is to be connected to the current health context increasingly characterized by patients with chronic diseases, which implies a profound modification on the part of medical personnel in the approach of the relationship with the disease (Assal, 1999).

In the acute illness model, health care providers learn to suppress their emotions. Inversely in the chronic care setting, long-term care requires practitioner involvement and strong internal motivation within the profession (Assal, 1999, p.105). In addition, the patient today is no longer a passive subject and, furthermore, is not always appreciative of healthcare professionals (Assal, 1999, p. 106), as might have been the case in the past. Patients expect "compassionate" care, and this aspect has become a professional obligation for clinicians (Sinclair et. al., 2016), but very little is known about the state of research on the outcomes of this new identity challenge (ibid.). Equally little is known about the stress associated with the work of physicians, medical school residents, and all professionals who work closely with suffering and/or dying people (Tartas et al., 2016; Figley, 1999; Bobbo, 2015).

In 2016 (Rotenstein et al., 2016) in a review of the scientific literature on the problem of mental distress among medical school students it was found that out of 122,356 students 27.2% suffer from depression or depressive symptoms and that out of 21,002 students 11.1% have suicidal ideation. Depression affects males and females across the board, while depressive symptoms increase by 13.5% as students enter medical school. Only 15.7% of students underwent psychotherapeutic treatment to resolve the problem. From the results of this literature review, we can state that a monitoring of these future physicians' psychic health could be a starting point for educational training interventions that, on the one hand, support the vocational choice of the path to medicine and, on the other hand, implement self-care strategies that lead to Compassion Satisfaction, that is the pleasure of performing one's profession.

As physicians themselves testify in this historical period marked by the covid pandemic - 19: "Health care organizations and society have a responsibility to help address these stresses and challenges." (Shanafelt T, Ripp J, Trockel M., 2020)

¹ The contribution was written by four hands: Paola Rigoni wrote and edited paragraphs 2, 3 and 4; Natascia Bobbo wrote and edited paragraph 1.

2. Research Designs

2.1 Research Objectives

The primary objective of the study was to describe the state of well-being, as well as to assess the quality and quantity of coping and self-care skills possessed by the residents. As suggested in the literature, an early intervention on awareness of any distress present during training can prepare these future professionals to better manage secondary distress such as Compassion Fatigue or burnout (IsHak et al., 2013). The constant monitoring could allow the prevention of states of suffering that prelude to burn-out and the "maintenance of the caring role". The elaboration of the data of this survey could be a preliminary phase to the structuring of a series of training meetings with the trainees, on the phenomenon of Compassion Fatigue and stress management, with the intent to combine research with intervention (action research).

2.2 Sampling Methodology

The target subjects involved were medical oncology residents practicing at the Istituto Oncologico Veneto (Oncological Institute of Veneto, Padua) enrolled in any of the five years of the course.

The simple random sampling method was used, assigning the same probability of selection, that is, each resident had the same probability of joining the sample. A number of twenty participants out of thirty-four enrolled in the residency was established, believing this number to be adequate for the source population. No value of representativeness is expressed, accepting Marradi's (2007) position that "representativeness", is a concept that assumes innumerable intermediate states between total absence and total presence.

We considered this target group of subjects of particular interest first because they are performing in an environment with a high level of stress and secondary suffering, and second because there is limited research available to date on the emotional state of residents in relation to experiencing such a work environment (Tartas, 2016).

2.3 Data Collection and Analysis Methodology

First of all, the subjects involved self-completed a validated test, the Professional Quality Of Life Scale, ProQOL (Stamm, 2009), version 5. The validated Italian version of the test is provided by the test authors themselves on their online site (www.proquol.org); this is followed by an ad hoc questionnaire, consisting of four questions on socio-demographic data, respectively: gender, year of birth, geographical origin, and year of enrolment; ten dichotomous questions that investigate the area of self-care, one with a Likert scale and one with a multiple-choice question that is linked to the perception of the work environment. Data collected were subjected to analysis using dedicated software (Spss).

