BETWEEN EMPATHY AND EXHAUSTION: EXAMINING HEALTHCARE PROVIDERS' COMFORT WITH PEDIATRIC DEATH WORK

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Phoenix Children's

BACKGROUND

Death Work

- Any therapeutic or supportive work conducted by a helping professional surrounding death, including bereavement counseling, palliative care, working with individuals during/after a disaster, counseling those who are actively dying, and crisis intervention

(Chan and Tin, 2012)

Death Competency

- Specialized skills in the areas of death, dying, and bereavement in order to work with clients effectively

- Grief, loss, and bereavement are inevitable parts of the human experience
- Healthcare worker's experience is variable
  - Role
  - Setting
  - Case Exposure
- Noticeable gap in education/training
  - Consequently, the effect of this work on professionals

(Galiana et al., 2019; Harrawood et al., 2011)

STUDY OBJECTIVES



To assess multidisciplinary health care providers' perceived comfort in caring for children at EOL



To identify areas in which we can improve education, support, and skills of multidisciplinary health care providers around EOL care

METHODS

Anonymous survey - qualitative and quantitative data	Demographics, Likert scales, Ranking, & Free Text Response
Participants from inpatient and outpatient settings	Providers, Trainees, Bedside staff (i.e. RN, PCT, RT, HUC, CM), & IDT staff (i.e. CCLS, Art/music/pet therapy, Spiritual Care, Psychology/MHT, SW)
Identified "Study Champions" (19)	Content feedback, appropriate listservs for distribution & survey promotion
Open data collection for 3 months	

THE SURVEY TOOL

- A definition of death work provided
- Capture work environment
  - ICU vs. general floor
  - Years experience
  - End-of-life case exposure
  - Palliative care training
- Comfort with providing care
  - Treating symptoms
  - Addressing questions (patient +/- family)
  - Addressing spiritual & culture needs
- Coping and support around death work
  - Impact on emotions
  - Fulfillment around work
  - Prioritizing own needs
  - Boundaries – work impacting personal life & vice versa
  - Resources & when to ask for help
  - Support from peers/leadership

”Death work" refers to any supportive, therapeutic, or remedial work in response to death or matters related to death (Ho Chan & Tin, 2012).

RESULTS: DEMOGRAPHICS

477 surveys completed

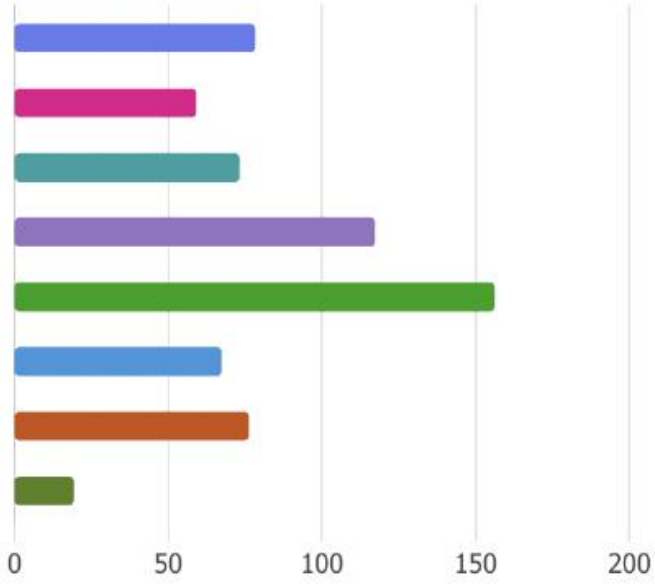
Majority were:

- Female (n=401, 84%)
- Nurses (n=212, 44%)
- <10 years experience (n=308, 65%)
- ICU (n=249, 52%),

Nearly all experienced personal loss (n=428, 90%)

