

The Key to Self-Care



Finding a way of being with our pain

Michael Kearney MD
Self-Care and Compassion in Health care
Our Lady's Hospice
Tuesday 25th April 2017

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Self-care of Physicians Caring for Patients at the End of Life

"Being Connected . . . A Key to My Survival"

Michael K. Kearney, MD

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THE CLINICIAN'S STORY

Dr C is a 45-year-old hematologist-oncologist in private practice for 11 years at a large, urban, community hospital. Dr C directs his hospital's clinical research program in oncology and has an appointment at the nationally ranked medical school in his city. He sees about 500 patients a month, 6000 patients a year, of whom 60 to 120 require end-of-life care. Dr C is married, with 3 school-aged children. He enjoys music, travel, tennis, and good food with friends. Dr C shared stories of Ms J and Mr B, 2 patients who had recently died on the same day. He had very different relationships with each.

Ms J, a 55-year-old woman, presented in 2003 with lymphadenopathy in the groin that proved on biopsy to be poorly differentiated adenocarcinoma. Further workup revealed an ovarian mass, liver metastases, and a CA 125 level of more than 1000 units, leading to a diagnosis of ovarian cancer. She did not smoke or drink alcohol. Ms J was single and was cared for lovingly by her mother. Ms J underwent surgery for debulking and then received 6 cycles of chemotherapy with carboplatin and paclitaxel, achieving good response. After approximately 12 months of remission, her tumor progressed, at which point she received cisplatin and gemcitabine, initially with good response. Subsequently, she developed symptomatic bone metastases. Renewed chemotherapy included doxorubicin, then topotecan, neither affording a response, and radiation therapy was given for the bone metastases.

When Ms J first came to see Dr C, in his words, "She was riddled with disease and in a lot of discomfort." Under his care she was able to work, travel, and enjoy her life for 4 years, at which point she had significant worsening of dis-

ease. Ms J enrolled in hospice and, cared for by her mother, died at home.

Mr B was a 50-year-old single man with cutaneous B-cell follicular lymphoma. Mr B had type 2 diabetes mellitus, hypertension, and previous surgical resection of lung cancer. He smoked 1 pack of cigarettes a day but did not drink alcohol. Mr B was treated expectantly, but 6 months after initial diagnosis, he presented with pancytopenia, disseminated intravascular coagulation, fevers, weight loss, and diffuse lymphadenopathy. A lymph node biopsy confirmed a diagnosis of diffuse large-cell lymphoma. Mr B received rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone and had an ini-


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Author Affiliations: Palliative Care Service, Santa Barbara Cottage Hospital and Visiting Nurse and Hospice Care of Santa Barbara (Dr Kearney), and La Casa de Maria Retreat and Conference Center (Dr Weininger), Santa Barbara, California; Department of Psychiatry and Dalla Lana School of Public Health, University of Toronto, Toronto, Ontario, Canada (Dr Vachon); Counseling Psychology Program, University of British Columbia, Vancouver, Canada (Dr Harrison); and Department of Medicine, McGill University, Montreal, Quebec, Canada (Dr Mount).
Corresponding Author: Michael K. Kearney, MD, Palliative Care Service, Santa Barbara Cottage Hospital, PO Box 689, Pueblo at Bath Street, Santa Barbara, CA 93102-0689 (mkearney@sbch.org).

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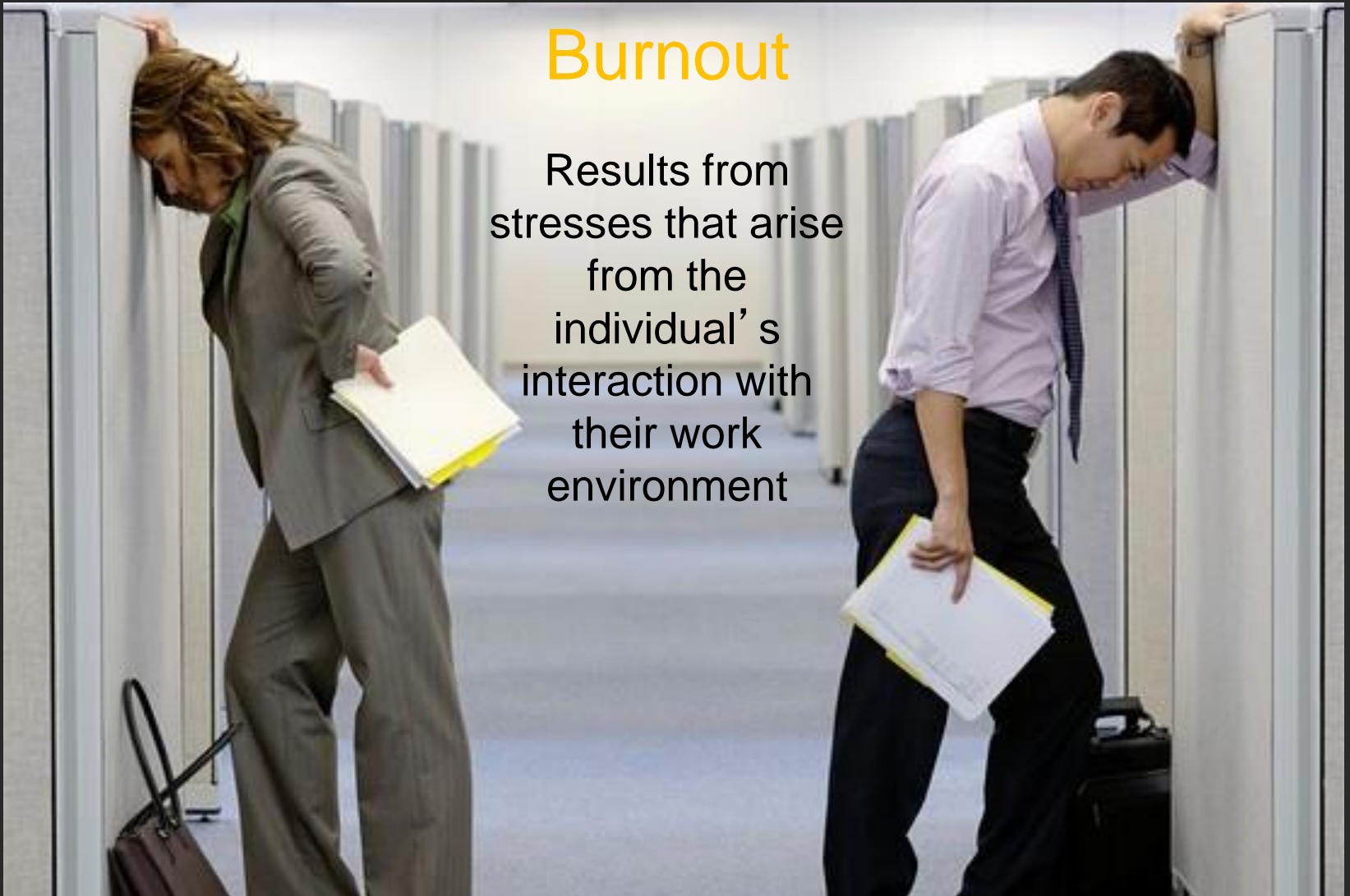
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Caregiver stress – 3 Syndromes

- Burnout
- Vicarious Traumatization
- Moral Distress Syndrome

Burnout

Results from stresses that arise from the individual's interaction with their work environment



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Burnout

Results from stresses that arise from the individual's interaction with their work environment

Prevalence:
30% US
physicians and
nurses

“The stuff that burns me out has nothing to do with loss... it’s fighting insurance companies”

Dr C, medical oncologist

Some stressors specific to end-of-life care

- Inadequate time with dying patients
- Inadequate coping with one's own emotions/grieving
- The need to carry on “as usual” in the wake of patient deaths
- Inability to live up to one's own internalized standards (e.g. to provide a “good death” – every time and for every patient!)

6 Major Organizational Antecedents of Burnout

- Workload
- Control
- Reward
- Community
- Fairness
- Values

Maslach et al. 2001

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“The greater the mismatch between the person and the work environment, the greater is the likelihood of burnout. A better match or fit is associated with greater engagement with work.”

Maslach et al. 2001

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“The greater the mismatch between the person and the work environment, the greater is the likelihood of burnout. A better match or fit is associated with greater engagement with work.”

Maslach et al. 2001

The opposite is also true → “Job satisfaction”

3 Key dimensions of burnout

1. Overwhelming physical and emotional exhaustion
2. Feelings of cynicism and detachment from the job
3. A sense of ineffectiveness/ lack of accomplishment

Maslach et al

Clinicians who are “burnt out”...

- Higher risk substance abuse, anxiety, depression, suicide...
- Make more medical errors
- Lose their sense of empathy
- More prone to leave clinical practice

Vicarious Traumatization (“Compassion Fatigue”)



- *Evolves specifically from the relationship between the caregiver and the patient*
- *Also known as “secondary traumatic stress disorder”*
- *Symptoms are of PTSD*

Symptoms and Signs of Vicarious Traumatization

Increased Arousal

- Irritability and hyper-vigilance
- Difficulty in concentrating

Re-experiencing

- Intrusive thoughts
- Sleep problems including nightmares
- Distress in reminders of work with suffering

Avoidance

- Social withdrawal
- Avoidance of emotionally difficult clinical situations
- Numbness and disassociation

Moral Distress Syndrome



Moral distress occurs when an individual identifies the ethically appropriate action but is prevented from acting in accordance with their convictions by external constraints and is often expected to act against their convictions

Moral Distress Syndrome



- Feelings of frustration, impotence, and isolation; of being devalued & marginalized
- May lead to clinicians leaving their profession
- When repeated, may lead to lingering sense of having been compromised - “moral residue” - and may erode sense of self-worth

Common endpoint = **Burnout**

3 Key dimensions of burnout

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- A sense of ineffectiveness/ lack of accomplishment

Maslach et al

OMG!

