

The transformation process for palliative care professionals: The metamorphosis, a qualitative research study

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Abstract

Background: Palliative care professionals are exposed daily to high levels of suffering. This makes them particularly vulnerable to suffering from stress, which can lead to burnout and/or compassion fatigue.

Aims: To analyse the professional trajectory of palliative care workers over time and the factors which influence this trajectory.

Design: A qualitative study was designed based on the Grounded Theory approach, using semi-structured individual interviews. Interviews were recorded audio-visually and transcribed verbatim for subsequent analysis using the procedure described by Miles and Huberman. This process was supported using ATLAS.ti 6 software.

Setting/participants: A total of 10 palliative care professionals from Extremadura (Spain) took part in the study.

Results: The analysis revealed a common trajectory followed by participants in their working lives: pre-palliative care/honeymoon/frustration/maturation. In addition, factors which influence this trajectory were identified. Details of the self-care strategies that these professionals have developed are described. The result of this process, which we have metaphorically termed ‘metamorphosis’, is the formation of a professional who can work satisfactorily within a palliative care context.

Conclusion: During their professional activity, palliative care professionals go through a series of phases, depending on the relationship between the cost of caring and the satisfaction of caring, which can influence both the care provided to patients and families and their own personal circumstances. Being aware of this risk, and implementing self-care strategies, can protect professionals and enable them to conduct their work in an optimal manner. Reflecting on the experiences of these professionals could be useful for other health professionals.

Keywords

Palliative care, self-care, qualitative research, emotional stress, compassion, burnout, trajectory professional

What is already known about the topic?

- Palliative care professionals are exposed daily to situations with high levels of suffering which can lead to burnout and/or compassion fatigue.
- In contrast to other healthcare professionals who also work in high-stress environments, research suggests that compassion satisfaction may counteract the risk of compassion fatigue in palliative care professionals.
- However, the trajectory and transformation process that healthcare workers experience in themselves over time is not yet well understood, nor are the various factors involved in this process.

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What this paper adds?

- This study explains the process of metamorphosis which palliative care professionals undergo, thus allowing compassion satisfaction to overcome compassion fatigue.
- In addition, the study identifies the factors which may influence the trajectory of this evolution, such that palliative care professionals reach a stage in which they can carry out their work in a satisfactory manner.
- Finally, we analyse the strategies recommended by the study participants in order to facilitate self-care: Being aware of the need for self-care; taking a break to reflect; recognising feelings and having the capacity for self-control; knowing how to recognise your limits; developing communication skills; comprehensive and specific training and disconnecting from work during free time and developing hobbies.

Implications for practice, theory or policy

- The implementation of training in self-care strategies for beginner palliative care professionals might prevent the onset of burnout syndrome and/or compassion fatigue.
- The results of this study are transferable to other palliative care professionals, at least within similar contexts.
- The results of this study may help other palliative care professionals reflect on their self-perception and understand their own processes better.

Introduction

Palliative care professionals are exposed daily to situations with high levels of suffering. This makes them especially vulnerable to experiencing stress, which can lead to burnout and/or compassion fatigue, both at an individual and at a team level.^{1,2}

According to Maslach and Leiter,³ burnout is ‘the index of dislocation between what people are and what they have to do. It represents an erosion in values, dignity, spirit, and will – and erosion of the human soul’. It is characterised by emotional exhaustion, depersonalisation and a low feeling of self-realisation⁴ and is associated with low quality of care, patient dissatisfaction, higher rates of medical errors, and personal and professional consequences.⁵

‘Compassion fatigue’ refers to an emotional state with negative physical and psychological consequences, which results from prolonged care for suffering persons, when the professional carer absorbs the distress, anxiety and fears of the patient or the family they attend (countertransference).⁶ Professional carers who demonstrate high levels of empathy when exposed continuously to the pain and suffering of others, combined with an incapacity to disengage from work and a restricted social support network, have a higher risk of presenting with compassion fatigue.^{7,8}

