Review Article

Medic-Aide: Developing a Medic Specific Staff Support Service in Palliative Care

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Abstract: *Objective*: A pilot project and service evaluation to identify the benefits of offer medical staff psychological supervision to support them in a) managing patient distress and b) self –care. *Methods*: A fixed model of supervision was offered with pre and post outcome measure in the form of a questionnaire. *Results:* Overall the feedback across the service as a whole offered positive feedback in terms of the goals as above. Additional service developments and service extension considerations were also offered for future groups. *Conclusion:* Although the feedback was offered from a very small pilot group, the groups has shown benefit and continues to be offered and reviewed.

Keywords: Psychological supervision; Supporting medical staff with patient psychological problems; Staff support in palliative care, Psychological supervision in palliative care, Medics psychological supervision.

INTRODUCTION

The Francis Report (2013) recognised the significance of the interface between staff and patient experiences of healthcare and concluded that greater attention in supporting staff in their roles was central to making improvements to healthcare. This has resulted in a number of practical initiatives focusing on staff wellbeing, towards creating a more nurturing environment for staff, with increasing calls for principals of compassionate management to underpin models of working across all healthcare services (Kings Fund, 2022 & 2021 & 2021; NHS England, 2021, West, 2019; West 2016; Kings Fund 2016).

Whilst this varies across clinical settings, the support in most part focuses on staff self-care as distinct from self-care in the context of professional interactions with patients. This can mean that those needs arising from staff - patient interactions may remain unacknowledged. In recognition of this, palliative care services have developed Level 2 supervision groups to support nursing staff to manage their own/ patient distress as well as exploring the more subtle effects on overall patient expereince and care (NICE guidelines 2004).

Research to date suggests that palliative care staff remain at higher risks of burnout and work-related stress as well as on-going emotional distress and mental health issues as a direct result of their work environment and role (Hussain 2021; Bugaj, 2020; Hill, Dempster, Donnelly and McCorry, 2016; Kamua, Medisauskaite and Lopes 2014; Pierce *et al.*, 2007; Quattrin, 2006).

In response to this, the promotion of the NICE guidelines (2004) 4 tier model of psychological supervision for nurses working in palliative care has provided specific evidence of not only the importance of, but also the impact of psychological supervision for nursing staff working in palliative care Specific benefits have included increased confidence in detecting and managing psychological distress in patients and reduction in the risk of burnout and emotional depletion in staff themselves. The model has been adapted by CHPS NELFT to provide support for nurses in

community teams, to extend support to, and provide parity across palliative care teams in acute and community settings. This has provided effective outcomes at both a personal and professional level for nurses in a variety of community settings (Hussain 2021; NICE Guideline, 2004).

However, over a decade later, the picture for medical staff working in palliative care is lacking. The literature indicates that there are notable gaps in the level and availability of support offered to medical colleagues at both a personal and professional level and that current medical education needs to change and look specifically at the psychological aspects of medical care to include both detection and management of psychological distress in patients as well as self-care across all stages of professional practice (Royal College of Physicians, 2022, Hussain, 2022; Gramm *et al*., 2020; Bharmal *et al*., 2019; Jenkins *et al*., 2010).

Whilst there are a handful of early studies suggesting the evidence for the benefits of psychological supervision for medical practitioners, current studies suggest that the support system and structure of implementation remains somewhat random. This is in part due to the fact that not all studies measure the same aspects and /or the same staff group and that the services for psychological support in general were few and far between (Goodhart *et al*., 2015; Russell, 2020; Feld, 2006; Monti *et al*., 2004; Hagedus, 1999).

Most relevantly-Goodhart *et al*., (2022) make the point that core to their findings were issues such as voluntary attendance and flexibility in what was offered (i.e. both individual and group options) allowing for greater individual needs. They found a high number of medical staff in attendance with a request for individual not group supervision. This reiterating the point that systems such as level 2 support are largely only open to nursing staff, and medical colleagues are often not considered.

