# Self-Reflection on Experiences in Palliative Care

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## 1. Palliative care: experiences and self-reflection

Physicians often face death in clinical practice, particularly in palliative care. Experiences with severely diseased and dying patients may significantly impact their own attitudes towards disease and death. Both the influences on and the consequences of such encounters have not yet been fully elucidated on the empirical level. Concerning these topics, palliative care specialists may be regarded as a paradigmatic group for physicians and health care professionals in general. Therefore, this paper examines the following research question: Which effects does the self-reflection on the practical experiences with patients' death, dying, and the end of life exert on physicians in palliative care?

The research question is addressed from a medical standpoint by considering recent medical literature sources on experiences and emotions in palliative care. These sources depict a variety of topics that take into account patients and relatives on the one hand and physicians and health care professionals on the other hand. For the research question, only the second perspective is considered. The focus lies on physicians' self-reflection. Consequently, not all experiences and difficulties that health care professionals perceive are analyzed, in particular not all emotions, but only those that become contents of self-reflection. This distinction between emotions and self-reflection on emotions is occasionally difficult to make. Nevertheless, the dedicated topic is physicians in their relationships to themselves. Emotions in general are considered less informative for the research topic. Therefore, the entire spectrum of emotions in palliative care cannot be reviewed here. Rather, literature references are sought regarding reflections, self-assessments, conclusions, and inferences about the self.

Concerning methods, international, peer-reviewed publications on empirical studies in medical journals are considered for the recent time period from 2016 to 2024, supported by additional papers that illuminate and explain the frameworks of the topic. English and German publications are included. Studies stem from a broad international background, such as from Germany, Switzerland, the United Kingdom, Denmark, France, Estonia, the United States of America, Japan, and Taiwan. Given the predominantly English literature, this manuscript is also written in the English language. Empirical studies are selected for the full range of palliative care, both in-hospital and out-patient, as well as hospice care. The inclusion of publications is not based on a systematic literature review because the articles are highly heterogeneous in approaches, target groups, methods, and conclusions, a fact that precludes the comparisons of details and suggests individual valuations of papers.

After an introduction to the topic (section 1), the term self-reflection is analyzed (section 2). Grief is a frequent emotion in health care (section 3). Despite the relative lack of dedicated investigations, empirical studies occasionally address self-reflection in palliative care (section 4) and coping strategies as well as educational interventions to arrive at it (section 5). The conclusions provide a summary of the results (section 6).

## 2. Self-reflection

Existential situations evoke strong emotions in the short term. Their long-lasting effects on health care practitioners can be mediated by delayed reflections. Self-reflection is a psychological term that refers to the reflection of one's own self regarding inner, mental processes, such as emotions and thoughts. Self-reflection may contribute to self-knowledge, self-concept, and self-image. It is not the same as self-awareness, which refers to a conscious experience of oneself.

Within a universe of self-related terms and associated non-self terms, self-reflection may be regarded as a component of self-perception, relating to introspection and metacognition.[1]

1 See Morin, Alain: »Toward a glossary of self-related terms«, in: Frontiers in Psychology 8 (2017), article 280, https://doi.org/10.3389/fpsyg.2017.00280.

The concepts of reflection and metacognition have undergone changes when they entered health care from their psychological origins.[2] One definition reads:

> »reflection is commonly framed as an ongoing systematic, disciplined, back-and-forth mental activity of observing, questioning, analyzing, exploring, and refining thoughts/actions for gaining clarity in understanding and achieving productive outcomes«.[3]

In contrast, metacognition involves the regulation of cognitive processes.[4] Nevertheless, this concept is also widely debated in the literature.[5]

Self-reflection constitutes an important component in cognitive behavioral therapy,[6] in which it is part of supervision. It may be defined as »[t]he conscious understanding of one's own emotions, feelings, thoughts, and attitudes at the time of their occurrence, and the ability to continuously follow and recognize them«.[7] From a psychotherapy stance, the relationship between self-reflection and emotions may be described as follows:

> »Self-reflection is not attention that gets carried away by emotions, overreacting and amplifying what is perceived. Rather it is a neutral mode that maintains self-reflectiveness even amidst turbulent emotions. […] in most cases cognitive and emotional reactions are simultaneous and both occur at the same time during self-reflection«.[8]

The European Association for Palliative Care (EAPC) recommends six sections in the syllabus on the suggested curriculum for palliative care: basics of pal-

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2 See Merkebu, Jerusalem/Veen, Mario/Hosseini, Shera/Varpio, Lara: »The case for metacognitive reflection: a theory integrative review with implications for medical education«, in: Advances in Health Sciences Education: Theory and Practice (2024), https://doi.org/10.1007/s10459-023-10310-2.