Burnout syndrome relates to stress resulting from the interaction of professionals with the work environment, while compassion fatigue refers to the cost of the care itself. A significant difference between the two is that professionals affected by compassion fatigue can continue working.⁹

In contrast to these negative consequences, palliative care professionals describe feelings of satisfaction resulting from their work with terminal patients. For this reason, previous studies have produced the surprising result that such professionals do not present with high levels of psychological distress; in fact, they experience lower levels of

burnout syndrome than other healthcare professionals, including oncologists.^{10,11} Focus groups of *cancer care workers* have demonstrated that contact with patients and their families is their greatest source of job satisfaction.¹² Stamm¹³ suggests that compassion satisfaction could counteract the risk of compassion fatigue. In an in-depth qualitative study of palliative care nurses, Vachon et al. found that the connections nurses make with their patients in confronting death can involve both suffering and meaning. They described three patterns of nurses’ experience of death confrontation: integrating death, fighting death and suffering death. While some nurses reported feeling nourished from their contacts with dying patients (empathic resonance), others sometimes experienced feeling frustrated (discordance) or powerless (consonance).¹⁴

Several studies have investigated the interpersonal factors which promote resilience, defined as the capacity to cope with situations of continuous stress, which favours self-confidence and the improvement of professionals’ skills.^{15,16} Previous research has elucidated the strategies used by palliative care professionals to avoid developing the syndromes described above, and enable them to maintain a satisfactory work–life balance.^{17–23} However, the trajectory that palliative care workers experience within themselves over time has not yet been well documented, nor have the factors which affect this process, with the exception of the model described by Harper²⁴ with reference to nurses caring for dying patients.

Our research was carried out in the Regional Palliative Care Programme in Extremadura (Spain). This programme comprises eight Palliative Care Support Teams (PCST) which support hospitals, homes and social healthcare centres. A total of 35 professionals from medicine, nursing and psychology form multidisciplinary teams. Our initial

Table 1. Selection criteria for participants.

Age:
 Sex:
 Discipline:
 Years of work experience in palliative care (more than 2 years required to be considered eligible):
 General area of health care:
 Civil status:
 Personal family responsibilities: (underage children or dependent or elderly people who are cared for at home)
 Type of patients and workload: (patient loads, highly clinically complex patients, patients with fewer resources or less accessibility, etc.)
 Size of palliative care team relative to workload:
 Favourable or unfavourable relations within the team:

Table 2. Profile of professionals interviewed.

Participants	Age (years)	Sex	Profession	Civil status	Personal family responsibilities	Years of work experience	Years of experience in palliative care
1	42	F	Nurse	Divorced	2 children and dependent elder	15	8
2	39	F	Psychologist	Single	0	17	12
3	45	M	Doctor	Married	2 children and dependent elder	20	8
4	44	F	Doctor	Married	2 children	18	8
5	40	M	Nurse	Divorced	2 children	15	8
6	40	M	Doctor	Married	2 children	16	8
7	46	F	Doctor	Single	1 child	16	11
8	42	M	Nurse	Married	1 child	12	6
9	46	F	Psychologist	Divorced	0	22	6
10	39	M	Psychologist	Married	0	10	6

intention in carrying out this study was to learn more about the onset and prevention of burnout syndrome and/or compassion fatigue. However, in the end, the main objective of the study was to analyse the professional trajectory of palliative care workers over time and the factors which influence this trajectory.

Methodology

A qualitative research design was considered the most appropriate method to achieve our objective, as it allows for the exploration of in-depth questions about how and why phenomena occur.²⁵ We utilised a Grounded Theory approach, and data were analysed using constant comparison and following the method proposed by Miles and Huberman²⁶ and Creswell.²⁷

The study was granted ethical approval by the Clinical Research Ethical Committee of the Infanta Cristina Hospital Complex in Badajoz, Spain.

