



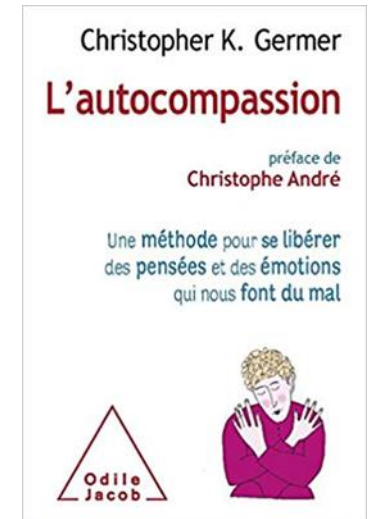
Compassion et autocompassion: Un message important pour tous.

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Chaire de soins palliatifs infirmiers
Service de soins palliatifs et de support
Centre hospitalier universitaire vaudois
Université de Lausanne



QUESTIONS CRITIQUES

- Qu'entendons-nous par la compassion?
- La compassion: important pour qui?
- La compassion: Pourquoi est-ce important dans la prise en charge des personnes en fin de vie ?
- La compassion: Est-ce important pour les soins palliatifs infirmiers ?



➤ QUE SIGNIFIE « COMPASSION » POUR VOUS ?

QUELLE EST L'EXPÉRIENCE DE LA COMPASSION
DANS VOTRE VIE ?

AVEZ-VOUS ÉPROUVÉ UN MANQUE DE
COMPASSION ENVERS VOUS-MÊME OU
ENVERS LES AUTRES ?



MESSAGE CLÉ 1



Nos expériences personnelles de la compassion façonnent l'importance qu'elle a dans notre vie et la façon dont nous prenons soin de la vie des autres.



PHOTO LANGAGE

- 2-3 secondes par image.
- Choisissez-en **une** qui reflète la question qui vous est posée (diapositive suivante).
- Notez pourquoi vous avez choisi cette diapositive
- Retour d'information



QU'EST-CE QUE CELA SIGNIFIE (POUR MOI) D'ÊTRE UNE INFIRMIÈRE EN SOINS PALLIATIFS COMPATISSANTE ?





