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OMG!

- Overwhelming physical and emotional exhaustion
- Feelings of cynicism and detachment from the job
- A sense of ineffectiveness/ lack of accomplishment
- Frequent fantasizing about changing job

Different models of self-care

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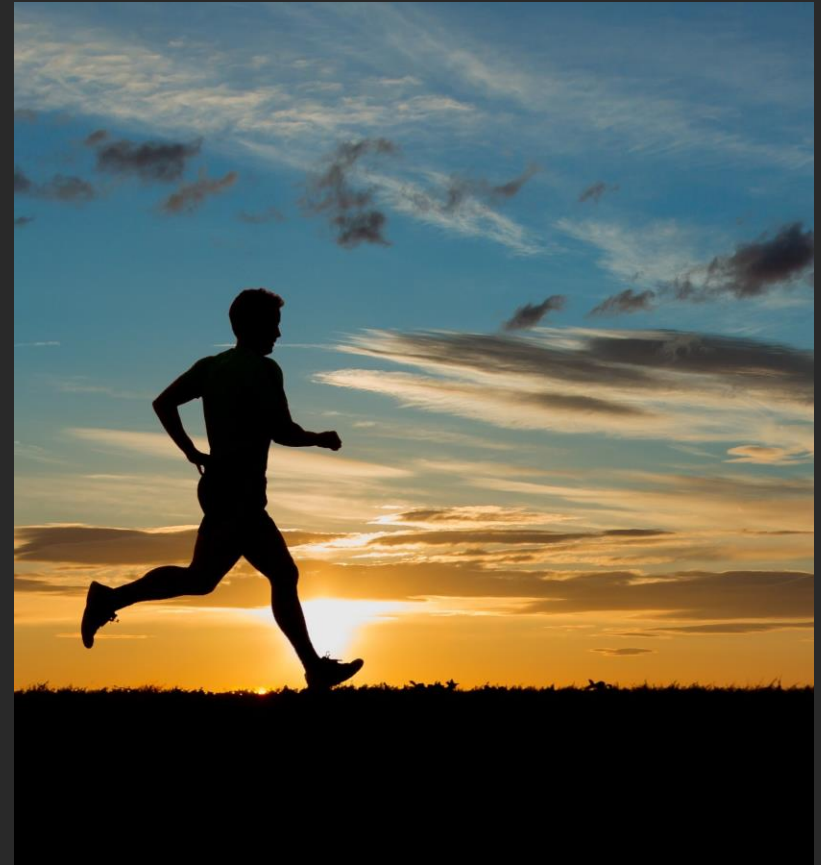
Practical model

Practical model: Good professional boundaries



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Practical model: Rest & Renewal outside work



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Practical model

However, an exclusive reliance on this approach to self-care can result in clinicians who are less empathic to patients, and who experience work as less rewarding

Psychological model

Psychological model: Self-awareness

- Mindfulness
- Self-knowledge
- Self-Compassion

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Physicians providing end-of-life care are subject to a variety of stresses that may lead to burnout and compassion fatigue at both individual and team levels. Through the story of an oncologist, we discuss the prodromal symptoms and signs leading to burnout and compassion fatigue, represent the evidence for prevention. We discuss the signs and symptoms leading to burnout and compassion fatigue and consider factors that may mitigate burnout. We explore the practice of empathy and discuss an approach for physicians to maximize well-being through self-awareness and self-care. Learning objectives: With end-stage illness, find ways to secure practical applications of self-care in the workplace.

JAMA. 2009;301(11):1155-1161.

www.jama.com


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“One last question: Can you please explain the importance of the “breathing underwater” metaphor? I keep deleting it because people cannot breathe underwater, so to me the metaphor would mean that self-care with self-awareness is impossible. Since you keep putting it back in again, can you explain why this particular metaphor is important?”

JAMA editor

Practical model



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Self-awareness

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What is “clinician self-awareness”?

Clinician Self-Awareness

1. Self-Knowledge
2. Mindfulness
3. Self-compassion

Self-Knowledge

Includes a clinician's understanding of her/his family, religious and cultural background, her or his emotional and psychological process, and having worked through personal issues that could lead to prejudice and/or interfere with clinical objectivity

Mindfulness

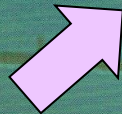
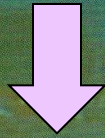
The purposeful, non-judgmental attentiveness to one's own experience, thoughts, and feelings

Mindfulness enhances the cognitive capacity to be highly present and focused, while simultaneously allowing the practitioner to monitor her/his own subjective experience and interactions with others and the environment (“meta” or “dual” awareness)

Self-compassion

Involves a clinician becoming aware of self-judgment and self-criticism. Working through these feelings allows the clinician to cultivate an attitude of kindness and self-compassion towards her/himself

Mindfulness



Self-Knowledge



Self-compassion

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Reactive-Awareness

- In practice the usual mode of awareness is not mindfulness
- For most of us “Reactive-Awareness” is the default mode
- This describes how, in times of stress, awareness collapses into a constricted view of reality where trigger events can unleash a cascade of reactive behaviors

Cultivating & practicing self-awareness - 2 step process

1. Develop self-awareness as on-going practice
 - Self-knowledge, mindfulness, and self-compassion
2. Apply self-awareness skills in the moment
 - Practice “exquisite empathy”

1. Develop self-awareness as on-going practice

- Mindfulness meditation
- Reflective writing
- Supervision/Mentoring
- Peer Group Support
- Educational initiatives
- Research initiatives
- Psychotherapy
- Spiritual direction

1. Develop self-awareness as on-going practice

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2. Apply self-awareness skills in the moment

“Exquisite empathy”

- Highly present
- Sensitive attuned
- Finely-boundaried
- Heartfelt

Richard Harrison

Spectrum of burnout



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Spectrum of burnout



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Practical Model: Boundaries and R & R

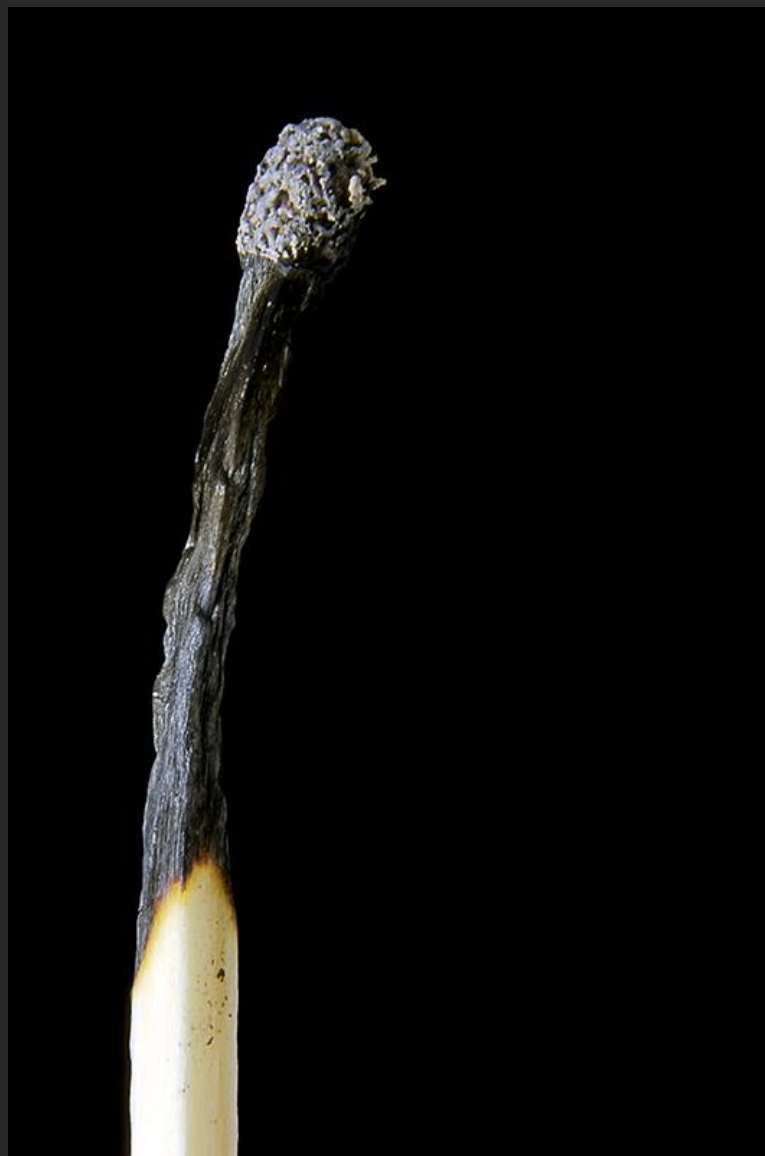
Psychological model: Self-awareness based