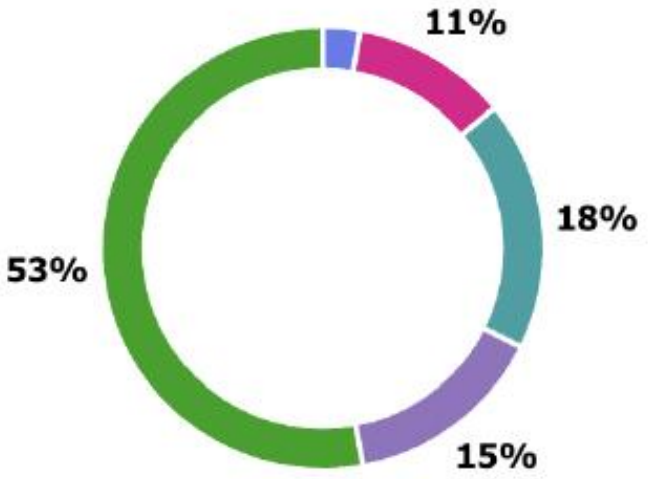
EOL Training = 43% (n=207)

Emergency Department	78
CVICU	59
NICU	73
PICU	117
General Inpatient Floor	156
Oncology Floor	67
Outpatient Clinic	76
Other	19