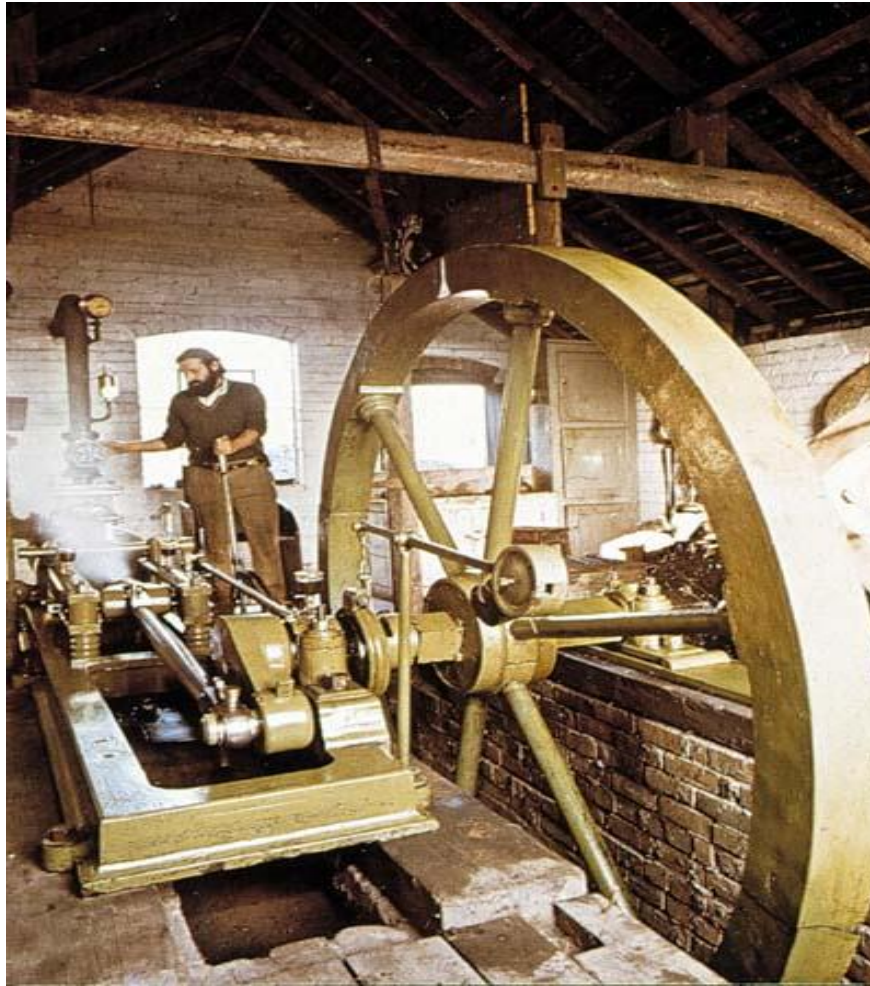


















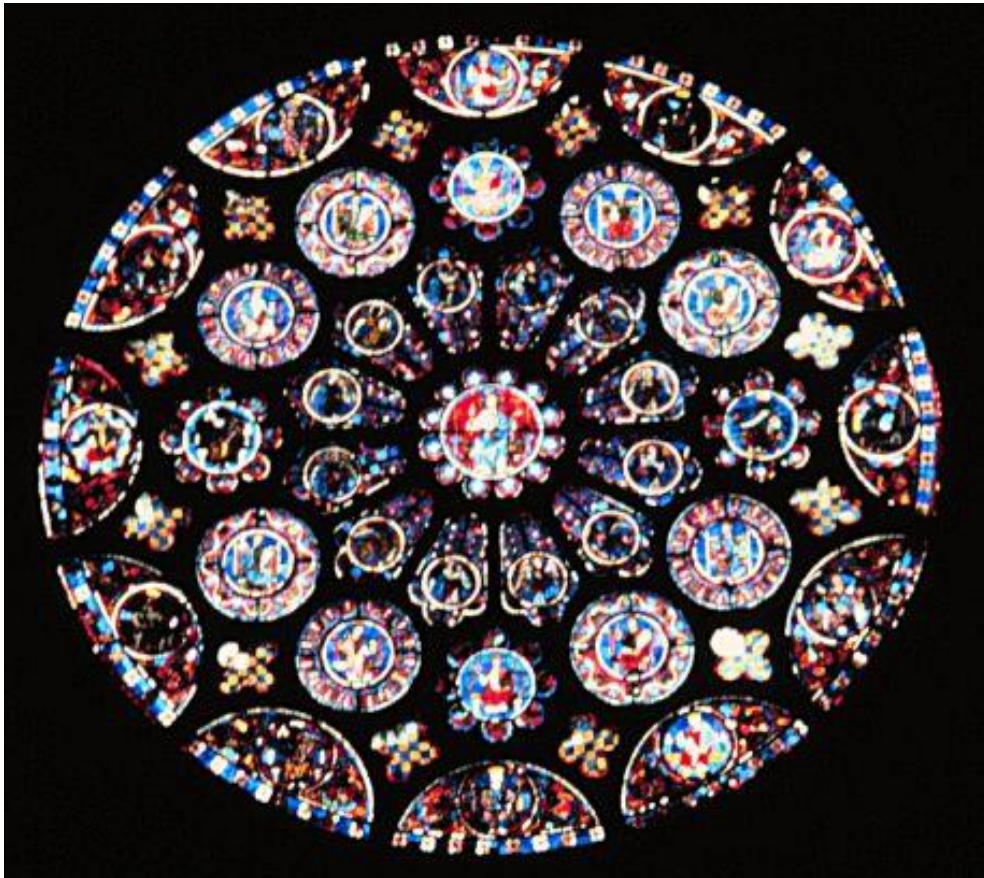




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UN MOMENT DE RÉFLEXION



QU'ENTENDONS-NOUS PAR LA COMPASSION?



