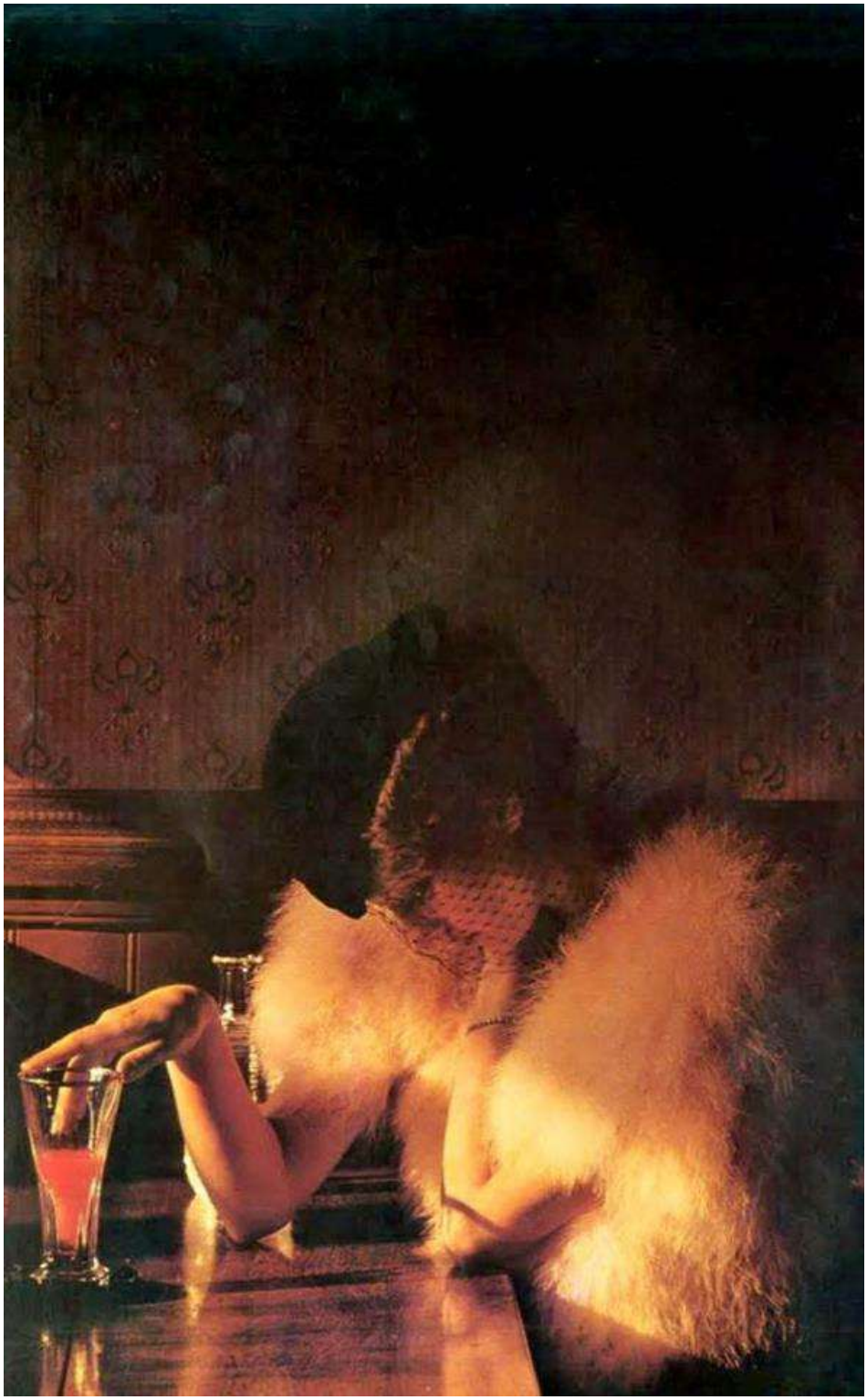
THE NORTHERN HOSPITAL

COMPASSION FATIGUE



"Girl in a Bar", Paris Vogue print, 1971, (Artist, unknown).