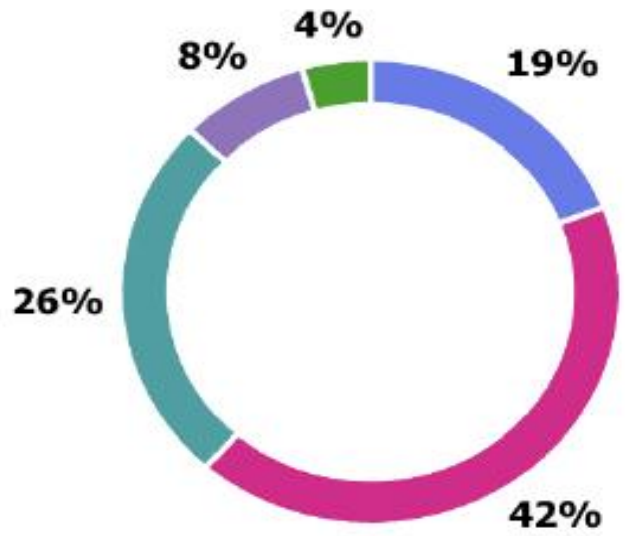
RESULTS: CASE EXPOSURE

Life-Limiting Illness

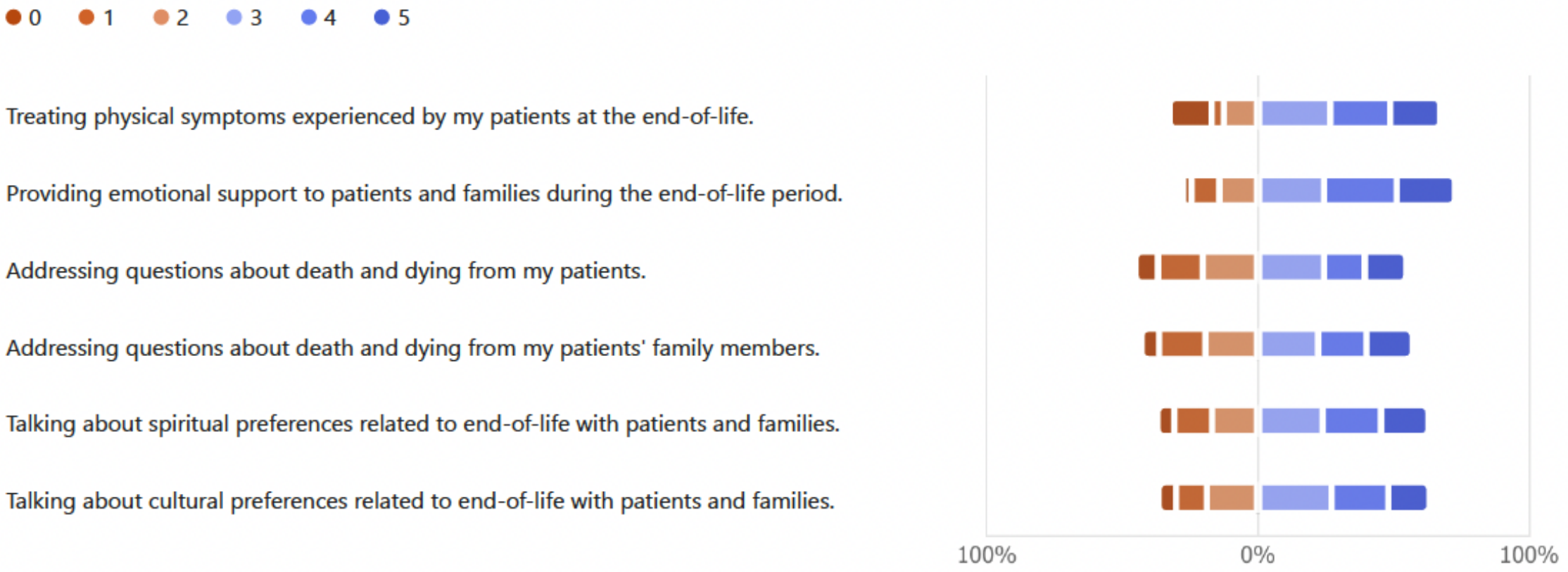


Never	13
<5 cases	54
5-10 cases	87
11-20 cases	70
>20 cases	252

EOL Cases



RESULTS: COMFORT WITH DEATH WORK



ASSOCIATIONS:

- MD, Psychosocial and CLS – saw the most EOL cases
- Comfort in treating sx and providing emotional support **increased with**:
  - Years of experience, > # of EOL cases, PPC training, and ICU setting
- Comfort with addressing spiritual needs **increased with:**
  - Years experience, psychosocial role, > # of EOL cases, Onc setting
- **Consistent discomfort with addressing cultural needs**
- When comfort with addressing questions at EOL was reportedly high
  - Family Qs >>> Patient Q's
  - **EXCEPT: oncology floor**
- ED and General Inpatient units most uncomfortable with death work
- Age and personal loss – no gross effect on responses

RESULTS:

I fully accept that I cannot completely control life; for example, the life and death of a patient.

I am able to cope with my own experience(s) related to death.

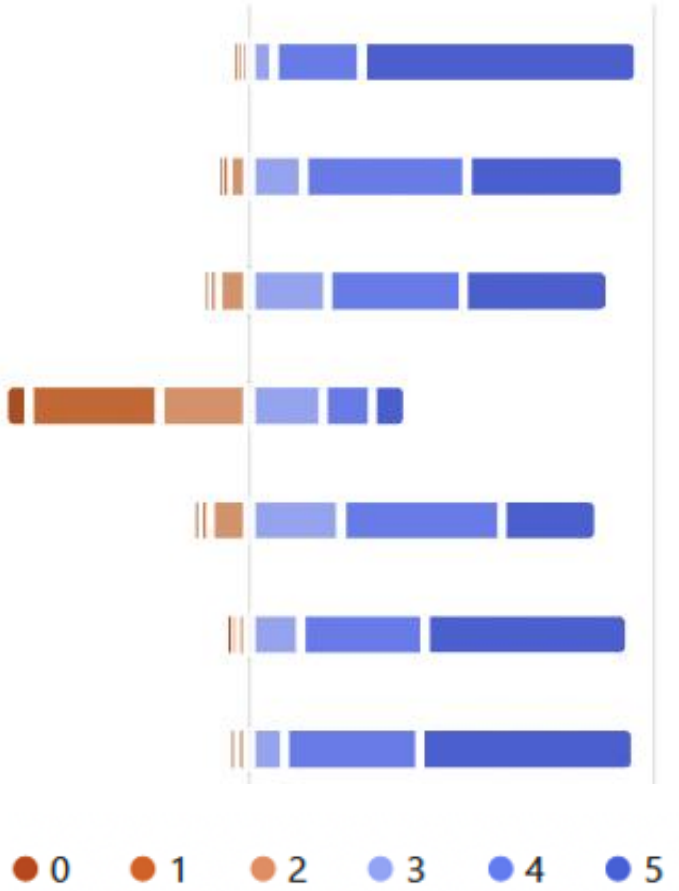
I can fully accept the nature of death work, including all related emotions and feelings.