LA COMPASSION EST UN PHÉNOMÈNE MONDIAL



الرحمة
الرحمة
الرحمة

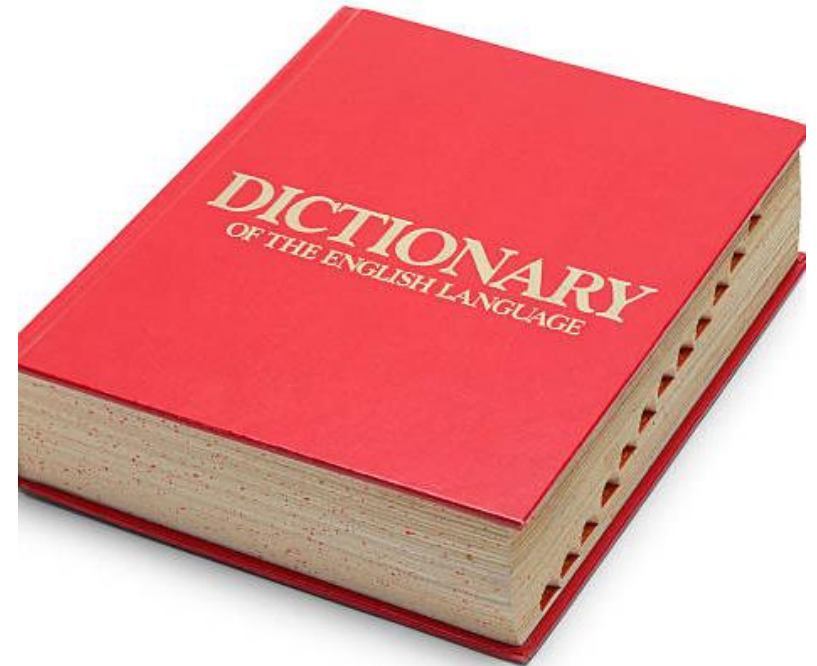


DEFINITIONS CLASSIQUES

La Compassion -du latin
«Com» (avec) et «Pati»
(souffrir)

L'empathie - dérive du grec
« empathia » (passion) et
« pathos » (sentiment). La
capacité générale de résonner
avec d'autres états émotionnels

‘**Empathic distress**’ -une
réponse forte, orientée vers
l'auto-protection contre la
souffrance d'autrui



L'EMPATHIE

“ une conscience accrue de l'expérience d'une autre personne en tant que chose à comprendre mais pas nécessairement à souffrir. Il s'agit donc d'une prise de conscience de l'expérience d'une autre personne, mais n'entraîne pas l'intention de soulager la souffrance ni les compétences nécessaires pour le faire.

Le cle de compassion



Vachon, M.L.S., & Harris, D.L. (2016) The liberating capacity of compassion. In D. Harris & T. Bordere (eds.), Handbook of social justice in loss and grief: Exploring diversity, equity, and inclusion (pp. 265-281). New York: Routledge.

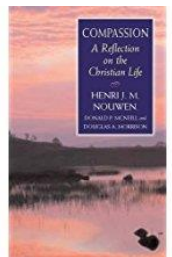


BEAUCOUP DE DEFINITIONS



Compassion asks us to go where it hurts, to enter into places of pain, to share in brokenness, fear confusion and anguish... La compassion signifie l'immersion totale dans la condition d'être humain.

Henri J. M. Nouwen, Donald P McNeill Douglas A Morrison. Compassion: a reflection on the Christian life. Revised Edition 2006. Image.



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Faculté de biologie et de médecine
Institut universitaire de formation
et de recherche en soins



LA COMPASSION EN RÉPONSE À LA SOUFFRANCE



- La souffrance ne peut être traitée que si elle est reconnue
- Avoir le courage de poser des questions difficiles à vous-même et aux autres
- Avoir la force d'attendre (et entendre) la réponse



MESSAGE CLÉ 2



- La compassion offre une voie vers le soulagement de la souffrance.
- Les soins compatissants nécessitent des aptitudes, des compétences et du courage.

LA COMPASSION: IMPORTANT POUR QUI ?



POURQUOI EST-CE IMPORTANT POUR LA PRATIQUE CLINIQUE?