Spectrum of burnout

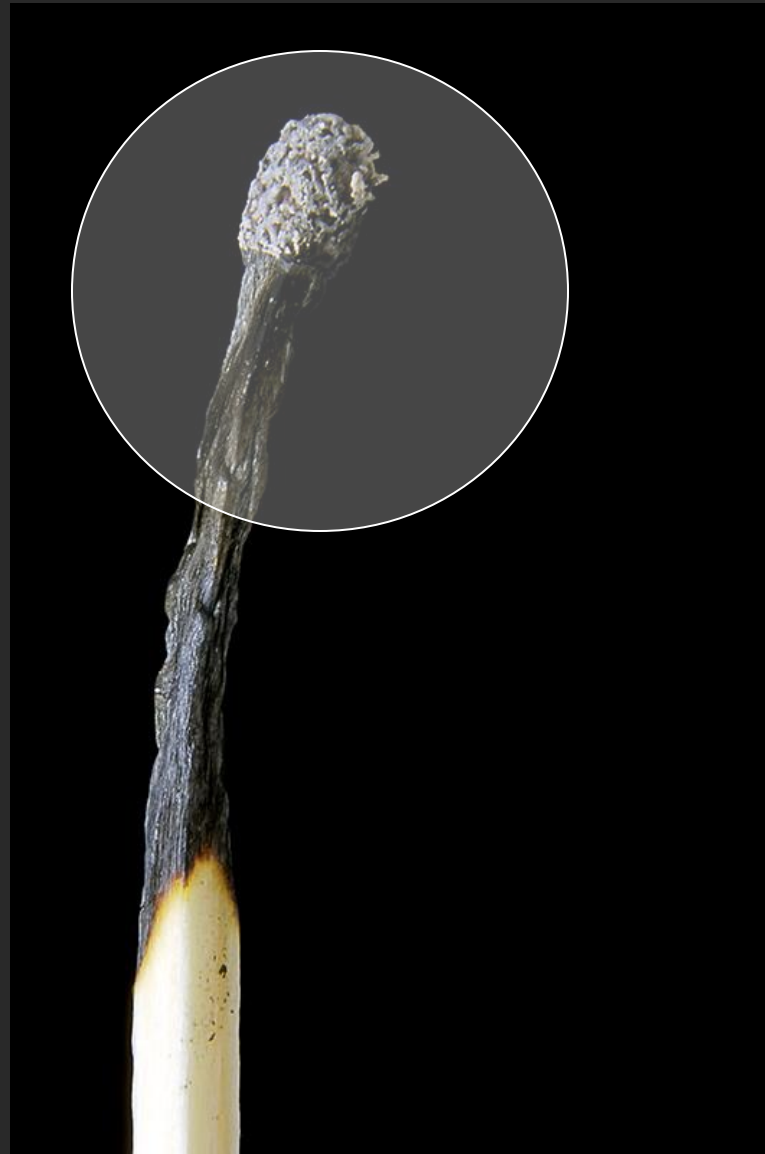


Me!

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It was painful to listen to these stories

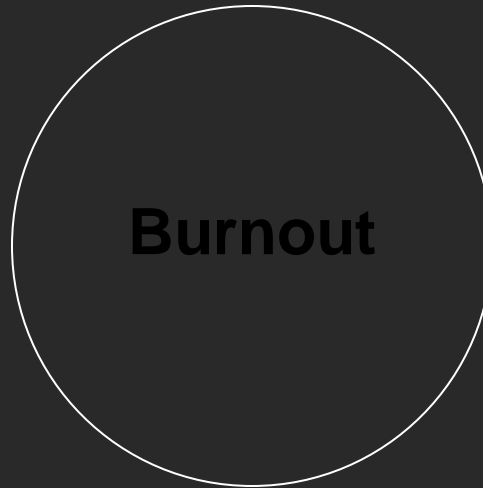


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It was painful to listen to these stories

**I realized I didn't have a good way of dealing
with this chronic heart pain**

Common Endpoint



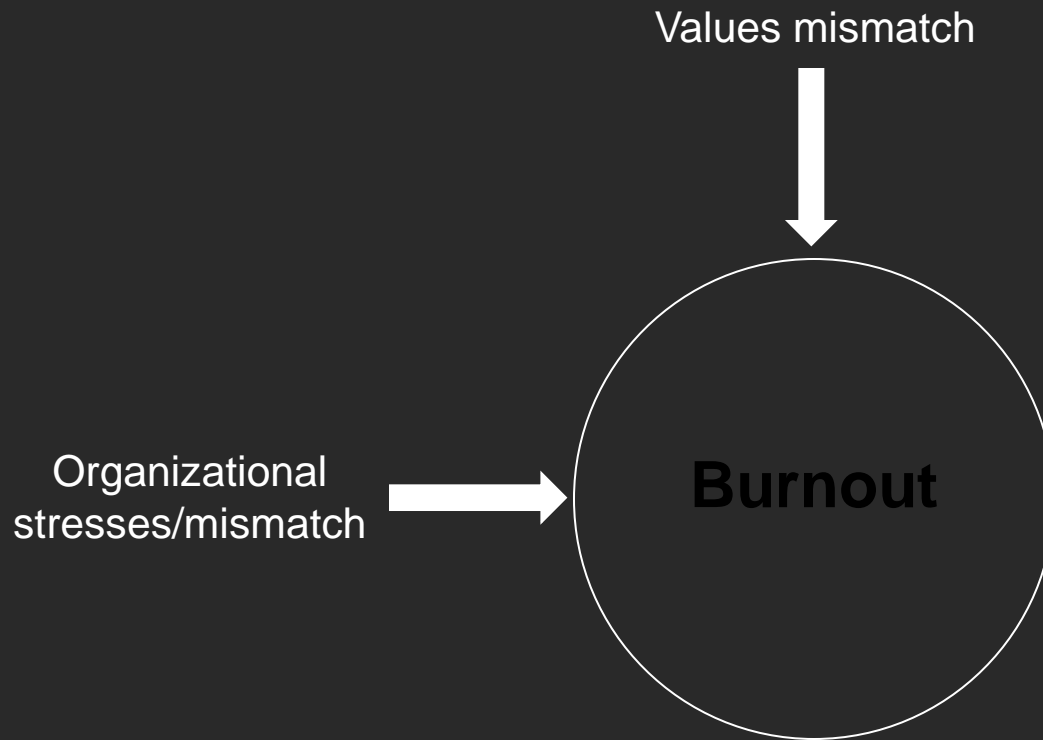
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Organizational
stresses/mismatch