To address this gap and offer more parity across services and professionals, CHPS NELFT and Saint Francis Hospice collaborated in a pilot project and service evaluation, offering an adapted medic-specific model of psychological supervision with an aim to extend and expand implementation.

This paper presents an overview of the project and evaluation, outlining service design, delivery, and recommendations from outcome measures.

NB: Whilst this pilot was specific to a palliative care hospice setting, the model is applicable to any setting where staff must work with and manage high levels of patient distress impacting on their levels of self -care.

Aims of the project
The project aimed to support medical staff address issues of managing patient distress and promoting self-care in equal measure, supporting staff to identify their own and their patients' emotional needs within a safe environment, via access to specialist psychological supervision.

As the project was in its infancy, processes and procedures of implementation were intentionally flexible/ open ended in order for a specific model to evolve.

Group members
The pilot project aimed to support non-Consultant grade medical staff working at Saint Francis Hospice through provision of access to group supervision by a consultant clinical psychologist.

Groups included all non-Consultant medical team members and were split in to two as follows:
Group 1 more senior medical staff – ST3-6 grade doctors who were in training to become palliative medicine consultants, and speciality doctors who had made a career choice to develop higher level specialist palliative medicine knowledge and skills.
Group 2 Junior staff - ST1 / ST2 staff on GP vocational training schemes who had been placed into a 6 month palliative medicine post as part of that training.

Individual slot - As required. (This was a combination of adapted solution focused principles and reflective practice with the aim of managing work -specific issues within the existing group context i.e. self-care and managing patient distress with any mental health issues being referred to generic or medic specific mental health services.

Practicalities
Each group was offered monthly sessions, lasting approximately 1 hour.
Dates were set in conjunction with staff rotas and availability, with a focus on ensuring as many staff as possible could attend.

All groups took place using a virtual platform Microsoft Teams.
The project ran for a six-month period to fit in with the length of medical training placements where necessary.
Individual slots were offered as required.

Intervention model
The groups adopted an integrated model, which included principles adapted from London Cancer Alliance Level 2 training, relevant research, and related recommendations as well as practice-based evidence of clinicians running staff support/ supervision groups across acute services.

Interventions were flexible, responding to issues raised, in order to allow an opportunity for attendees to cover psychoeducational as well as exploratory material, allowing members themselves to identify themes for each group as well as an opportunity to bring case examples from clinical practice.

Group Content
General themes were identified for each session and related psychoeducational strategies (though there was some flexibility within slots for personal experiences and case studies).

Themes arising across both groups
✓ Self-care whilst working in a hospice environment
Definitions of self-care, Trauma focused model links, relevance and priority given to self -care, current strategies, accountability, barriers, boundaries between professional and personal and options outside group. Also, managing personal distress at work and functional splitting (healthy and unhealthy strategies), equating self and patient care. Identifying sources of support and gaps. Setting personal goals.

✓ Introduction by the facilitator to the Level 2 model developed by London Cancer Alliance
Introducing Level 2 principle of '*The three Ss'* model. This is broken down as follows: Stuckness -feeling stuck with an emotion, Suffering -Levels and types of suffering and so clinical management, Safe - Safeguarding and risk. The model is used to help clinicians identify and assess emotional distress in their patients and outlining the context of each stage and examples.

✓ Exploring patient distress and psychological strategies to support them
Personal experiences of witnessing and managing patient distress, distinctions between healthy and unhealthy responses and what the markers may be, identifying responses and boundaries of communication, dealing with consequences of traumatic deaths or treatment plans for patients with patients and their families (some of whom may be unclear or disagree).

Personal and professional challenges. Considering how to protect oneself when in distress, compartmentalisation of boundaries and identifying points of external referral for self or patient

Challenges of patient relationships, techniques of validation and contextualisation of patients as people, achieving balance in context of emotional impact on self with challenging psychological cases.

✓ Working with the death of patients
Witnessing patients die in in great distress and pain as opposed to peacefully: Impact on participants' professional practice and personal emotional states. Also, deaths with predicted and unpredicted endings (including agitated death).