Participants

All research participants signed a consent form to take part in the study and gave permission for audio-visual recording

of their interviews (a negative response to the video recording was not a limiting factor, since participants could elect to be recorded only in audio). These interviews, which ranged between 45 min and 1.5 h in duration, were conducted between June and September 2011.

The sample was selected using a purposive sampling process, aimed at achieving a variety of profiles according to established theoretical criteria (Table 1).

Collection and analysis of data were conducted simultaneously and the sample was considered complete once further information was redundant. In the end, a total of 10 participants took part in the study. Participants' characteristics are described in Table 2.

Data collection technique

Semi-structured individual interviews were used to collect data using an interview guide, enabling the progression from more general prompts to more specific and sensitive questions (Table 3).

Since the members of the research team and the study participants were co-workers, it was determined that the interviews should be conducted by external interviewers, in order to obtain richer and more descriptive information

Table 3. Indicative script for interviews.

Can you tell me how you started working in palliative care?

Can you tell us about your work and the effect it has on you as a person?

Do you think that in order to care for end-of-life patients you need to be made of 'something special'?

Try to remember a situation that has had a strong emotional impact on you. Explain it to me. (Try to get the respondent to explain the situation in detail.)

How do you think these special situations influence you?

Do you know how to identify the emotions that these situations generate in you?

What types of things allow you to overcome these situations?

In the example you have given me:

Can you explain how you manage the situation in front of the patient/family?

And how do you handle it in front of your own family and friends?

And when you're alone?

Do you think that you have needed or need some type of support to manage the variety of complex situations and situations which affect you emotionally?

How do you think the rest of your workmates manage these situations? In order to maintain anonymity, you don't have to name them, you can speak in general terms (if possible, try to get them to talk about their colleagues in palliative cares as well as those in other specialties).

Would you like to say something else about this subject?

regarding the participants' experiences and environment. Thus, interviews were conducted by three neutral interviewers, with non-health-related professional profiles (philosopher, coach and social educator), who were selected for their demonstrated capacity for active listening and other communication skills. These interviewers were trained specifically in the conduct of semi-structured interviews and in *verbatim* transcription.

All participants chose the location for their interviews; most were conducted in participants' homes, except two cases which were conducted in the participant's workplace. All, except one, were audio- and videotaped.

Data analysis

All textual data obtained were coded and categorised inductively using the procedure for textual analysis described by Miles and Huberman²⁶ (data reduction, data display and drawing and verifying conclusions) and according to the method of constant comparison, in order to identify both the common trajectory and the differences between participants.

The analysis was supported by the software ATLAS.ti, version 6. As soon as a transcription became available, five researchers codified it individually and then shared their results with the other team members. This also allowed for the continuous revision of the sample criteria and their adaptation to the needs of the study. Codes were grouped into categories and the analytical framework was established through discussion between four researchers.

Results

The analysis of data collected enabled the identification of a common professional trajectory followed by participants

and of a series of factors which influence this trajectory. The study therefore details the self-care strategies that these professionals utilise to perform their work in a satisfactory manner.

Common professional trajectory

From the experiences related by study participants, common aspects in their trajectory can be identified: a prior phase of working in other areas and of 'motivation' to work in palliative care; the 'honeymoon stage' at the beginning of their professional activity in palliative care; the 'frustration' stage resulting from the differences between expectations and reality; and finally, the 'maturation' stage, which allows for the satisfactory development of their professional activity.

Pre-palliative care phase and motivation to work in palliative care. Before working in palliative care, the interviewees had come from other health services such as oncology, internal medicine, hospital emergency departments, intensive care units, primary care centres, and nongovernmental organizations (NGOs) related to cancer (in the case of the psychologists).