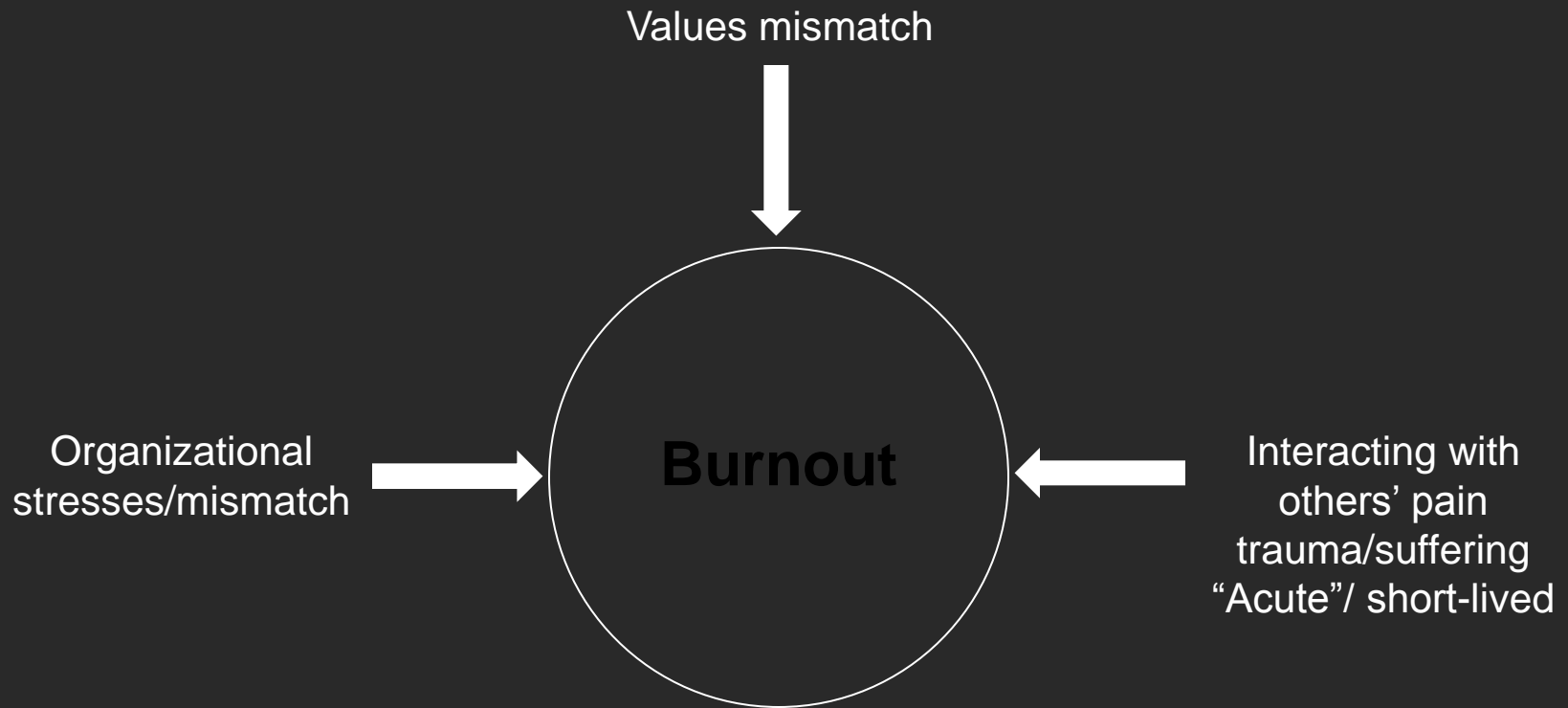


Burnout

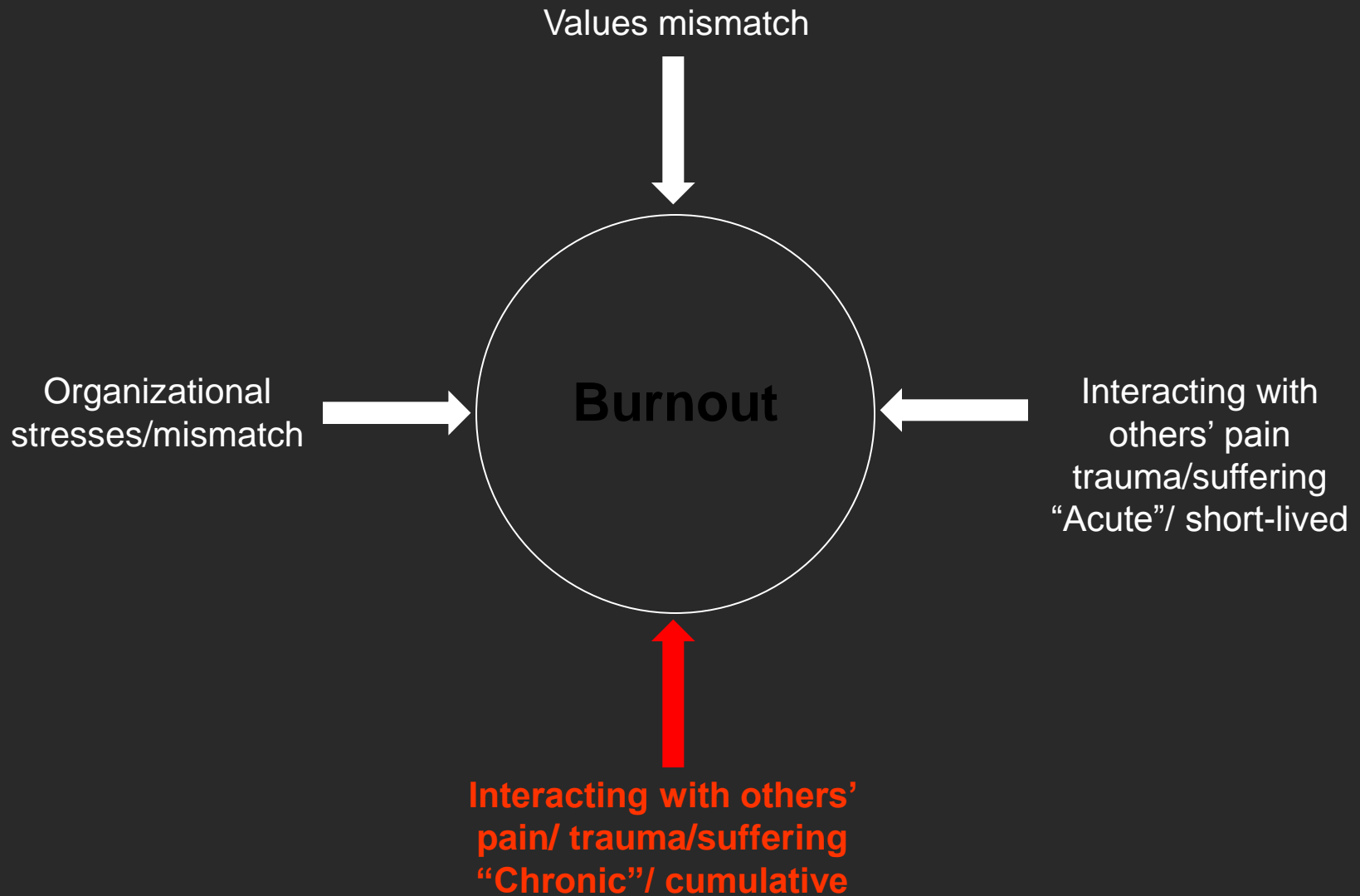
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**Was there another, less destructive way, of
being with my pain?**



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Was this the outline of another way of being with pain?

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The ways I knew of being with pain

Heroic

- Medical model
- “Treat or retreat” (fight or flight)
- Outward focused
- Trust information, expertise, technology
- A power over/down model

The ways I knew of being with pain

Wounded Healer

- Mindfulness, Self-knowledge, self-compassion
- “Being present to” – “Holding” – “Waiting”
- Inner focused
- Trust in our own experience and the innate healing potential of the other
- An egalitarian model



I began to see this was the outline of another model of self-care
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Spiritual model



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Spiritual model

- Connecting with nature
- Feeling the pain in our heart
- Releasing the pain
- For the welfare of all



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Connecting with nature

- The process of paying sensory attention to a natural process/ being
- Attitude – respect, openness, gratitude
- “Inner” (e.g. MOB) and “outer” (e.g. sense meditation)

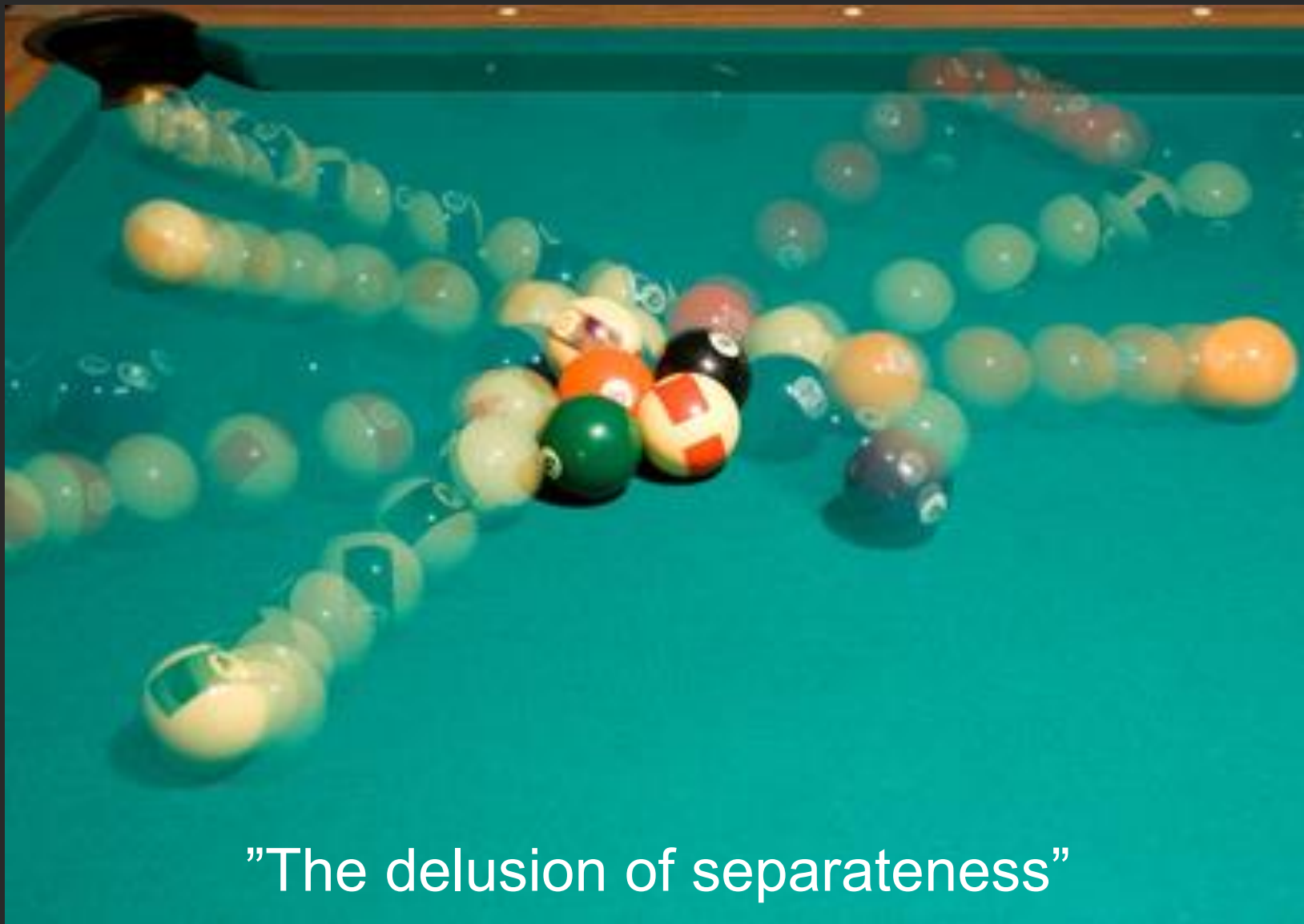
What does nature connection do?

Helps us to remember who we are

We think (and feel) we're...