3. Results

3.1 Description of the Sample of Subjects Involved and the Data Collected

20 residents participated, of whom 14 were female and 6 males, with an average age of 29 (tab. 2).

| Value | Frequency | Percent |
|-------|-----------|---------|
| 27 | 1 | 5,00 |
| 28 | 7 | 35,00 |
| 29 | 6 | 30,00 |
| 30 | 2 | 10,00 |
| 33 | 2 | 10,00 |
| 35 | 1 | 5,00 |
| 37 | 1 | 5,00 |

Table 1: Age

| | |
|----------------|-------|
| N | 20 |
| Mean | 29,75 |
| Std Dev | 2,65 |

Table 2: Average Age

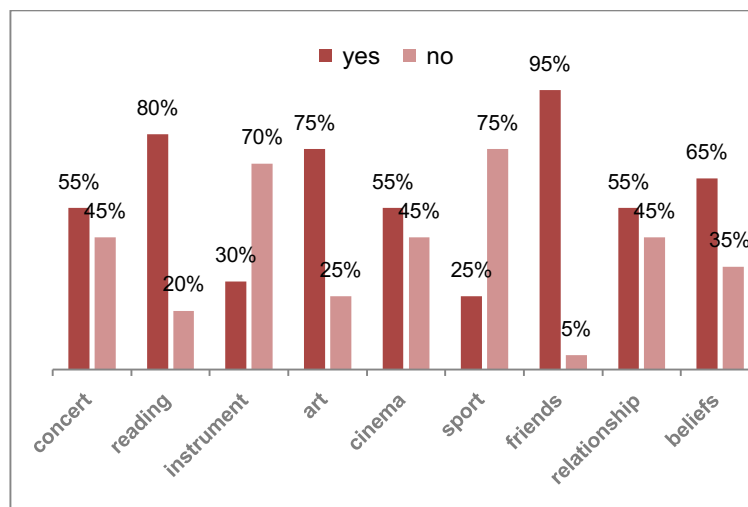
Of these 20, 4 were from the first year of specialization, 5 from the second, 6 from the third, 4 from the fourth and 1 from the fifth (Table 3). Of the participants, 7 were from the Veneto region, 11 from other Italian regions (5 from the center, 4 from the north and 2 from the south), 1 from North Africa and 1 from Eastern Europe.

| Value Lable | Frequency | Percent |
|-------------|-----------|---------|
| 1 | 4 | 20,00 |
| 2 | 5 | 25,00 |
| 3 | 6 | 30,00 |
| 4 | 4 | 20,00 |
| 5 | 1 | 5,00 |

Table 3: Year of Specialization

3.2 The Questionnaire Outcomes: Self-care, Working Environment and Protection

In the dimension of self-care, most of those involved stated that they continue to cultivate their interests despite the number of hours they work. In particular (graph 1) all have read at least one book in the last three months, have gone to a museum or an art exhibition, have gone to the cinema, go out with friends in the evening and sleep well at night. The only dimension in which a low percentage of affirmative responses occurs is sports.

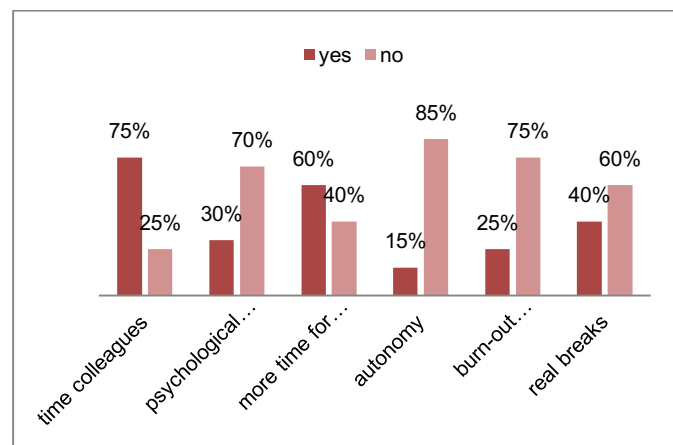


Graph 1: Self Care

No significant correlation was found between item size and year of major or geographic origin. Due to the size of the sample and the unevenness in the gender distribution, it is not possible to compare the gender variable with the other states of the other variables.

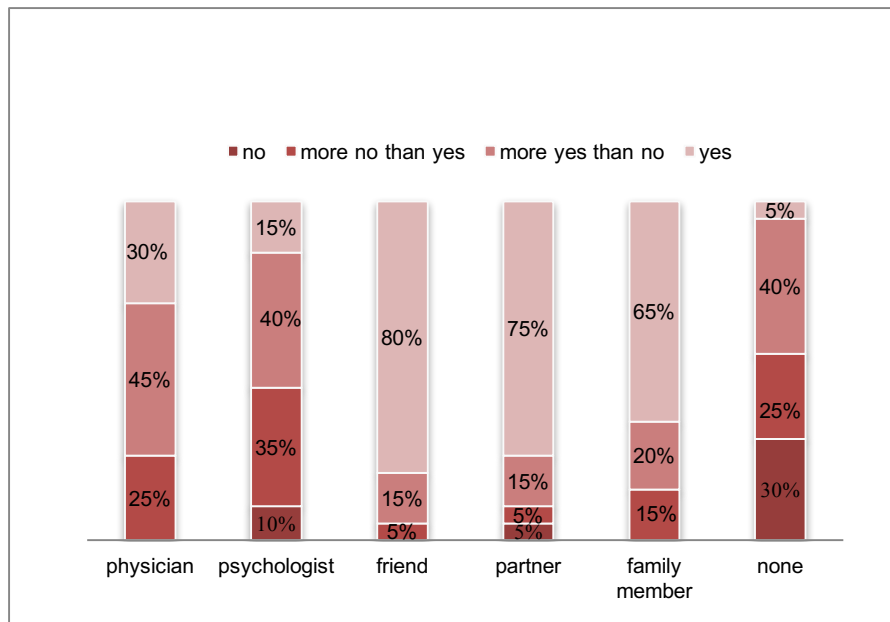
Regarding the work environment, it was asked what could be helpful in coping better during particularly tiring periods.