There's a fire starting in my heart
Reaching a fever pitch, it's bringing me out the dark
Finally I can see you crystal clear
Go 'head and sell me out and I'll lay your ship bare
See how I leave with every piece of you
Don't underestimate the things that I will do

There's a fire starting in my heart
Reaching a fever pitch
And it's bringing me out the dark

The scars of your love remind me of us
They keep me thinking that we almost had it all
The scars of your love, they leave me breathless
I can't help feeling
We could have had it all
(You're gonna wish you never had met me)
Rolling in the deep
(Tears are gonna fall, rolling in the deep)
You had my heart inside of your hand
(You're gonna wish you never had met me)
And you played it, to the beat
(Tears are gonna fall, rolling in the deep)

Baby, I have no story to be told
But I've heard one on you
And I'm gonna make your head burn
Think of me in the depths of your despair
Make a home down there
As mine sure won't be shared

(You're gonna wish you never had met me)
The scars of your love remind me of us
(Tears are gonna fall, rolling in the deep)
They keep me thinking that we almost had it all
(You're gonna wish you never had met me)
The scars of your love, they leave me breathless
(Tears are gonna fall, rolling in the deep)

I can't help feeling
We could have had it all
(You're gonna wish you never had met me)
Rolling in the deep
(Tears are gonna fall, rolling in the deep)
You had my heart inside of your hand
(You're gonna wish you never had met me)
And you played it, to the beat
(Tears are gonna fall, rolling in the deep)

We could have had it all
Rolling in the deep
You had my heart inside of your hand
But you played it, with a beating

Throw your soul through every open door (woah)
Count your blessings to find what you look for (woah)
Turn my sorrow into treasured gold (woah)
You'll pay me back in kind and reap just what you sow (woah)

(You're gonna wish you never had met me)
We could have had it all
(Tears are gonna fall, rolling in the deep)
We could have had it all
(You're gonna wish you never had met me)
It all, it all, it all
(Tears are gonna fall, rolling in the deep)

We could have had it all
(You're gonna wish you never had met me)
Rolling in the deep
(Tears are gonna fall, rolling in the deep)
You had my heart inside of your hand
(You're gonna wish you never had met me)
And you played it to the beat
(Tears are gonna fall, rolling in the deep)

We could have had it all
(You're gonna wish you never had met me)
Rolling in the deep
(Tears are gonna fall, rolling in the deep)
You had my heart inside of your hand
(You're gonna wish you never had met me)

But you played it
You played it
You played it
You played it to the beat.

Adele, "Rolling in the Deep" 2010.

Compassion fatigue is a relatively recently recognized condition, that is essentially a fading, blunting or habituation of empathy due to the cumulative toll of continually dealing with stressful or emotional situations. If unnoticed and/ or unimagined it can lead to significant mental and physical health consequences not only for the sufferer but also collaterally with family, work colleagues, and an organization as a whole.

COMPASSION FATIGUE

Introduction

Compassion fatigue, also known as **secondary traumatic stress** (STS), is a relatively recently recognized condition that is characterized by a **gradual lessening of compassion** over time, in those who are exposed to trauma and distress on an almost daily basis over a prolonged period of time.

Compassion fatigue shares many of the features and consequences of so-called "**burnout**" except that burnout is more strongly associated with the organizational environment whereas compassion fatigue is more related to the cumulative effects of grief associated with caring for sick, disturbed, and traumatized patients directly.

Health professionals, in particular in the fields of Emergency Medicine, Intensive Care, Oncology, Psychiatric Services and Paramedic Services are at high risk of developing compassion fatigue, however the condition is not unique to Health workers, being also frequently seen in the **law enforcement** and **legal professions** as well.

Compassion fatigue can have significant detrimental effects on the physical and mental health of those who suffer it, as well as impairing professional performance.

Recognition of the condition in others or indeed in oneself is an important aspect in dealing with compassion fatigue.

Strategies to deal with the condition are varied and must be individualized.

Prevalence

While compassion fatigue has been studied in various health professional groups, few studies have focused specifically on doctors and so the true prevalence within this group remains unknown.