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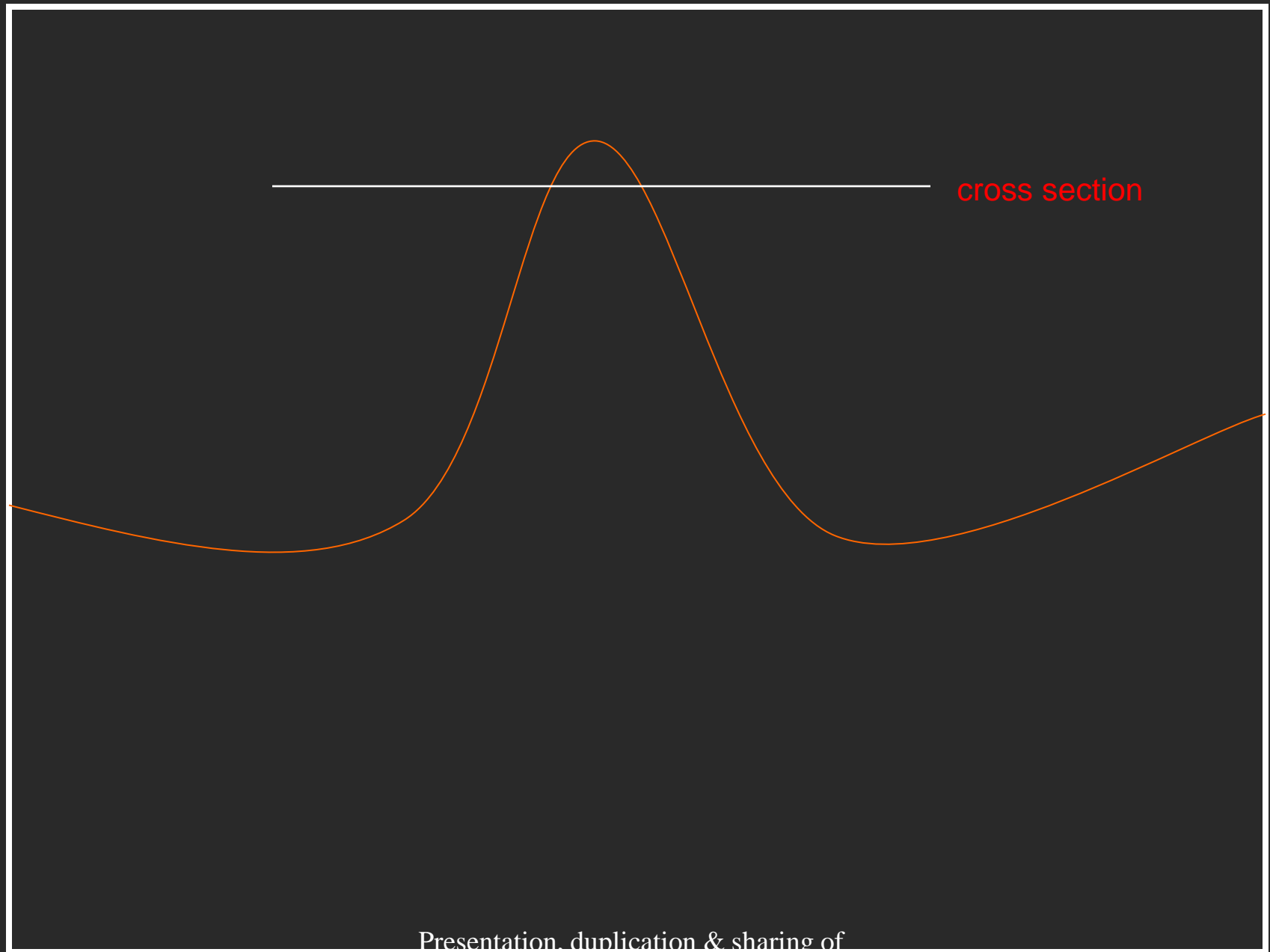
“The delusion of separateness”

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But our Native elders, mystics of all great spiritual traditions, and physicists tell us we're more like...



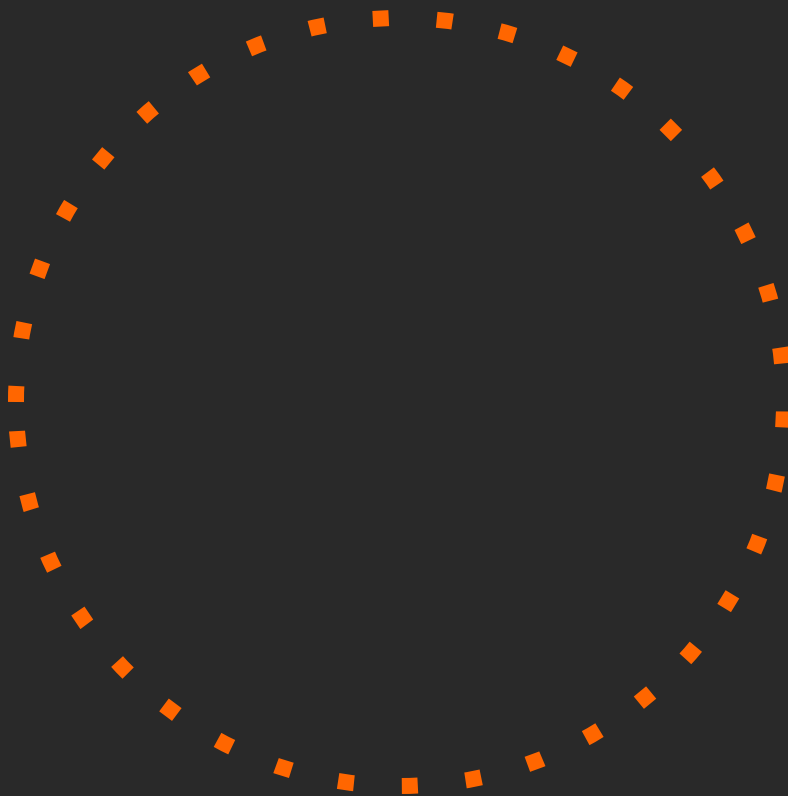
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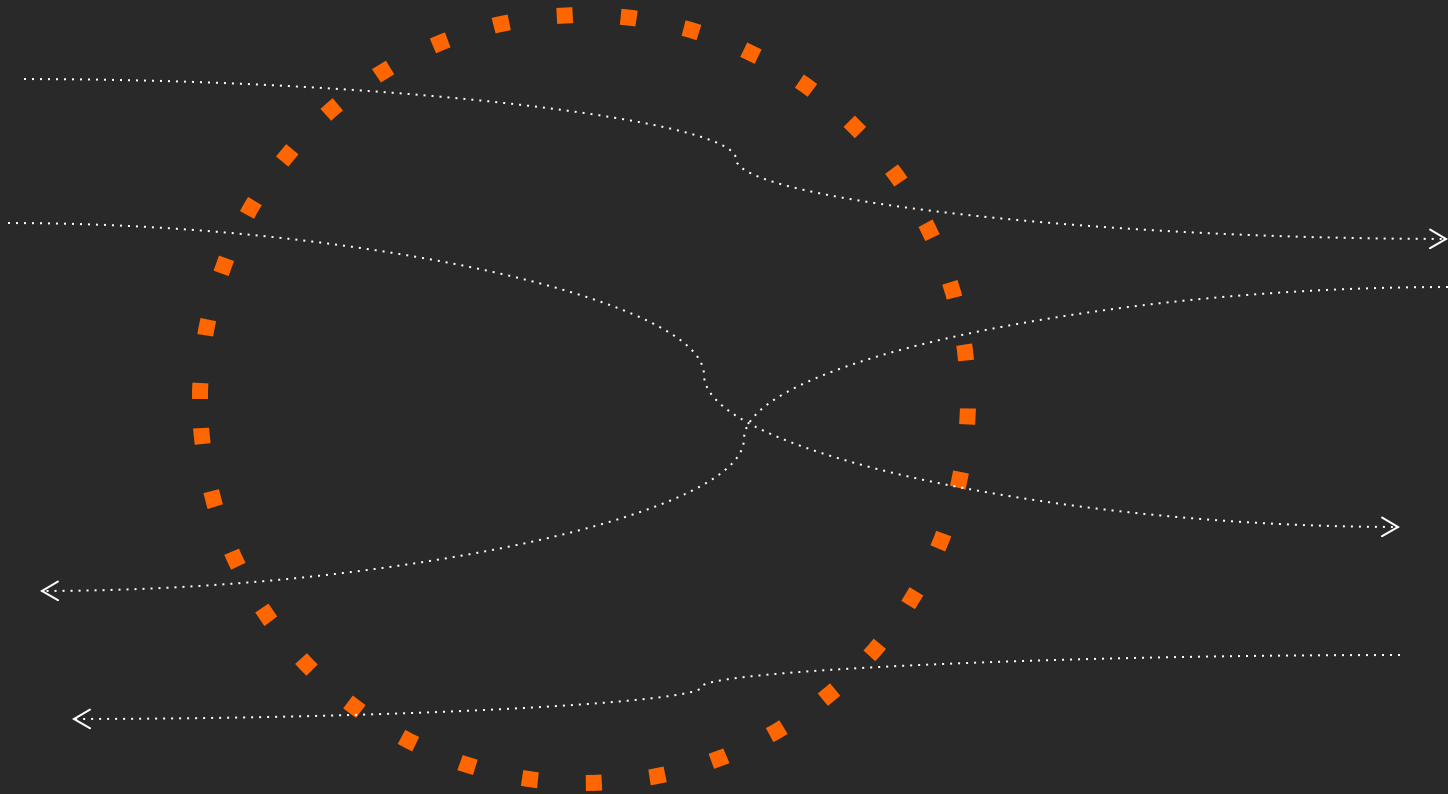