My emotions should not be impacted by death work.

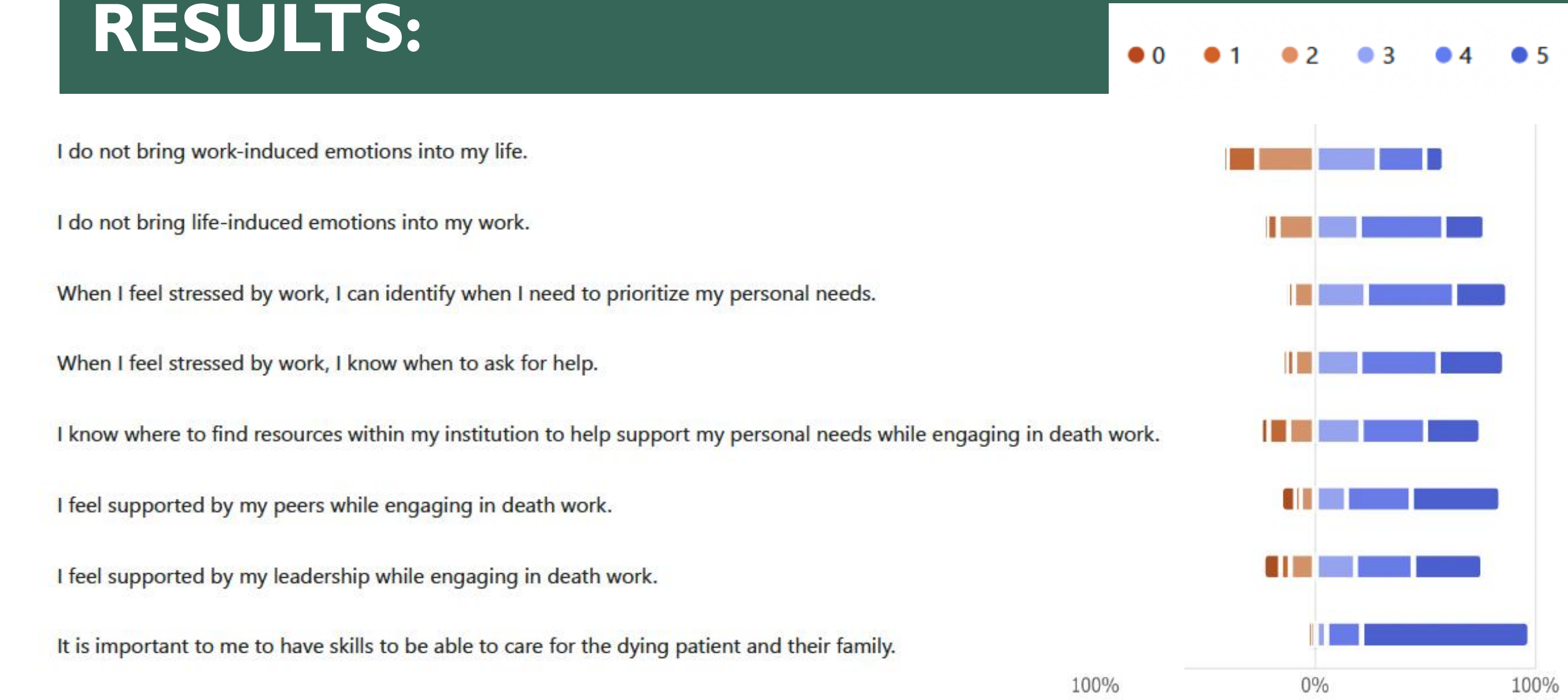
I can effectively cope with my emotions induced by death work.