Communication of death to relatives and friends: balance of sharing information (empathy versus oversharing) identifying markers. Problems with debriefing and alternatives, silence versus action.

✓ Introducing participants to psychological strategies to support themselves and patients
Introducing the APPLE technique which uses the acronym/ stages: Acknowledge, Pause, Pull back, Let it go and Explore as a form of self-grounding /practical strategy to allow time for immediate processing when dealing with more disturbing deaths. Using self-compassion and self-kindness as a therapeutic tool-becoming aware of a self-critical inner voice and Introduction to mindfulness practice.

✓ Experiences of DNACPR/Palliative sedation and reflections on the debate on assisted dying
Exploring experiences of DNACPR and palliative sedation in the context of personal and professional impact: General and Covid context. Contextualising the processes of DNACPR and PS on one continuum with changes of intention re treatment and patient outcome. Identifying self-affirming cognitions to support staff during challenging

endings as a result of these decisions: Is it the best / safest course of action for the patient? Is it the kindest course of action? For the patient. Recognition and validation of challenging actions in the context of specific self-soothing cognitions: The hardest actions for the professional are the kindest for the patient. Personal and professional thoughts on assisted dying and working with on-going reviews by medical bodies as well as considering possibility of approved legislation.

✓ Caring for palliative patients at home - Personal and professional challenges.

A change of role (care co-ordinator) as well as pace and complexity of care. Distance from patient and team and challenges of telephone triage and related impact on building relationships and related isolation. Different levels of support as in this setting no direct team around but via phones. Emails and booked visits so absence of immediate support. Importance of clear information in context of competing adjustments to setting and patient care/ team treatment plans.

✓ Transitions

Leaving placements and adjustments. Review of group. Identifying change in understanding of self-care and managing patient distress. Development of clinical and leaderships skills and confidence versus capacity. Identifying past achievements and future concerns.

Negotiating personal characteristics and new responsibilities What we leave behind and what advice we pass on to next cohort (Self-care/ Modelling our consultant/ Ask questions). The recognition of the power of words and what is important to the patient and negotiating healthy communication about distress within challenges of time and priorities. Identifying strategies to take on into professional life/ next placement, and application of learned strategies across contexts.

✓ Mindfulness

In vivo mindfulness and reference to information on general rules for good mental health including basic strategies such as: Go outside, learn relaxation, eat well, learn something new, move your body, stay connected, and set boundaries. Final thoughts and general review. Final outcomes measures completed.

Attendance
Total number of attendees: 7
Junior Staff - 3
Senior staff - 3
Individual slot - 1

Average monthly attendance across 6 months slots (Including individual):
Junior slot: 86%
Senior slot: 74%
Attendance for individual slot: 100%
Reasons for non-attendance included non-working days or AL, and patient emergencies.

Outcome data to date
A group specific questionnaire was designed to look at outcome measures at the end of the 6 month period, identifying clinical skills and capacity around self-care and managing patient distress. Whilst this was initially offered to attendees pre and post sessions, responses were minimal and not always by the same individuals. Due to the absence of consistency of feedback, it was agreed to focus only on the final questionnaire as a source of development of the group and less as clear evidence of benefits, though these may be implied.

Final session outcomes
Responses were designed to be answered using a Likert scale; Strongly agree, Agree, Neither agree or disagree, Disagree, Strongly disagree with questions set out below.

Of 7 questionnaires sent only 4 were returned with feedback as follows:
- *I understand the importance of on-going self-care in my role: 100%*
- *I am motivated in me to develop self-care skills: 50% Strongly agreed and 50% Agreed*

It is of significance that despite the awareness of benefit of the group- there is a shift of motivation regarding implementation of techniques. Exploration of this would be helpful.
- *I have the skills to identify psychological concerns in my patients: 50% strongly agreed 25% agreed and 25% neither agreed nor disagreed*

This response may indicate that perhaps specific detailed training is required to improve the relevant skill set. This may be moderated by individual differences in skills and confidence of application as the next response suggests:

- *I have the skills to confidently respond to psychological concerns in my patients: 75% strongly agreed 25% agreed*
- *I would recommend the group to my peers: 100%*
- *Given the choice I would prefer to attend: 75% Monthly 25% Fortnightly*
- *Given the choice I would prefer the format: 25% Individual 50% Monthly 25% Both individual and monthly*

The last two responses suggest that the implementation of the group must allow flexibility for individual needs as and when required.