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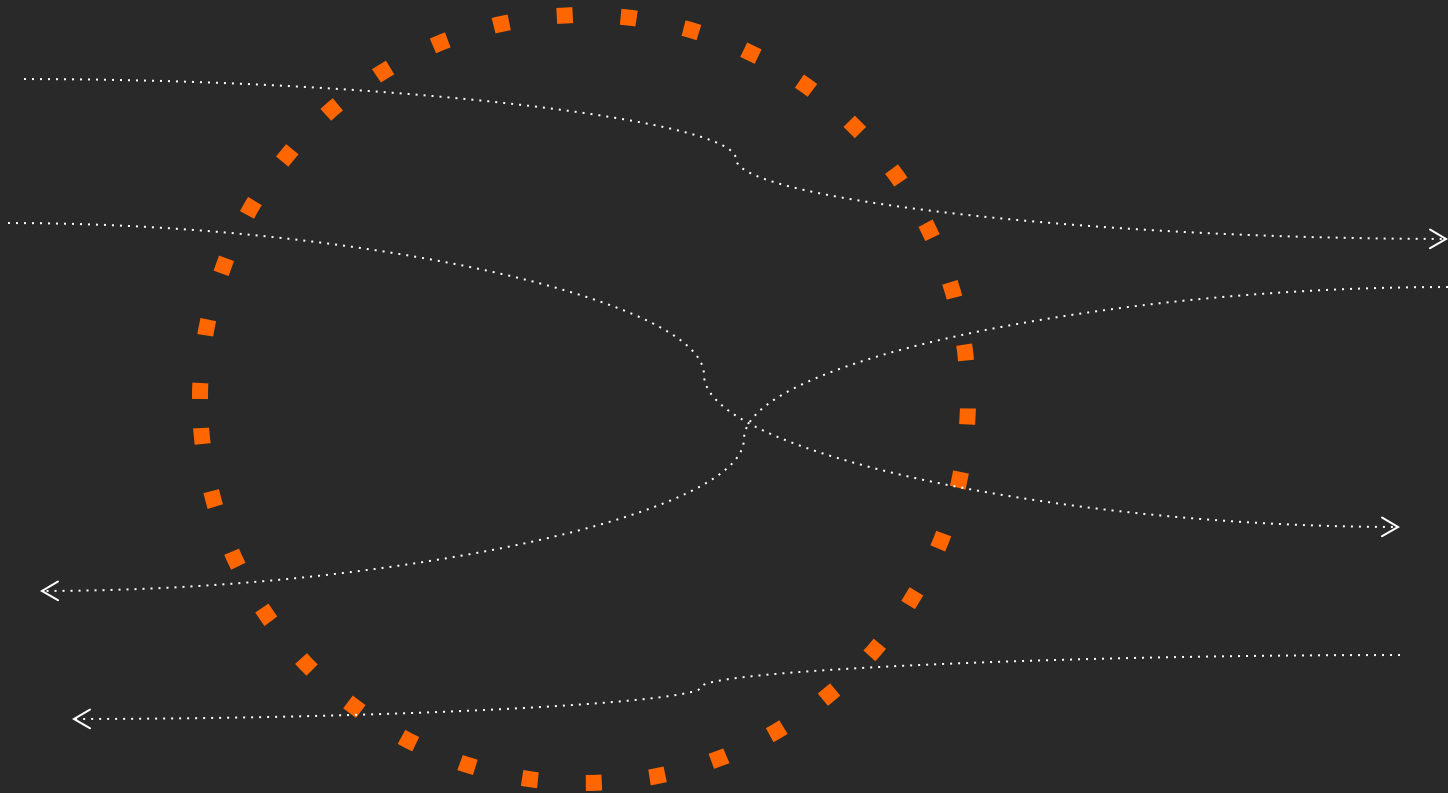
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Porous and fluid