In general, they reported that when they started working as healthcare professionals in other services, they were faced with patients in terminal situations with high levels of suffering. Participants described feeling under-prepared for such situations and perceiving a lack of sensitivity towards such patients on the part of their colleagues:

Those patients in the system itself, in general, they are neglected ... even the professionals who had accompanied them through the entire process of the disease came to a point where they abandoned them, weren't even interested in the patient ... (P3. Doctor)

Most interviewees reported that their entry into palliative care was not accidental. Apart from one professional who considered it a job opportunity (P8), the others had all been influenced by some type of personal situation (P1, P3), previous work experience (P1, P2, P4, P7, P10) or contact with palliative care-related services or training (P1–P10 – all participants).

In any case, certain factors were highlighted as important aspects of palliative care, in contrast with other services: multidisciplinary work teams, communication as a therapeutic tool, the consideration of the patient and his or her family as a unit for treatment, and the focus on integral care (with a bio-psycho-social and spiritual focus). In combination, these were sufficient motivation to consider working in palliative care:

The work of all the professionals who make up a team is essential. (P8. Nurse)

It's not just the patient who falls ill, the patient and his whole family fall ill. (P6. Doctor)

Honeymoon phase. The commencement of work in palliative care is characterised by enthusiasm and a high level of commitment. The participants emphasised their connection with the team and their concern for and involvement with families, remaining engaged with them even outside working hours. This period was referred to by some interviewees as the 'infatuation stage' or the 'honeymoon':

What I remember most about that time was the enthusiasm and the desire to learn, just like a recent graduate. (P2. Psychologist)

All the time you devoted to work didn't seem like very much. (P4. Doctor)

Phase of frustration: clash between expectations and reality. This first 'honeymoon phase' fades over time. Daily confrontation with suffering and death, difficulties surrounding the organisation of work (such as progressive overload of health care, increasingly complex situations and inflexibility of timetables) and conflicts arising between team members lead them to reconsider their work and to lower their expectations, often resulting in disenchantment and frustration:

Little by little you realise that things aren't as nice as you had thought, and, in the moment of truth, you face the harsh reality that puts you in your place. (P5. Nurse)

The system is very straitjacketed, very rigid ... it doesn't allow breathing space ... and sometimes change is necessary in order to breathe. (P3. Doctor)

It was very difficult for me to learn that there are some things that cannot be resolved. (P1. Nurse)

Phase of accepting reality or maturation. After a variable period of time comes a phase in which the professionals recognise that palliative care work carries a great emotional burden. This requires that self-care strategies be implemented so that practitioners are able to give their best, and provide better assistance to the patient and family throughout the illness. The practitioners become more realistic in recognising how much they can do as well as their limitations and try to establish a balance between the cost of care, the satisfaction of caring, and their personal lives:

There is a part of the suffering which we cannot reach. (P3. Doctor)

You have to know how to recognise your own limits. (P1. Nurse)

During this process, and with the accumulation of life experience, a transformation or 'metamorphosis' occurs naturally in professionals working in palliative care, changing their outlook on life and enriching them as people:

You think about life in a different way, you value what you really have: health, family ... you learn to stay grounded, and your priorities in life change. (P4. Doctor)

You learn to value life, and to value a good death ... to have a great deal of love for life ... and overall, it makes you feel happier. (P7. Doctor)

Factors which influence 'professional trajectory'

A number of factors which influence, to varying degrees, the transformation process are described below:

Personality/character. According to the professionals interviewed, it is not necessary to be 'made of special stuff' to perform palliative care work, although they recognise that not all healthcare professionals would be able to do so:

We are normal, ordinary people ... although not everyone could work in this field. (P3. Doctor)

The interviewees highlighted certain personal characteristics necessary for this work, among them, special sensitivity to the suffering of others, an optimistic view of life, and values such as humility, a vocation for helping others, and a capacity for self-sacrifice; in essence, possessing a humanistic profile.

Other qualities are acquired progressively over years of experience and through comprehensive, specific training in the field. These include the continuous development of communication skills, learning to connect with the feelings of others, and, especially, the capacity for adaptation to the needs of each patient and family:

We adapt to each patient and family ... to how they are experiencing their illness, to their beliefs, to their values ... And this chameleon-like ability to adapt to each patient and family is fundamental ... you learn to place yourself on the same human and emotional plane as the person you are caring for. (P6. Doctor)

Emotional impact events. All the professionals interviewed were able to identify specific situations they had experienced which had produced a strong emotional impact.