Compassion fatigue is better documented among Nursing staff. Indeed, the term initially emerged to describe the phenomenon affecting nurses working in EDs in the 1950s.

Although burnout is a different entity, Arora et al. found a global prevalence of burnout in over 60% of emergency physicians compared with 38% of general physicians. [1]

This may indicate a similarly increased risk of compassion fatigue .

Risk Factors

Working within the stressful and fast-paced environment of EDs presents a unique set of risk factors that are physically and emotionally demanding and can predispose to compassion fatigue.

In any given work environment there will be a large range of factors that can increase the risk of both burnout and compassion fatigue.

These factors include:

1. Personal factors:
    - Overly perfectionist personality/ unrealistic expectations.
    - Those who have low levels of social support
    - Those who have high levels of stress in their personal life.
    - Poor coping or emotional skills
2. Patient factors:
    - **Drug and alcohol affected patients**
    - Illness related factors:
        - ♥ Dying patients (and their families)
        - ♥ Trauma patients
        - ♥ Critically unwell patients (in particular children)
        - ♥ **Psychiatric patients**
    - Personality related factors:
        - ♥ **Violent / aggressive patients**
        - ♥ **Personality disordered patients**
    - Communication barriers:
        - ♥ Language barriers
        - ♥ Intellectual impairment
        - ♥ Dementia / confusion
    - Cultural and/ or religious barriers
    - (Inappropriately) frequent attenders:
        - ♥ Demanding/ manipulative/ unrealistic expectations.

- The **socially disadvantaged** for whom society and all other health care workers have disowned on the basis of "no medical or psychiatric issue"

    - ♥ The homeless
    - ♥ The lonely
    - ♥ The economically disadvantaged

3. Departmental factors:

- High case loads:

    - ♥ High acuity, complex cases
    - ♥ High patient turnover
    - ♥ ED overcrowding

- **"Performance" measures and targets** that have more to do with politics than with optimal patient care.
- Access block
- Aggressive/ uncaring / bullying attitudes of co-workers
- **Distracting work environments**:

    - ♥ Constant/ unrelenting background **noise pollution:**

      From staff, patients and patient relatives.

      From ignored repeated and continuous false alarms.

      From constant overhead calling of CODES/ MET calls/ Chimes testing/ unnecessary "announcements".

    - ♥ Bright lights at night
    - ♥ Disruptive/ loud/ difficult patients.
    - ♥ Continual interruption from phones / mobile calls
    - ♥ Continual (but unavoidable) interruption from colleagues competing for attention/ priorities.

- **Dangerous work environments**:

- ♥ Inadequate security staffing.
- ♥ Inadequate medical / nursing staffing
- ♥ Inadequate inpatient support
- ♥ Inadequate staff appreciation/ understanding/ caring of potential hazards:

  e.g. **potential weapons** such as kitchen knives being left in clinical areas - particularly those involving aggressive psychiatrically disturbed patients.

4. Institutional factors:

- A culture of "silence"
- A non-caring culture
- **A culture of bullying**
- A culture that disparages "weakness"
- Lack of Peer Support services
- Lack of Counselling services
- Inappropriate rostering: excessive hours/ inadequate seniority/ backup support.

Protective Factors

A number of mitigating or **protective factors** against compassion fatigue have been recognized.

These include:

1. Increased years in the profession
2. Greater experience in the ED
3. A higher level of educational background
4. Shorter shift lengths
5. Adequate manager support **at work.**

6. Supportive supervisors

7. Access to mentors

8. Role and skill acquisition through adequate and appropriate teaching programs

9. Building "emotional resilience" (although how this is best achieved is unclear).

10. A positive and supportive **departmental culture**

11. Mutual interdisciplinary respect

Effects of Compassion Fatigue

Evidence from North American studies indicates that compassion fatigue disrupts lives, destroys careers and adversely impacts on organisations. [1]

The consequences of compassion fatigue can be considered in terms of the effects:

1. **On the Health worker**

   Compassion fatigue can result in marked detrimental effects on the Heath Worker.

   The following effects have been identified:

   - Psychological disorders:

     Psychological disorders have been independently associated with compassion fatigue.