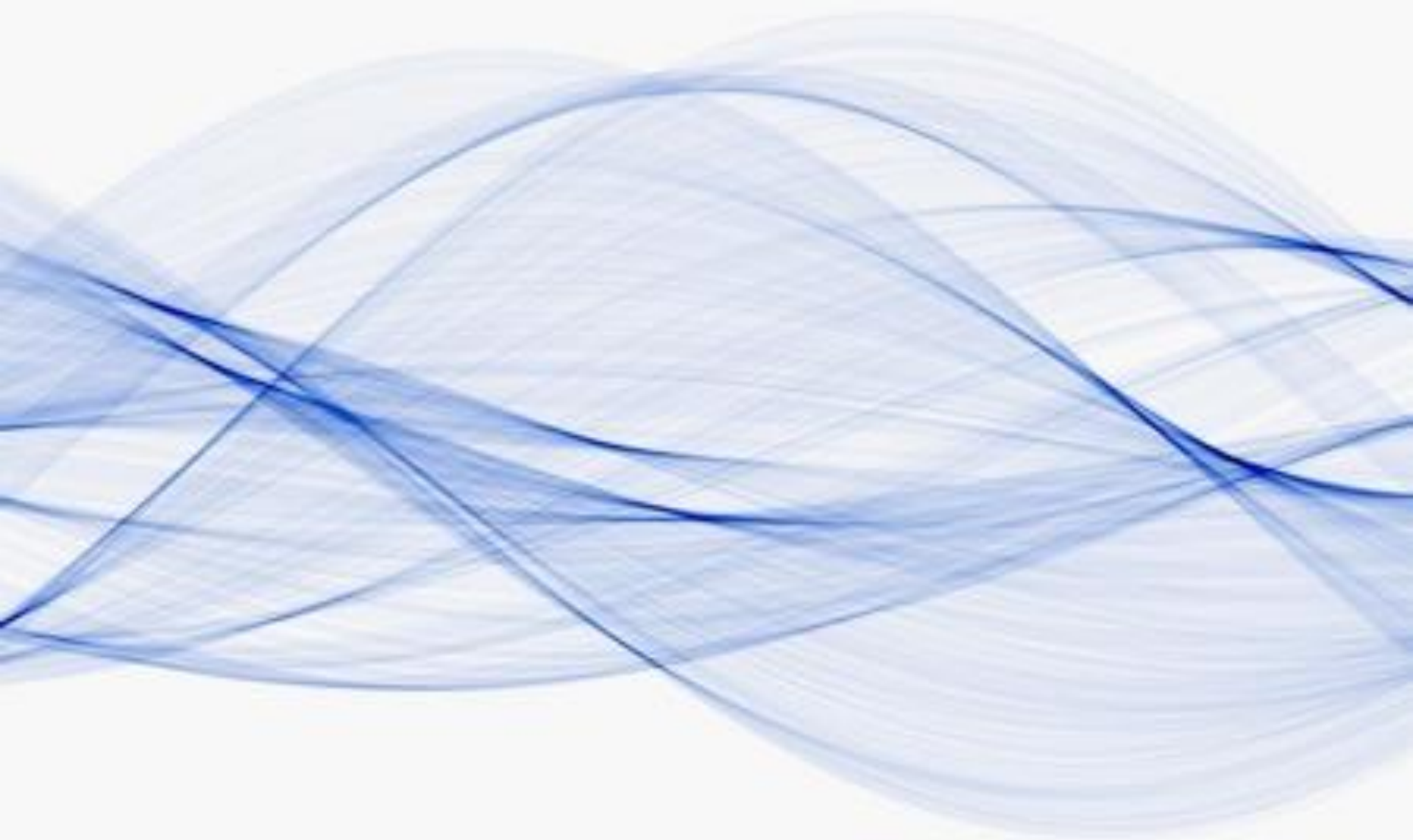


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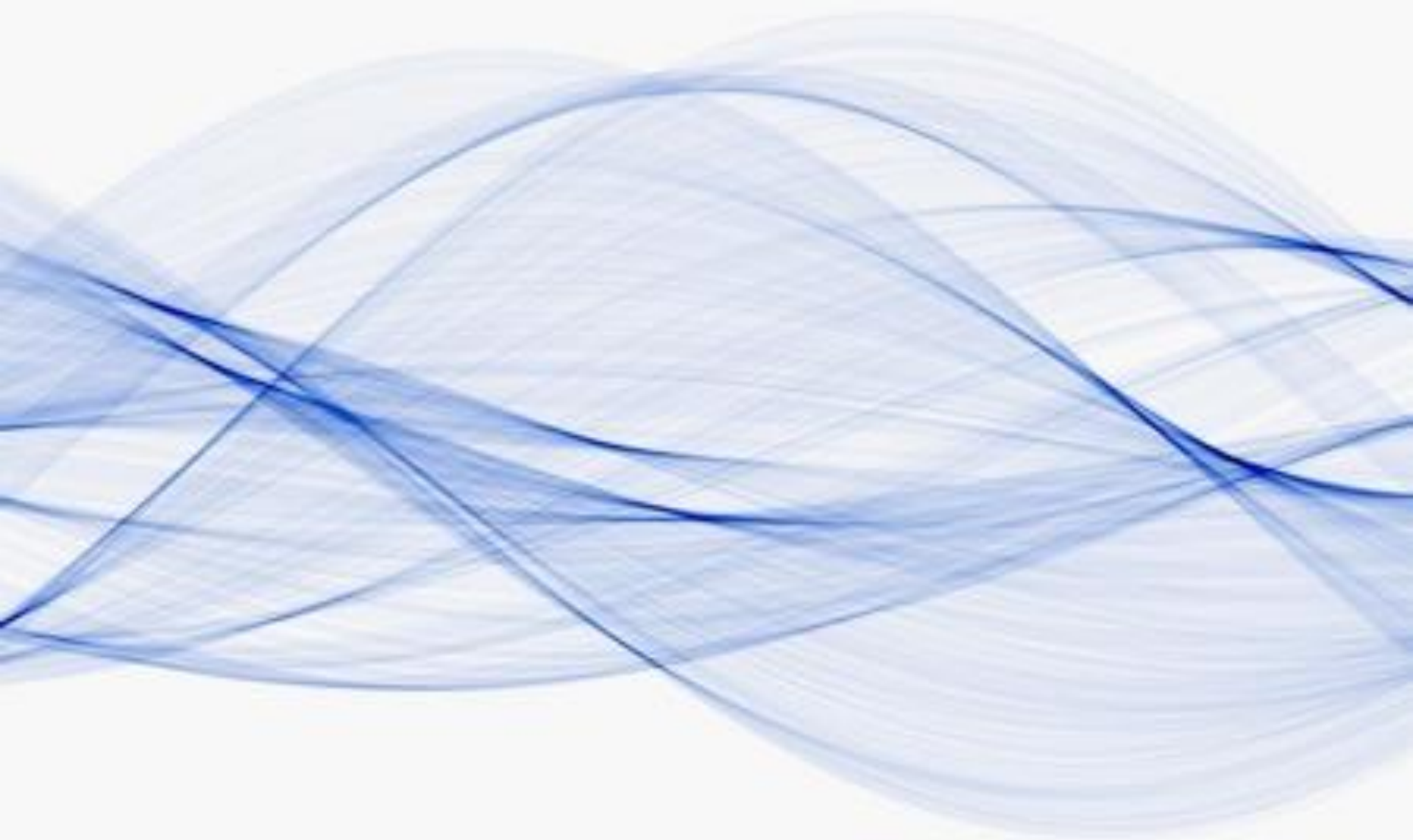
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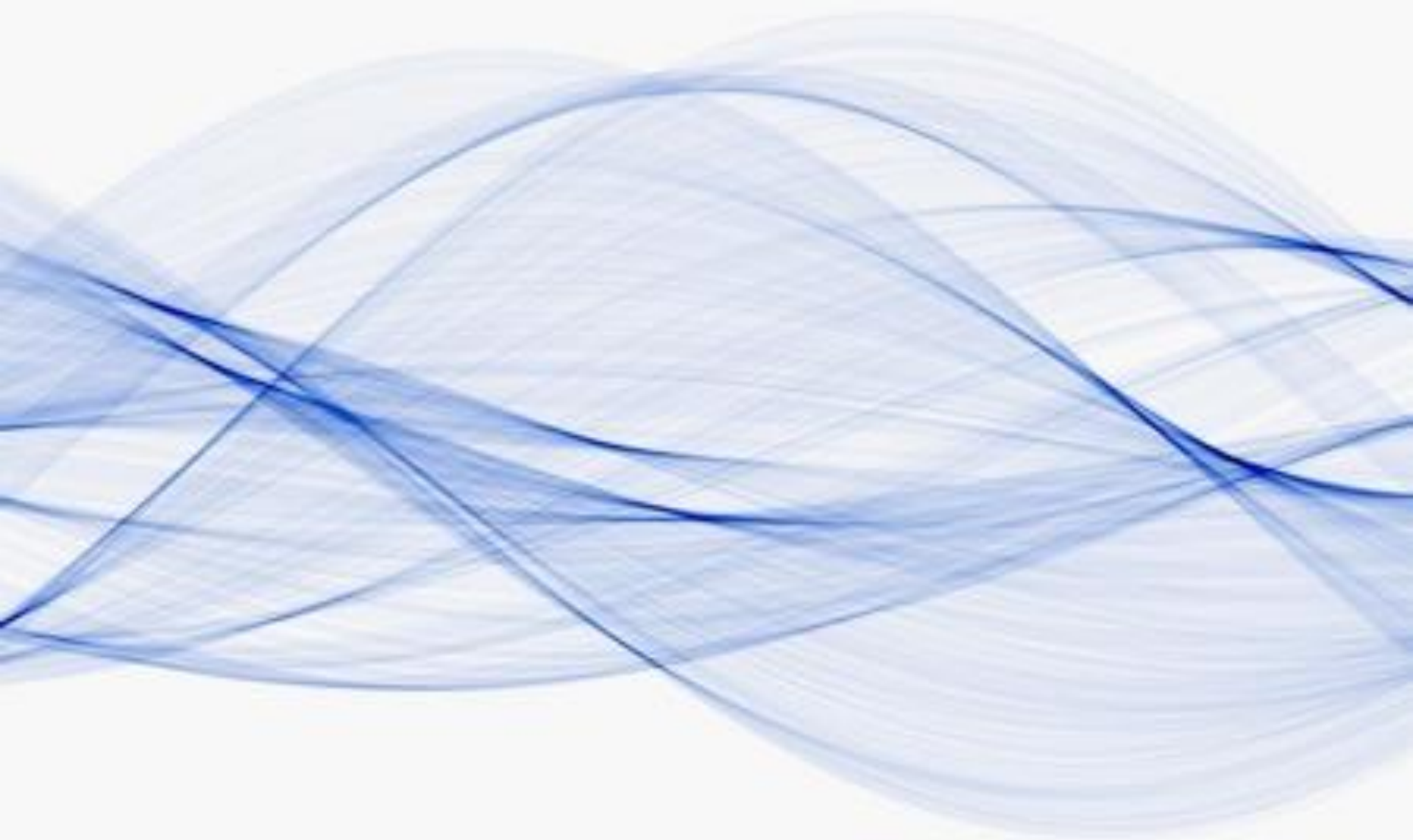


Interactive and interdependent



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Mutually conditioning and co-arising



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The background of the slide features a series of overlapping, flowing, wavy lines in various shades of blue, creating a sense of movement and depth. The lines are more concentrated in the center and fade out towards the edges.

We are more “happenings” than we are “things”...

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What does nature connection do?

Helps us to remember who we are

Allows us to experience other-than-human nature as

*“It’s all alive,
It’s all intelligent,
It’s all connected,
It’s all relatives”*

What does nature connection do?

Helps us to remember who we are

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*“It’s all alive,
It’s all intelligent,
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It’s all relatives”*

*As we do, we may know a different kind of power,
a sense of belonging and kinship,
and a caring and desire do what we can to relieve another’s suffering*

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Spiritual model

- Connecting with nature
- Feeling the pain in our heart
- Releasing the pain
- For the sake of all beings



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But why would anyone want to do this?

A number of wisdom traditions tell us that,
paradoxically, healing is sometimes found where we
might least expect it:
in the wound, in the pain, in the suffering

“May you have the commitment to know what has hurt
you,
allow it come closer to you, and in the end to become
one with you.”

St Fintan

“Your defects are the way that glory gets manifested. Whoever sees clearly what’s diseased in himself begins to gallop on the way... Self-complacency blocks the workmanship. ... Don’t turn your head. Keep looking at the bandaged place. That’s where the light enters you.”

Rumi

“Ring the bells that still can ring,
Forget your perfect offering.
There’s a crack, a crack in everything;
That’s where the light gets in.”

Leonard Cohen

The “felt sense”



“First – feel your body. Your body can, of course, be felt from the outside but I am asking you to feel it from the inside.

The “felt sense” is a special kind of internal bodily awareness; a bodily felt, implicitly-rich sense of some situation, problem, or aspect of one’s life. The felt sense is the holistic, implicit, bodily sense of a complex situation.”

Eugene Gendlin

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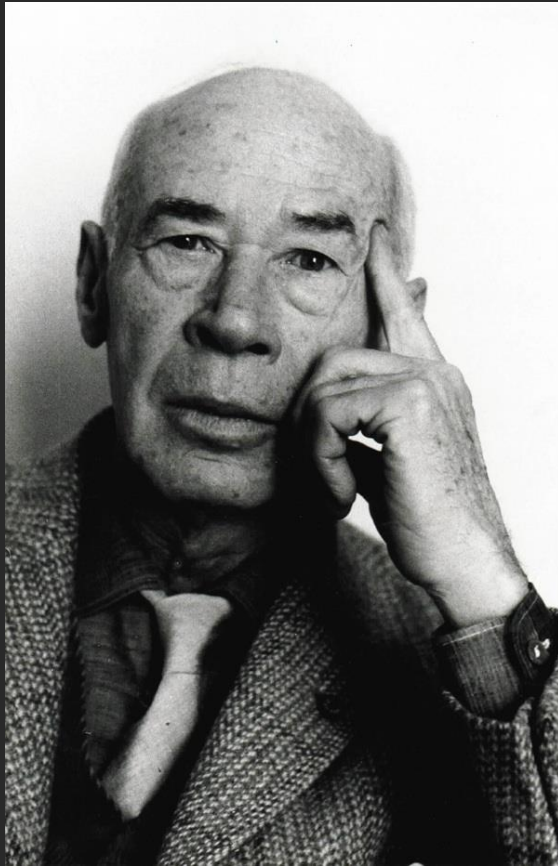


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Releasing the pain

- A choice
- To let go of
- To let go to
- Without expectation of outcome

The healing power of surrender



Henry Miller

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“At Epidaurus, in the stillness, in the great peace that came over me, I heard the heart of the world beat.