Thus, they expressed negative emotions and feelings of frustration, rage, indignation, fear, sadness, pain and powerlessness:

In those moments the feeling of sadness is total, and in some moments of fear of the same thing happening to me I couldn't help crying. (P4. Doctor)

A large part of our frustration is because ... although you know you aren't going to cure someone ... you do want to support them, to ensure they have a less painful end and, when that can't be achieved – because there are times that it can't – it's very frustrating for us. (P3. Doctor)

However, remembering other situations, participants expressed positive emotions such as satisfaction, a feeling of being useful, peace and serenity, personal enrichment and gratitude:

I have feelings that I'll never forget in my life, and that make me feel good ... I have learned a lot from them ... how lucky I am to work in this. (P1. Nurse)

This work enriches you as a person ... it's a beautiful job that fulfils you as a person ... you feel useful. (P8. Nurse)

This daily exposure to situations with high levels of suffering encourages professionals to explore their own coping resources, and to learn to channel their emotions, which results in better self-knowledge.

Finding a balance between the 'cost of care' and 'the satisfaction of caring' which tilts towards the latter is an important factor in protecting palliative care professionals and in giving meaning to their work.

Experiencing extreme situations. Despite their years of experience, all interviewees identified specific types of complex situations which still present a challenge, and which generate a stronger emotional impact. Among these, certain situations stand out, including those in which the professional identifies personally with the patient or family, caring for children and young people, dealing with dysfunctional families with a great deal of hostility between family members and towards health professionals, situations where the patient or family are acquaintances, friends or family members, single individuals with no families, and patients who present with numerous difficult-to-control symptoms:

I find it difficult to manage their aggressiveness, their pain, their anxiety, their demands, their sadness because everything is so mixed up ... None of us like to be treated aggressively ... we're people. (P1. Nurse)

There are some very, very difficult days ... when you're faced with a young patient who you know, who you went to school with or you used to go for drinks with ... you know that the end will come ... you feel it as he says goodbye to you, with a look, with a touch, with a conversation ... it makes your hair stand on end, and a tear gets out. (P8. Nurse)

These extreme situations can be both painful and personally inspiring, and over time, the workers learn how to manage and channel their emotions:

If I have learned anything in this job, it's that you have to work a lot with your values, your priorities, your personality, your emotional aspects ... You have to have these things resolved for yourself in order to deepen those of other people, and help them. (P9. Psychologist)

Teamwork. Teamwork was considered an important protective factor by all the professionals interviewed, although some also referred to the team as a distorting element, especially in small teams or when there are poor personal relations between practitioners.

The ability to express emotions and share them with one's co-workers is acquired over time. The creation of a good working environment and the encouragement of humour among colleagues can serve as a safety valve:

When you listen to your workmates who are suffering as much as you are ... it helps a lot ... knowing that in situations of emotional overload, you can count on a colleague protecting you. (P5. Nurse)

Keeping things to yourself in this work isn't good, because sooner or later things will come out and one of them will explode. (P4. Doctor)

Humour is a very established aspect of our team ... it serves as an escape valve for us ... it gives our team a very positive atmosphere. (P6. Doctor)

Over time, the team's members learn to look for strategies to improve relations, citing communication as a key tool in caring for the team.