3 Ibid.

4 See ibid.

5 See ibid.

6 See Prasko, Jan/Mozny, Petr/Novotny, Miroslav/Slepecky, Milos/Vyskocilova, Jana: »Self-reflection in cognitive behavioural therapy and supervision«, in: Biomedical Papers of the Medical Faculty of the University Palacký, Olomouc, Czechoslovakia 156.4 (2012), pp. 377–384, https://doi.org/10.5507/bp.2012.027.

7 Ibid.

8 Ibid.

liative care, pain and symptom management, psychosocial and spiritual aspects, ethical and legal issues, communication, as well as teamwork and self-reflection.[9] The latter section includes knowledge on teamwork, networking and delegation, as well as burnout prevention.[10] The final category demands comprehension for »[o]ne's own way how to manage burdens«, »[o]ne's own way how to manage personnel concern«, and »[t]he chance of debriefing oneself by supervision«.[11] According to the contexts of this paper, only the final entries relate to self-reflection, in the sense that self-reflection helps to develop self-help strategies and that supervision promotes self-reflection.

## 3. Grief and behavior

Health care professionals may be deeply touched by their experiences with dying patients. Within the wide spectrum of potential emotions, grief is a frequent reaction that may lead to changes in behavior and promote self-reflection. Nevertheless, only few personal narratives enter into the literature. One conclusion from a hospital practitioner, who prefers to remain anonymous, is: Sometimes, everything that can be done is not enough, and sometimes, it is too much; at the end of life, the human being is most important.[12]

The grief that health care professionals experience is not the same as that of loved ones, relatives, and close friends. Nevertheless, it is also individually shaped because professionals establish different types of relationships with dying patients, in particular regarding the time and the intensity of contact. The following quotation stems from a publication by clinical research coordi-

9 See European Association for Palliative Care (EAPC): Recommendations of the European Association for Palliative Care (EAPC) for the development of undergraduate curricula in palliative medicine at European medical schools. Report of the EAPC steering group on medical education and training in palliative care, 2013, Vilvoorde, Belgium: EAPC, https://dadun.unav.edu/bitstream/10171/34516/1/Recommendations%20of%20the%20EAPC%20for%20the%20Development%20of%20Undergraduate%20Curricula%20in%20Palliative%20Medicine%20At%20European%20Medical%20Schools.pdf [08.08.2024].

10 See ibid.

11 Ibid.

12 See Anonymous: »Alles, was in unserer Macht steht«, in: Ethik in der Medizin 34 (2022), pp. 687–688, https://doi.org/10.1007/s00481-022-00728-4.

nators.[13] They do not provide clinical care for patients in the narrow sense of the term. Instead, they build a rather functional relationship by focusing on research issues, for which patients become participants who occasionally, but not always, benefit from research interventions. Given this seemingly distant relationship in a potentially non-productive research endeavor, the experience of grief in the team is remarkable:

> »Knowing that patients with serious illnesses die did not protect or prepare us for the waves of emotion we experienced when a patient in our study died. Some of us have had personal losses after which we also thought: ›Maybe I do not have the right to be upset‹— a childhood friend we are no longer close to dies, or we learn that a good friend has had a miscarriage—and our grief is confounded by our feelings of guilt. We experience disenfranchised grief: grief that is not openly acknowledged, socially accepted, or publicly mourned. For us, there is no place to grieve with the patient's family or the clinical care team.«[14]

The authors highlight that their grief cannot be easily expressed in their roles, leading to exclusion from the community of mourners, who at least receive the chance to comfort themselves mutually. This experience leads to the insight that all stakeholder groups in health care should be included in measures that address sorrow, for example bereavement rounds,[15] supervision, personal advisory meetings, or religious services. This includes not only physicians, nurses, therapists, and typical palliative care staff, but also overlooked groups in this field, such as research personnel, housekeeping, and lay volunteers.

Do health care professionals turn away too soon from dead patients? The noise of clinical medical practice may contradict cultural conventions, and it may disturb the dignity of the dead, family members, and hospital personnel.[16]

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13 See Deary, Emma C./Daskalakis, Elizabeth/Abrahm, Janet L./Morris, Sue E./Amonoo, Hermioni L.: »At a loss: patient deaths and clinical research coordinators«, in: Journal of Clinical Oncology 41.16 (2023), pp. 3072–3073, https://doi.org/10.1200/JCO.23.00040.