The most interesting data concerns psychological support (graph 2). The psychologist emerged as the only figure recognized for individual protection in the professional sphere, however in the questionnaire less than half felt that psychological support could be helpful. More than half declare that they prefer to have more time to discuss with colleagues even aspects not related to the clinic and the possibility to have more time for themselves as positive environmental factors. The sample considers it less supportive to have information on how to protect themselves from vicarious discomforts such as burn-out, to have more autonomy in the choices that must be made and to have a dedicated environment in the work context where they can take real breaks.



Graph 2: Working Environment

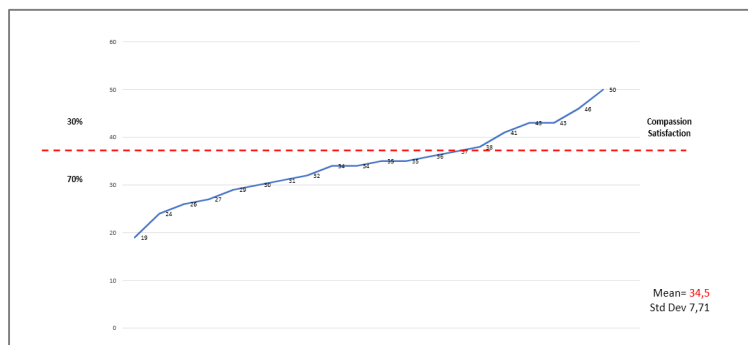
In the dimension of protection, the contrasting figure of the psychologist emerges once again. Less than half of those interviewed believe that, in a moment of personal difficulty, it would be useful to turn to a psychologist (graph 3). More than half declare that they would prefer to talk about their difficulties with a friend (80%), a partner (75%) or a family member (65%).



Graph 3: Protection

3.3 The ProQol Test Outcomes

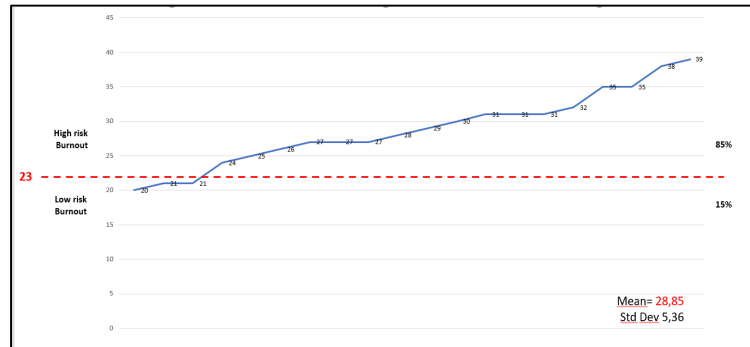
The ProQol test measures three dimensions. Compassion Satisfaction is the pleasure that comes from doing your job well and effectively. This satisfaction may be related to relationships with colleagues, personal ability to propose and implement changes in work protocols or feeling that one's work is worthwhile. High scores on this subscale coincide with higher satisfaction. The calculated average satisfaction score is 37. If the score is less than 32 there may be problems with one's job or there may be areas of concern. The sample presents an average of 34, 5 (graph 4).