     These can include feelings of :

     - ♥ Alienation
     - ♥ Helplessness
     - ♥ Hopelessness
     - ♥ Sleep disturbances.

   - Psychiatric disorders:

     Psychiatric disorders have been independently associated with compassion fatigue.

     These include:

     - ♥ Anxiety

- ♥ Depressive disorders.

- Physical health effects:
  - ♥ Alcoholism
  - ♥ Acute myocardial infarction.
  - ♥ Compassion fatigue may also be correlated with higher mortality in general.

- Effects on personal life:
  - ♥ The collateral damage of compassion fatigue may include a breakdown in family dynamics, lifestyle choices and financial decisions.

2. **On the Patient**

Compassion fatigue has long been implicated in the delivery of **suboptimal patient care.**

- Compassion fatigue leads to an increased number of medical errors because of unchecked cognitive biases.

  In a study involving UK emergency physicians, up to a third described having made "stress-related" mistakes that could have harmed patients, and 10% of all surveyed reported that these had harmed patients. [1]

- Compassion fatigue propagates physician disconnection with patients, thereby breaking down communication, the very foundation of shared decision-making and patient-centred care.

3. **On Colleagues**

- The additional work generated through absenteeism, combined with poor performance and potential for medical error has multiplier effects, putting pressure on other members of the department who are then subject to increased risk of compassion fatigue themselves.

4. **On the organization**

- There is a consistent theme of **job dissatisfaction** leading to wider system issues.

  Lack of job satisfaction *accelerates* compassion fatigue.

This in turn can lead to a higher rate of absenteeism.

The accumulated "brain and skill drain" can result in a system that is crippled, perpetuating further compassion fatigue downstream.

Management

Management must necessarily be tailored to individual needs on a base by case basis, according to the particular risk factors a department has as well as to the degree of compassion fatigue an individual may have.

In general terms management will consist of:

1. Initial recognition:

    - Compassion fatigue is increasingly pervading EDs.

      It is imperative to recognise symptoms and appreciate the potential impacts on individuals, patient care and health systems of leaving this untreated.

      As frontline healthcare providers, it is essential to acknowledge this potentially destructive process and instigate changes to prevent it.

      When it comes to managing compassion fatigue, recognition is the key. It can be easy to recognise stress in others, but hard to discuss it with them. It is harder to recognise it in ourselves, particularly because it is most likely to manifest when we are tired, overworked and stressed. [2]

      We must be vigilant for both ourselves as well as our colleagues.

2. Recognizing the presence of **risk factors** and eliminating or at least **minimizing these** when identified.

3. Assisting in the **specific** needs of the sufferer on a **case by case** basis.

    - The initial response must be to get the person out of the stressful situation.

      Not only is this required for patient safety, but also it can rapidly halt the progression of compassion fatigue. This might be as simple as a quick tea break or some fresh air. In more extreme circumstances, sometime off might be required.

      Prevention and ongoing management of compassion fatigue is focussed on general well-being.

Physical, mental and social well-being positively impact on our resilience, satisfaction and compassion. The converse is also true and physicians are notorious for not looking after themselves.

Management and prevention will rely on a **holistic approach** to well-being.

This includes addressing **social, emotional, physical, cognitive and vocational** needs of individual staff members, and creating a **culture of well-being** within an organisation. [3]

References

1. Suzanne Hamilton et al. Compassion Fatigue in Emergency Medicine: The cost of Caring. Emergency Medicine Australasia (2016) 28, 100 - 103.

   - doi: 10.1111/1742-6723.12533

2. A. Cross. Compassion fatigue: A personal perspective. Emergency Medicine Australasia (2016) 28, 104 - 105

   - doi: 10.1111/1742-6723.12534

3. Liz Crowe. Identifying the risk of compassion fatigue, improving compassion satisfaction and building resilience in emergency medicine. Emergency Medicine Australasia (2016) 28, 106–108

   - doi: 10.1111/1742-6723.12535

Dr J. Hayes

Acknowledgements:
Dr Suzanne Hamilton.
1 March 2016