14 Ibid.

15 See ibid.

16 Fürholzer, Katharina: »Post-mortem dignity between piety and professionalism. Plea for a moment of silence in everyday clinical practice«, in: Ethik in der Medizin 35 (2023), pp. 529–544, https://doi.org/10.1007/s00481-023-00787-1.

## 4. Reflection on experiences: empirical studies

Subjective learning outcomes were assessed in medical students who cared for seriously ill patients during an elective course in Germany.[17] Coping strategies included »writing a reflection paper« as part of the reflection phase, i.e. a paper that provided the basis for a reflection seminar.[18] The students' emotional condition was evaluated, e.g. feeling »overwhelmed« when meeting a patient, regarding the topic social and self-competence.[19] Student competences may be distinguished according to knowledge, skills, and attitude.[20] Self-assessment items, which students rated after the course, included the following examples: »I have all the skills and competences I need to be aware of my feelings and maintain a balance between empathy and professionalism while meeting with a severely ill patient« and »I can handle being directly confronted with my own mortality.«[21] The latter sentence received the lowest learning gain in comparison to all evaluation items.[22] In summary, the authors emphasize the mutual influences between emotions, reflection, and professionalism. The students showed difficulties to relate existential experiences to themselves and to draw personal conclusions.

A study from Switzerland identified topics that were important for conversations about approaching death.[23] Several focus groups were offered to major stakeholders, namely not only health care professionals, but also patients and patient representatives.[24] Among the four main themes that were identified from the empirical material, the following one acknowledges the im-

17 See Thyson, Tabea/Schallenburger, Manuela/Scherg, Alexandra/Leister, Anne/Schwartz, Jacqueline/Neukirchen, Martin: »Communication in the face of death and dying – how does the encounter with death influence the patient management competence of medical students? An outcome-evaluation«, in: BMC Medical Education 22.1 (2022), p. 25, https://doi.org/10.1186/s12909-021-03060-5.

18 Ibid.

19 Ibid.

20 See ibid.

21 Ibid.

22 See ibid.

23 See Felber, Sibylle J./Guffi, Tommaso/Brem, Beate G./Schmitz, Felix M./Schnabel, Kai P./Guttormsen Schär, Sissel/Eychmüller, Steffen/Zambrano, Sofia C.: »Talking about dying and death: Essentials of communicating about approaching death from the perspective of major stakeholders«, in: Palliative and Supportive Care (2023), pp. 1–10, https://doi.org/10.1017/S1478951523001621.

24 See ibid.

portance of the connection between emotions and self-reflection: »Recognizing and reflecting on own emotions and reactions«.[25] Its subthemes included »[r]eflecting on own beliefs and emotions« and »[b]eing aware of own insecurities«.[26] Self-care strategies are recommended.[27]

A study in Japan examined the learning processes of young medical residents who had graduated up to five years ago.[28] The residents provided care for dying patients and participated in semi-structured interviews.[29] Residents' perceptions included »feelings of guilt and powerlessness both as a person and as a doctor« in the category »mixed feelings associated with providing care for dying patients« and »the importance of facing patients', families' and one's own emotions« in the category »reflections on the experience of providing care for dying patients«.[30] Accordingly, attending physicians should »[t]ake various approaches to promoting residents' deep reflection on their experiences«.[31] Overall, the residents' experiential learning was viewed as depending on the reflection on their experiences.[32] The authors highlight that »identities as doctors« are shaped by existential questions.[33]

Spiritual care is frequently regarded as essential in hospice care in Taiwan, and an interview study investigated experiences of physicians and nurses with spiritual care in a palliative care unit in a hospital with a Buddhist background.[34] The interviewees, who were largely non-religious, referred to the »providers' lack of preparedness« as a challenge for providing spiritual care.[35] One quotation from the interviews mentions »the inability to notice«,

25 Ibid.

26 Ibid.

27 See ibid.

28 See Arai, Kazuko/Saiki, Takuya/Imafuku, Rintaro/Kawakami, Chihiro/Fujisaki, Kazuhiko/Suzuki, Yasuyuki: »What do Japanese residents learn from treating dying patients? The implications for training in end-of-life care«, in: BMC Medical Education 17.1 (2017), p. 205, https://doi.org/10.1186/s12909-017-1029-6.

29 See ibid.

30 Ibid.

31 Ibid.

32 See ibid.

33 Ibid.

34 See Tao, Zoe/Wu, Poshu/Luo, Amber/Ho, Tzu-Lin/Chen, Ching-Yu/Cheng, Shao-Yi: »Perceptions and practices of spiritual care among hospice physicians and nurses in a Taiwanese tertiary hospital: a qualitative study«, in: BMC Palliative Care 19.1 (2020), p. 96, https://doi.org/10.1186/s12904-020-00608-y.