I know what the cure is:

It is to give up, to relinquish, to surrender, so that our little hearts can beat in unison with the great heart of the world.”

“The Colossus of Maroussi,” Henry Miller

Spiritual model

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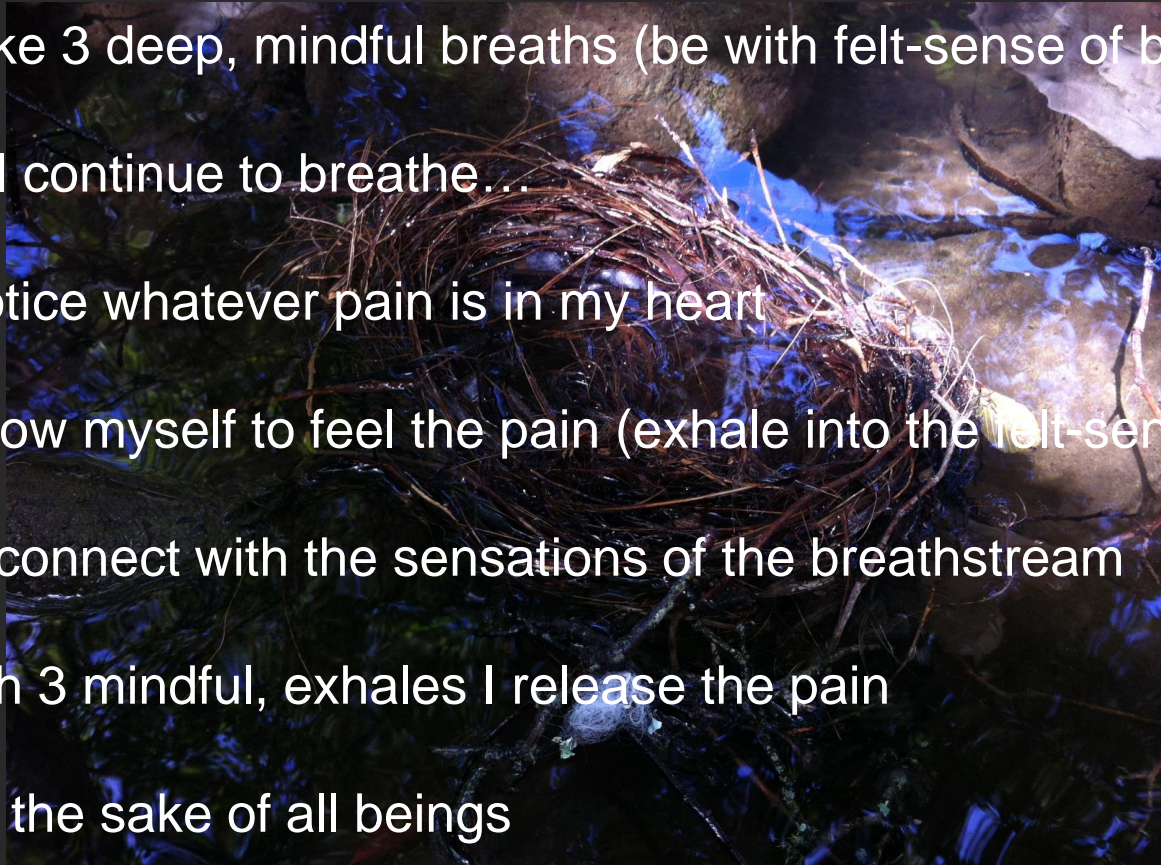
For the sake of all beings

- “Bodhichitta”
- *“The overarching yearning for the welfare of all beings”*
Joanna Macy
- Arises spontaneously from deep connection
- In releasing our pain we’re releasing energy back into web of life

*The more connected we are, the more we care; the more we care,
the more we want to do all we can to relieve the suffering and
promote the happiness of those we care for*

Spiritual model: *At the bedside*

- I take 3 deep, mindful breaths (be with felt-sense of breath)
- As I continue to breathe...
- I notice whatever pain is in my heart
- I allow myself to feel the pain (exhale into the felt-sense of)
- I reconnect with the sensations of the breathstream
- With 3 mindful, exhales I release the pain
- For the sake of all beings





So, in conclusion...

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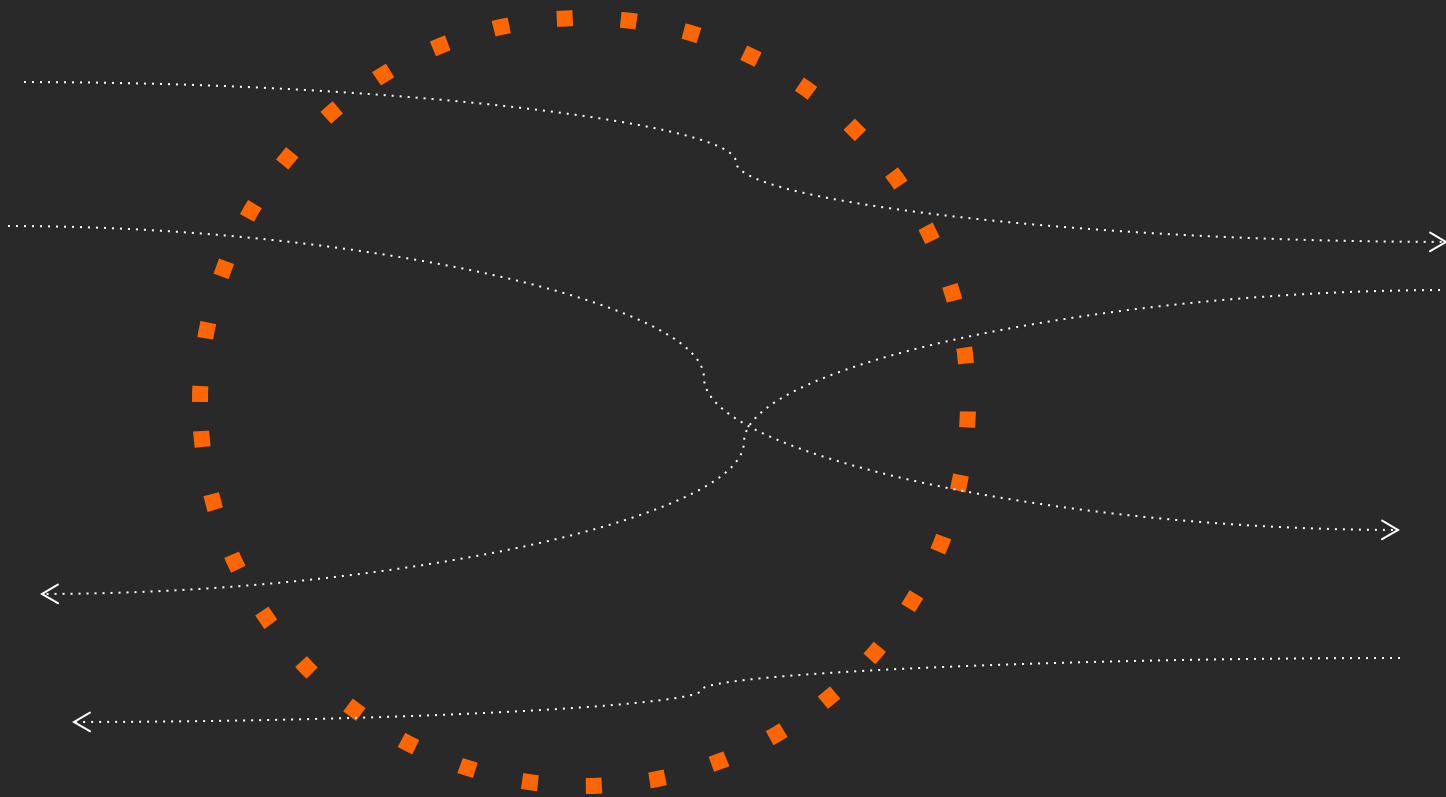
Psychological model



Practical model

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The spiritual model of self-care



Offers us another way of being with our pain

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The spiritual model of self-care



By becoming the flow-throughs we already are

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1. What is my de-fault relationship with pain?

- Heroic
- Wounded healer
- Flowing-through
- None of the above
- All of the above

1. What is my de-fault relationship with pain?
2. What are the advantages and disadvantages of being with pain in this way?

1. What is my de-fault relationship with pain?
2. What are the advantages and disadvantages of being with pain in this way?
3. Is this working? For my patients? For me?

1. What is my de-fault relationship with pain?
2. What are the advantages and disadvantages of being with pain in this way?
3. Is this working? For my patients? For me?
4. If not, how might I, could I, would I like to do it differently?

Remember

- There's no hierarchy of value intended here
- Each approach has it's own time and place
- Not about self-blame or judgment
- I personally operate from all three in any given day (probably mostly heroic, sometimes wounded healer, and occasionally - not enough - flowing-through)
- I find it helpful to be mindful of how I am with my pain at any moment so can consciously choose the mode of being with pain, my own and my patient's, that I think/feel might be the right/most helpful response in any given circumstances

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