Views of other healthcare professionals on palliative care practitioners. Another interesting aspect highlighted in the interviews is the relationship with other healthcare professionals. The majority of palliative care practitioners interviewed suggested that many other healthcare professionals neither understand nor value their work, considering palliative care a second-class form of medicine:

I don't understand how you could be working in that ... how you can stand it. (P1. Nurse)

There are many professionals who still don't know what we do, what we dedicate ourselves to ... they have this idea that we are just a pat on the back and that's it. (P8. Nurse)

We're the ones who help people die ... they see us as the angels of death. (P5. Nurse)

On the other hand, many other health workers value palliative care professionals, recognising the usefulness of their work and seeking their help when they have patients in terminal situations:

Some people see us as saviours ... many healthcare workers aren't able to face death ... Each of us has something valuable to contribute. (P1. Nurse)

The feeling of recognition, and feeling their work to be useful and worthwhile, is a source of satisfaction.

One of the challenges expressed by some of the palliative care professionals interviewed is trying to encourage other healthcare professionals to improve their level of care and attention at the end-of-life stage:

It's really frustrating that I can't make them see how precious they are to these patients, how necessary their help, their work, their care are for these types of people. (P1. Nurse)

The constant interaction with other healthcare professionals leads to highly developed communication skills and promotes values such as humility and generosity:

We're all human, nobody is perfect, we all need each other, whether we like it or not. (P1. Nurse)

'I and others. This section refers to the relationships that palliative care professionals establish with other people from outside the healthcare field, especially with their own families and friends. This type of work often teaches its practitioners to put everyday problems in perspective, which can make them feel isolated and see themselves as 'freaks':

When you're working in palliative care, talking about your work outside of working hours ... well, it's not a topic of conversation which people feel comfortable with. (P2. Psychologist)

From the outside they see us as freaks, as something different. Most people don't understand what we do. (P7. Doctor)

Working with patient and family. All the interviewees agreed that in palliative care, the patient and his family form a unit for treatment, whose fundamental objective is accompanying them through the entire end-of-life process and making the end less painful for them:

And when the patient dies, the families are left with the feeling that we have cared for them well. The pain is there, the

sadness is there, but really we are satisfied at having done a good job. (P3. Doctor)

There are some patients and families with whom palliative care workers connect more and establish closer relations, leaving a lasting impression:

I have met such wonderful people, they have shown me so many things, that the memories I have of them as people made me part of them. This makes you feel good, and gives meaning to our work. (P1. Nurse)

The recognition of the professionals and of the importance of their work by families, and the feeling of being useful, is another protective factor for palliative care professionals.

Death, suffering and life. The daily exposure to suffering and death makes professionals face their own death, something they had never considered before working in palliative care:

Now I'm clear on some things about how I would like to die, and things that I wouldn't like. (P7. Doctor)

This continuous exposure, and their adaptive capacity towards it, confers flexibility and resilience on the practitioners, which influences them when faced with difficult situations in their personal lives.

Indeed, despite this working environment, the professionals interviewed reaffirm their love of life, reporting that they feel more conscious of it since beginning work in palliative care:

I like life more since I've been working in palliative care ... it seems to me that I shouldn't waste it, that each of us must live it as faithfully as possible, how we want to live. (P1. Nurse)

It changes your values system ... getting up in the morning and saying, 'My God, I'm healthy, and I don't need anything else' Seeing my healthy son, and knowing to appreciate him ... you really learn to value life. (P7. Doctor)

Self-care strategies

As a consequence of this transformative process, palliative care professionals needed to re-evaluate the self-care strategies they had been using and adapt them which helped them to overcome situations of suffering and allowed them to perform effectively in their role as carers.

In the following, we have described the strategies considered most useful by the professionals interviewed:

- *Being aware of the need for self-care.* After years of work in palliative care, the practitioners highlight the need for self-care as a priority. This supports them and allows them to continue performing their work in a satisfactory manner:

To be able to do our job well, we need to look after ourselves. (P3. Doctor)

- *Taking a break to reflect.* Having moments of reflection is another high-priority strategy for some interviewees:

If you see that your day-to-day interventions don't generate wellbeing, but instead cause you stress ... stop. (P7. Doctor)

It would be advisable, every now and then, to separate yourself, distance yourself, reflect ... reflect internally, each one of us for ourselves ... this inner growth will allow us to keep caring for people much better. (P3. Doctor)