35 Ibid.

states that »you may not be mature enough to explore«, and refers to »worries of noticing things that you're unable to help with«.[36] These citations imply tasks of both personal and professional development in health care, for which physicians and nurses may show ignorance and the failure to notice patient problems that the former should address, a phenomenon that could be due to personal insecurities and educational deficits concerning spiritual care.

## 5. Coping strategies and education: empirical studies

A study in France investigated general practitioner residents concerning their knowledge of end-of-life care for dying patients.[37] Residents experience an impact of clinical duties on their personal lives.[38] This includes the difficulty to talk about death with patients. The residents reported a statistically significant »desire to avoid caring for dying patients« as a factor of »[d]istress in end-of-life care management«.[39] The residents' personal life was affected by the interaction between residents and their relatives, anxiety, insomnia, revival phenomenon, nightmares, and anorexia.[40] They reported a wish for »systematic psychological support in at risk departments« on a statistically significant level.[41]

The participants in a volunteer end-of-life training program in the United Kingdom (UK) used reflective diaries for several months.[42] Guidance included questions about thoughts, feelings, evaluation of the experience as good or bad, and the sense that could be recognized in a situation.[43] The qualitative

36 Ibid.

37 See Haardt, Victoire/Cambriel, Amélie/Hubert, Sidonie/Tran, Marc/Bruel, Cédric/Philippart, Francois; REQUIEM Study group: »General practitioner residents and patients end-of life: involvement and consequences«, in: BMC Medical Ethics 23.1 (2022), p. 123, https://doi.org/10.1186/s12910-022-00867-9.

38 See ibid.

39 Ibid.

40 See ibid.

41 Ibid.

42 See Germain, Alison/Nolan, Kate/Doyle, Rita/Mason, Stephen/Gambles, Maureen/Chen, Hong/Smeding, Ruthmarijke/Ellershaw, John: »The use of reflective diaries in end of life training programmes: a study exploring the impact of self-reflection on the participants in a volunteer training programme«, in: BMC Palliative Care 15 (2016), p. 28, https://doi.org/10.1186/s12904-016-0096-5.

43 See ibid.

data from the diaries illustrated the importance of self-awareness, personal growth, reconstruction of meaning, and coping strategies.[44]

Verbatim exercises are employed in some hospice and palliative medicine fellowship programs, such as one in the United States of America (USA).[45] The clinicians composed word-for-word accounts of their encounters with patients and clients.[46] This method promotes reflection, self-awareness, resilience, mindfulness, and reduction of burnout risk.[47]

A qualitative visual analysis was performed for images that physicians created at the end of a one-year palliative care fellowship in the United States of America (USA).[48] The images, which included both paintings and photographs, predominantly contained portraits and references to nature, but rarely to suffering.[49] The authors suggest that the images communicate positive perceptions of death, and they attribute this to the successful acquisition of physician skills during the time of the specialized clinical experience.[50] Thereby, physicians integrated scientific approaches and humanistic perspectives.[51] The metaphor of journey was discernible in the visual narratives, alluding to transition and transformation at the end of life.[52]

A study in Denmark assessed spiritual care training in the hospice setting among employees with qualitative and quantitative methods.[53] Participants

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44 See ibid.

45 See Powers, Christopher R./Snipes, Garrett E./Harbin, Katie Boykin/Fischer, Andrew/Anderson, Nancy/Cheng, Kevin/Ford-Scales, Kristi/Siefert, Bryan C.: »Integration of the verbatim exercise into a hospice and palliative medicine fellowship«, in: Palliative Medicine Reports 4.1 (2023), pp. 133–138, https://doi.org/10.1089/pmr.2022.0025.

46 See ibid.

47 See ibid.

48 See Arnold, Bruce L./Lloyd, Linda S./von Gunten, Charles F.: »Physicians' reflections on death and dying on completion of a palliative medicine fellowship«, in: Journal of Pain and Symptom Management 51.3 (2016), pp. 633–639, https://doi.org/10.1016/j.jpainsymman.2015.09.006.