Even though death is inevitable, I admire my contribution to my work.

When I feel stressed by work, I can still find meaning in my work.



RESULTS:

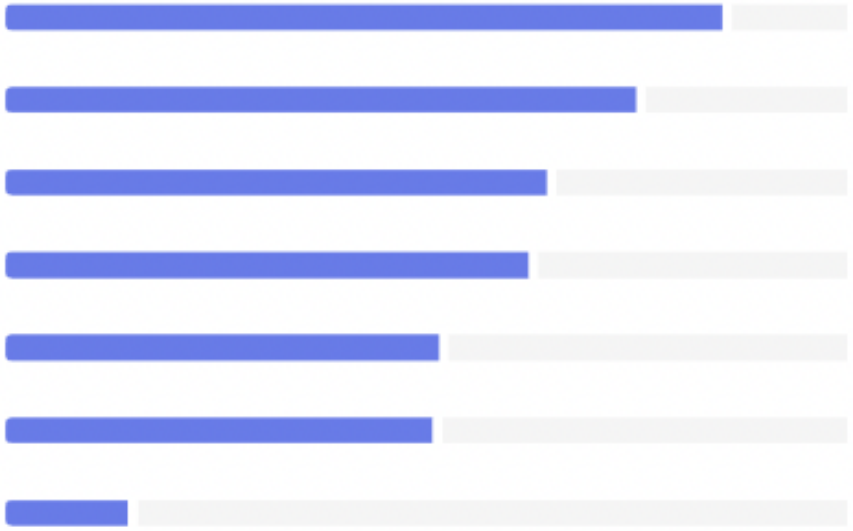

0
1
2
3
4
5
I do not bring work-induced emotions into my life.
I do not bring life-induced emotions into my work.
When I feel stressed by work, I can identify when I need to prioritize my personal needs.
When I feel stressed by work, I know when to ask for help.
I know where to find resources within my institution to help support my personal needs while engaging in death work.
I feel supported by my peers while engaging in death work.
I feel supported by my leadership while engaging in death work.
It is important to me to have skills to be able to care for the dying patient and their family.
100%
0%
100%

ASSOCIATIONS:

- MD and psychosocial admired work contributions **less**
- CLS and psychosocial reported **lower scores** on keeping work and life emotions separate
- > Years of experience offered:
  - **Greater** coping, acceptance of death work, keeping work/life separate
- PPC training **did not improve** spiritual/cultural comfort, acceptance of nature of death work or perceived coping
- > # of EOL cases offered:
  - **Greater** acceptance of death work and ability prevent death work from impacting one's emotions
- Consistent scoring for resource identification and support

PREFERRED RESOURCES

1. Death work education
2. Identification of resources for support while caring for dying patients
3. Death work simulation training opportunities
4. Identification of resources for support after a patient death
5. Development of a peer-directed support group for difficult clinical situations
6. Strategies to help identify when my personal feelings/experiences may impact my work
7. Other (please specify in Question 14)



TAKE HOME POINTS

- Death work is inevitable, and highly variable
- Role and practice setting will impact exposure to death work
- Exposure (EOL caseload + yrs of experience) → increase comfort with death work
- PPC training and education may supplement skills/comfort
- Opportunities for education/training in this space

THANK YOU – QUESTIONS WELCOMED!



Study Team:

- Brittany Camp, CCLS, PhD
- Jessica Hotchkiss, CCLS, PhD
- Allie Uber, MD
- Erica Barin, DO – HPM Fellow (25/26)
- Ryan Hare, MS (Biostats)