- *Recognising feelings and the capacity for self-control.* Naming the strong feelings experienced, and learning to channel them appropriately, is another effective self-care tool:

Listen to yourself, listen to your heart, listen to your body, and pay attention to it. (P10. Psychologist)

- *Knowing how to recognise your limits:* Recognition of their own vulnerability and being aware that some suffering cannot be alleviated helps workers to perform better:

It was very difficult for me to learn that there are things that can't be resolved, and you have to find the best way of living with them. (P1. Nurse)

Recognising that we aren't infallible. (P6. Doctor)

- *Developing communication skills.* The need to express feelings and emotions through talking and the ability to share these with someone are strategies that help practitioners perform their work well:

Being able to talk about it, to express it, being able to let it all out and cry. (P3. Doctor)

Venting emotions. (P4. Doctor)

- *Comprehensive and specific training.* This is a key tool, considered a source of greater security and self-confidence for professionals in caregiving roles.
- *Disconnecting from work during free time and developing hobbies.* Another priority strategy emphasised by all interviewees was the importance of balancing professional life with personal life. Having periods of time in which you only do things for yourself: reading, listening to music, going for walks, practising sports, cooking, gardening, going out with friends, getting in touch with nature, breathing fresh air, seeking moments of solitude, travelling and so on (P1–P10. Activities related to all participants):

You have to balance your working life with a personal life that means just as much as the emotional situation that you are experiencing during your workday. (P2. Psychologist)

Discussion

The professional trajectory described above could be influenced by different factors, including situations which could lead to burnout or compassion fatigue, on the one hand, and situations where compassion satisfaction is evident, on the other, with the different evolutionary stages falling into one category or the other depending on which way the balance is tilted. Furthermore, the refinement of self-care strategies, which palliative care professionals develop over time, could also influence this process. Thus, during the initial 'honeymoon phase', the satisfaction of caring is supplemented by the initial enthusiasm and motivation typical of any new beginning. Over time, this balance is tilted towards other, more negative aspects, such as workplace problems and conflicts between team members. In addition, the increasing awareness of the strong emotional impact of relationships with patients and families, which in many cases proves difficult to manage, also appears in the 'frustration phase'. Finally, after a variable period of time, and after continuous exposure to painful stimuli and the influence of the numerous factors detailed in the 'Results' section, the professionals begin to develop coping mechanisms, and put into practice self-care strategies which tilt the balance again towards the positive aspects, allowing them to perform their work in a satisfactory manner ('maturation phase').

It should be noted that, although the trajectory described appears to be a linear one, this may be a consequence of the fact that all participants interviewed have worked in the same palliative care programme over the same time period. Thus, it is possible that other professionals may not follow the same trajectory in a linear fashion. Rather, practitioners may change phase, and move between phases, depending on the various factors described in this study. The results presented here have been obtained in a particular context and using qualitative methods which do not allow generalizability. However, the rigorous method and level of analysis make results transferable, at least to similar contexts.

These different stages undergo a unifying process, which we have called 'transformation or metamorphosis', which occurs in palliative care professionals after they progress through the various phases and which is influenced throughout by several factors. Other models and adaptation processes have been described in the literature.^{24,28,29} According to Harper's²⁴ 'Line of Comfort-ability' model, there are six stages of adaptation experienced by nurses caring for dying patients (intellectualisation, emotional survival, depression, emotional arrival, deep compassion and Doer). This model proposes that 'learning to be comfortable in working with the dying patient and his family must

be preceded by a growth and developmental process or sequence including cycles of productive change, observable behaviour and feeling’.