49 See ibid.

50 See ibid.

51 See ibid.

52 See ibid.

53 See Chahrour, Wafie Hussein/Hvidt, Niels Christian/Hvidt, Elisabeth Assing/Viftrup, Dorte Toudal: »Learning to care for the spirit of dying patients: the impact of spiritual care training in a hospice-setting«, in: BMC Palliative Care 20.1 (2021), article 115, https://doi.org/10.1186/s12904-021-00804-4.

reported the need for spiritual self-reflection, self-awareness, and introspection in order to provide spiritual care for patients in existential distress.[54]

Despite the recommendations from the European Association for Palliative Care,[55] self-reflection is not necessarily taught as part of palliative care education in European medical schools, for example in Estonia.[56] According to data collection on educational curricula and questionnaire surveys for university employees in Denmark, teaching gaps in the four medical schools were identified for self-reflection, teamwork, spirituality, and ethics.[57]

## 6. Conclusions

The empirical studies, which were evaluated here, span a wide range of health care systems and cultures. They also focus on diverse concepts, research questions, methods, and target groups. Despite their heterogeneity, some thoughts emerge repeatedly. Table 1 summarizes diverging contexts and aspects of self-reflection in palliative care.

Literature sources declare palliative care a valuable reason for development, both as a person and as a physician. This development is mediated by self-reflection. Negative emotions may overwhelm health care professionals in palliative care. Grief, powerlessness, and guilt provide sources of discomfort for personnel in this area, and this discomfort is not only emotionally disturbing, but also intellectually challenging.

54 See ibid.

55 See EAPC 2013.

56 See Suija, Kadri/Mason, Stephen R./Elsner, Frank/Paal, Piret: »Palliative care training in medical undergraduate education: a survey among the faculty«, in: BMC Palliative Care 23.1 (2024), p. 19, https://doi.org/10.1186/s12904-024-01351-4.

57 See Brask-Thomsen, Maria Kolind/Jespersen, Bodil Abild/Grønvold, Mogens/Sjøgren, Per/Neergaard, Mette Asbjoern: »Danish medical schools do not meet international recommendations for teaching palliative medicine«, in: Danish Medical Journal 65.10 (2018), p. A5505.

*Table 1: Self-reflection in palliative care: contexts and aspects.*

| Categories | Subcategories | References |
|---|---|---|
| Personal development | Maturity | Tao et al. 2020 |
| | Growth | Powers et al. 2023 |
| | Personal growth | Germain et al. 2016 |
| | Reconstruction of meaning | Germain et al. 2016 |
| | Positive perceptions of death | Arnold et al. 2016 |
| Professional development | Identity as a physician | Arai et al. 2017 |
| | Professionalism | Thyson et al. 2022 |
| | Empathy | Thyson et al. 2022 |
| | Patient perception | Tao et al. 2020 |
| Negative emotions | Grief | Deary et al. 2023 |
| | Powerlessness | Arai et al. 2017 |
| | Guilt | Arai et al. 2017 |
| | Difficulty to talk about death with patients | Haardt et al. 2022 |
| | Impact of clinical duties on personal lives | Haardt et al. 2022 |
| Interventions | Self-care strategies | Felber et al. 2023 |
| | Reflective diaries | Germain et al. 2016 |
| | Reflection paper | Thyson et al. 2022 |
| | Verbatim exercise | Powers et al. 2023 |
| | Psychological support | Haardt et al. 2022 |
| | Bereavement rounds | Deary et al. 2023 |
| | Participatory theater | Chahrour et al. 2021 |
| | Visual arts | Arnold et al. 2016 |

Interventions may promote self-reflection. Coping strategies provide opportunities to reflect and overcome obstacles towards successful development. Coping may take varieties of routes that cannot all be reviewed here in a com-

prehensive manner. A distinct literature corpus on coping exists in the areas of psychology, medical psychology, and psychotherapy. Therefore, the coping strategies named here only provide a glimpse at a restricted selection of methods that were referenced in the papers on recent empirical studies in palliative care. Visual, narrative, and creative methods may promote and improve access to self-reflection.

The research question focuses on the relevance and recognition of self-reflection in palliative care, based on the experiences and emotions in this particular field of health care. In contrast, empirical studies more often investigate the perception of emotional reactions. Negative emotions are frequently associated with mourning, powerlessness, guilt, insecurity, and hurdles for communication. Nevertheless, studies increasingly take into account self-reflection and coping strategies that promote reflection, leading to an expanding corpus on this topic in the recent literature.

Self-reflection is viewed as a mental activity that helps to cope with experiences and emotions. Thereby, it may contribute to both personal and professional development in palliative care.

Physicians should receive more educational support to engage with their experiences, emotions, and self-reflection in palliative care, be it during their studies in medical school, during clinical specialization, and for continuing education. This support should also extend to all stakeholders, such as health care professionals and volunteers, within their specific contexts, respectively, such as during their professional work in clinical care and as part of volunteer training programs.