Graph 4: Compassion Satisfaction

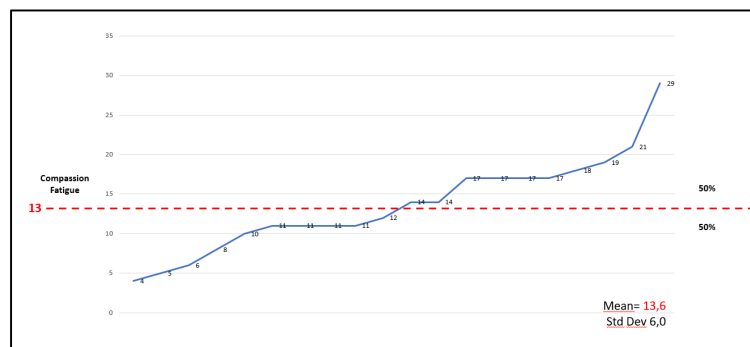
The second dimension is burnout. Most people have a rough idea of what burnout is. This syndrome is associated with emotional exhaustion, with depersonalization, manifested by a detached, sometimes openly hostile attitude, and reduced personal accomplishment that is embodied in a wearisome feeling of inadequacy to establish an effective helping relationship with one's patients. The subject feels that his/her efforts are not producing any change or feels that his/her efforts are not recognized in the work environment. These negative feelings have a gradual onset.

The higher the score on this subscale, the higher the risk of burnout. The calculated mean score is 23. The sample has an average of 29 (graph 5).



Graph 5: Burnout

The third dimension is Compassion Fatigue. Secondary Trauma (STS), and related work-related vicarious trauma relates to continued exposure to events with a high stress load. Symptoms of STS usually have a rapid course and are associated with particular events. The calculated mean for this subscale is 13. A score of 17 or higher is an indication of the presence of this syndrome. The sample presents a mean of 13 (graph 6).



Graph 6: Compassion Fatigue

4. Conclusion

The observational study that surveyed subjects exposed daily to the risk of experiencing vicarious distress (Cheli, et al., 2017; IsHak et al., 2013; Rotenstein et al., 2016; Sinclair et al., 2016), confirmed the trend highlighted by a recent review of the literature (Panagiotti et al., 2016). Most of the resident physicians in our study are at risk for burnout and have low scores on the subscale of the test measuring satisfaction related to pleasure in helping others. Such is the inference in statistical terms, but the interpretation of these results is not unambiguous. Stamm and Figley, the authors of the test, point out that the score may be influenced by a particular mood state, having had a "bad day," or experiencing a time when one has little time for oneself and is particularly tired and vulnerable. Only if the high score in Burnout or Secondary Traumatic Stress persists over time might there be cause for concern. Therefore, a single administration of the test does not define the psycho-emotional balance of the subjects, its outcome should be used as a means, a signal to recognize and accept the possible presence of a fatigue. Understanding the meaning of this fatigue/disorder is a practice of self-care that leads to continue to care for others with success and satisfaction.

The role of the educator fits right into this phase, into the subject's difficulty in recognizing these disorders and understanding their meaning in professional life. These disorders come to the attention of the educator because they can produce important effects on the quality of professional performance and the ability to express and act in compassion towards patients.

The educational intent is to guide these subjects towards a positive solution, through a path of knowledge and acquisition of new perspectives capable of implementing or evoking individual and group resources. The patient is a fragile subject who is going through a deep existential crisis due to the path of illness. If the doctor does not welcome the existential experience of the patient or fails to establish a relationship, she/he lacks not only in compassion, but also in communication. The result of this gap is a further experience of suffering of the patient for the lack of acceptance, with consequences that can also affect the dimension of therapeutic adherence. For the physician it is a source of frustration and a negative predisposition (the patient does not want to understand, it is difficult to relate to him, he/she is aggressive). This dysfunction in the relationship therefore presents mirror difficulties, and the physician her/himself becomes a fragile subject from an identity and psychological point of view.

The educator in this context monitors preclinical symptoms. The monitoring has two primary objectives: to precede a training, as this is the specific task of the educator, to prevent states of vicarious distress; to report situations and send to a consultation with a psychotherapist.

The average score on Satisfaction suggests a decline in the intrinsic motivation to the medical profession. Continuous exposure to suffering and workload can lead to complex emotional states that are not always easily recognized by the individual involved. Most professionals do not spend time trying to understand the effect that the work has on their cognitive processes, and how these also affect their emotional state. Educational intervention in this area should be in-formative: a skills course to recognize, interpret and deal with the emotions related to fatigue and burnout. Awareness is the vehicle through which to re-find an inner balance between expectations and reality (Zannini, 2005). This knowledge supports the reinterpretation of one's own motivations on the basis of the experience gained, so as to be able to grasp the elements of fragility in the difficulties on which to work without "consuming" satisfaction.

Physicians must be led to extend their training beyond the specific professional field, open the horizon to Medical Education, know the tools of Narrative Medicine and Medical Humanities, i.e., the area of research in which physicians themselves have questioned a certain didactic-formative paradigm that according to Bert (2006) forms a physician who does not criticize and does not disturb.

The transformation of workplaces into places where the prevention of these vicarious disorders is protected cannot occur if physicians, nurses, and practitioners do not stop to reflect on and understand how it can be created, implemented, and maintained.

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