The study by Georges et al.²⁹ showed a different pattern of practice from that described by Harper. They found two main approaches among nurses: the first and most prominent method was ‘striving to adopt a well-organized and purposeful approach as a nurse on an academic ward’, whereas the second was ‘striving to increase the well-being of the patient’. Our results reflect the importance of transformation and the necessity of avoiding the ‘duality’ described by Georges et al. in order to be able to adapt to the high levels of suffering which are encountered by palliative care professionals. This coincides with the work of Harper, which suggests that health professionals must learn to cope with the anxieties which arise from such interpersonal experiences, coming to grips with their own feelings about mortality. Harper²⁴ focuses on work-related losses which progress through a developmental learning process to balance personal needs, vulnerability and expectations.

Other studies, like that of Rose and Glass,³⁰ conducted on palliative care nurses, explored the relationship between emotional well-being and professional practice, making reference to the term ‘balance or equilibrium’, as opposed to ‘emotional imbalance’. Rose’s study describes a number of factors which influence the emotional development of the nurses, some of which are similar to those described in our study (the workplace environment and the organisation of work, the management of emotions, professional recognition, training, communication with other professionals, and being aware of limitations). In addition, the study describes self-care strategies (choosing a healthy lifestyle, the possibility of relaxation, recognition, advocacy and access to emotional support), which coincide with the findings of our analysis. Some research studies,^{18,19,21,22,23} mainly conducted on nurses, also describe self-care strategies for coping with situations of suffering, thus allowing them to perform effectively in their role as carers. Similarly, Sabo’s² review of nurses working in palliative and haematological cancer describes the importance of work environment and organisational factors in the presentation of burnout and/or compassion fatigue. These results reaffirm the findings of our analysis; however, our study is further enriched by the contributions and reflections of other health professionals (doctors and psychologists).

From another perspective, Sinclair³¹ explores the effect of frequent and prolonged exposure to death and dying patients on highly experienced palliative care professionals. The participants spoke of how working in palliative care has taught them to live in the present, to cultivate their spirituality and to reflect profoundly on their lives. Although the term ‘spirituality’ was not mentioned explicitly in our study, the concept can be found implicitly in all the interviews.

Both age and work experience have shown to be related to the risk of burnout,⁴ with younger and less experienced workers, who are more prone to stress and have fewer coping strategies, experiencing a higher long-term incidence of burnout. We suggest that exposure to situations of suffering on the part of palliative care professionals strengthens resilience, understood as the development of coping skills in the face of adversity, as described by Jackson et al.,³² and that this relationship is not merely a matter of age and professional experience, but is also influenced by other factors which contribute to the metamorphosis process. Consequently, we suggest that with accumulated experience, practitioners learn to value the importance of deep self-reflection, to face up to death and to solve their own internal conflicts, in order to be able to help others, that is, the process of metamorphosis. Through this self-reflection, they come to get the best out of themselves, their best ‘I’, as well as changing their values system, appreciating life more and learning to live more intensely. Being understood and listened to, and committing to caring for oneself are key to the ability to care for others in a context of suffering.³³ Our study did not extend to professionals who have left the field of palliative care, which may have been of interest and could be a subject of future research.

We believe that these results could be taken into account in the training of future professionals who are commencing work in the field of palliative care, to raise awareness of the risks to which they are exposed and the necessity of implementing self-care strategies to prevent the onset of compassion fatigue from the very beginning. Although it seems that all phases need to be experienced in order to successfully achieve ‘metamorphosis’, future research should examine how to better support palliative care professionals, in order to reduce the suffering and the potential for abandonment resulting from a failure to complete the process successfully. This, in turn, could assist them in carrying out their work in an optimal manner, both for their patients and for themselves.

Conclusion

Palliative care professionals, as a population, are at risk of developing burnout and/or compassion fatigue. Over time, during their professional activity, they go through a series of phases depending on the relationship between the cost of caring and the satisfaction of caring, which can influence both the care provided to patients and families and their own personal circumstances. Being aware of this risk, and implementing self-care strategies, can protect professionals and enable them to conduct their work in an optimal manner. Throughout this process, under the influence of numerous factors, they experience a personal transformation that changes their perspective on life.

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Declaration of conflicting interests

The authors declare that there is no conflict of interest.

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