NB: It is important to note that *ensuring* that all staff completed the questionnaire pre and post sessions would have offered a more accurate representation of views. Without this, we have no reliable comparison data and data gathered may only be used to focus on future service development.

Practical and psychological impact of groups to date
Positive verbal and written feedback indicated practical and psychological benefits for members of both groups.
- ➢ Staff reported that the group has been an *important reminder of the value of self-care* and *self-compassion* and the *implementation of personal strategies* to help manage the complexities of the work:
- ➢ Staff developed *individual self -care goals* and have also identified changes around their understanding of and barriers to self -care and self-compassion.
- ➢ Staff developed strategies to manage distress in vivo
- ➢ Staff developed a range of support structures within and external to team to manage general stress in the workplace.
- ➢ Staff developed management strategies to help ensure healthy boundaries of work and personal life
- ➢ Staff noted that the supervision groups *have helped to validate the effectiveness and skill of their current practice* in managing their patients' emotional distress, resulting increased confidence
- ➢ Staff had a safe space to explore complex aspects of their role, such as working with and witnessing suffering, despair, and distress in their patients.
- ➢ Staff had a safe space to discuss challenging professional issues / debriefing and gained clarity regarding professional decision making
- ➢ Staff became aware of factors influencing their emotional experiences and strategies to manage this and / or channel this to support professional action
- ➢ Staff felt contained and able to strengthen group cohesion by shared
- ➢ In terms of recommended changes/ criticisms: One member raised the point that increased structure for the senior staff would be more helpful for staff to be prepared better to discuss cases or consider topics and these adjustments were made for the next cohort to ensure there was time enough for members to benefit more fully from the session content.

Additional Comments:
Due to the low rate of returns of psychology specific questionnaires, following are additional comments from both senior and junior groups included in their own exit feedback regarding their medical placement experience as a whole. Comments as follows:
"I also received some formal therapeutic sessions with one of the psychologist as a part of rotation that helped a lot in managing anxiety, stress and coping up well in general and at work."
"Therapeutic support (in the form of supervision) was also an excellent outlet."
"These sessions, it helps me reflect the difficult cases I dealt with and how to approach these scenarios differently in the future."
"I found psychological supervision very useful to hear others speak about their challenges and I feel it contributed to a sense of belonging."

Additional recommendations included a) A Request for a mixed option of open and closed group format and b) a request for access to a specialist psychologist for de-briefing as and when needed.

Recommendations for development
Accepting that feedback is based on very small numbers - following are practice-based recommendations for development of this service within palliative care settings:
- ❖ A *fixed model would be most helpful as follows:*
Session 1- Outcome measures. Intro to group rationale and sessions / Ground rules/ Challenges of the role - personal and professional – current picture.

Session 2- Introduction to self-care and targets
Session 3- Managing patient distress and the 3 Ss with examples
Session 4 - Managing patient endings - personal and professional issues around achieving a good death
Session 5 - DNACPR/Palliative sedation experiences
Session 6 - Assisted suicide
Session 7 - Review of initial self-care targets and reflections

❖ It may be helpful to offer individual slots in *the form of a regular monthly drop-in slot.*
❖ There may be some *scope to work with medical training courses to develop and offer a fixed and on-going group* in conjunction with other aspects of medical training.
  ➢ *To develop links with existing doctor-specific therapy programmes and create a pathway for referrals*. This would support staff to appreciate the distinction both forms of support not only for themselves but for their patients also.

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