La nécessité de comprendre le concept de souffrance

La nécessité de dialoguer sur des questions de traitement ou pas

La nécessité d'apprécier la pertinence du choix et de la prise de décision éthique

La nécessité de réfléchir sur la place et le but de la technologie du point de vue professionnel

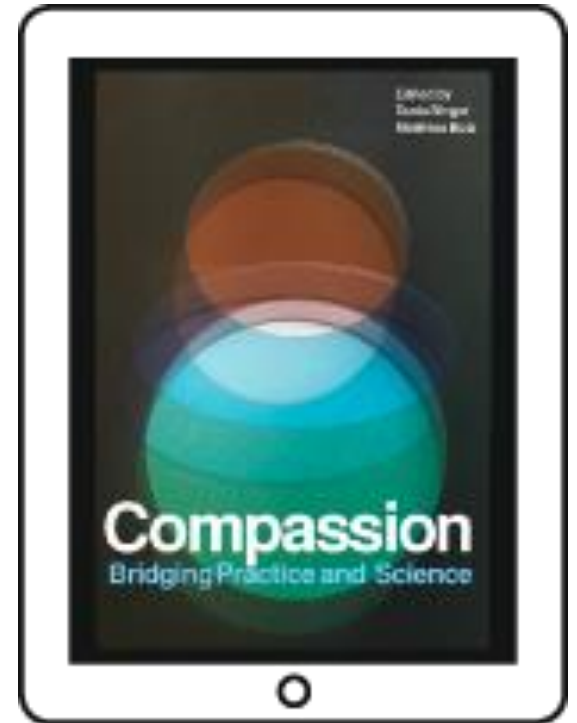


ET SI LA COMPASSION ÉCHOUE...



LA COMPASSION A-T-ELLE UNE BASE SCIENTIFIQUE?

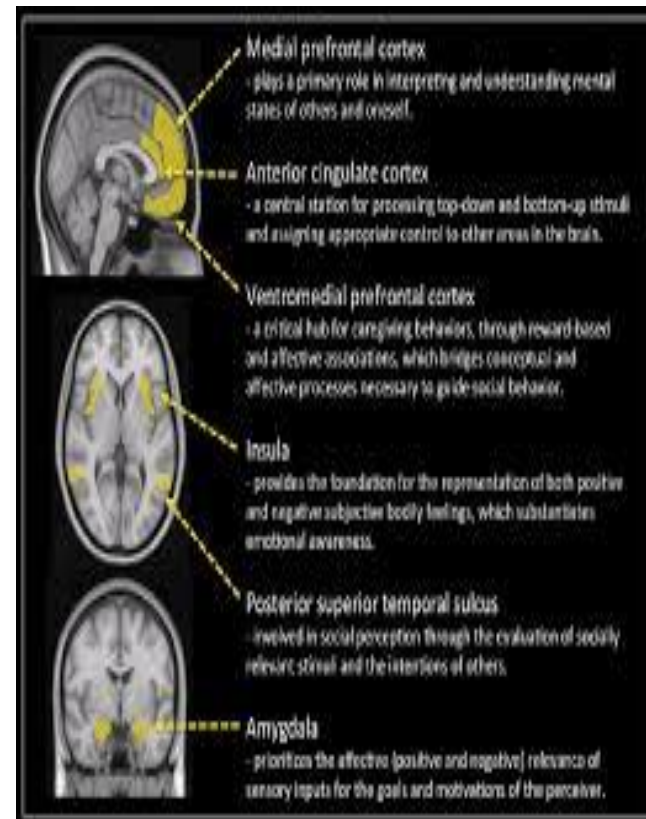
<http://www.compassion-training.org/>



L'EMPATHIE, LA COMPASSION ET LA NEUROSCIENCE

Les réseaux neuronaux d'empathie et de compassion sont les mêmes

Les 'neurones miroirs'

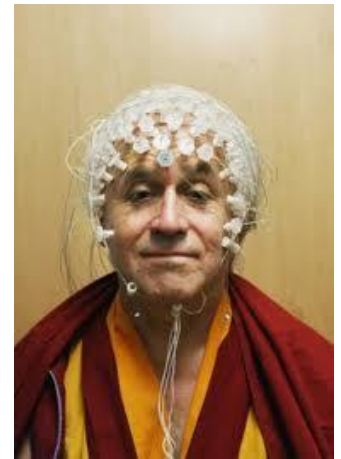


QU'EST-CE QUE ÇA VEUT DIRE?

Lorsque je me tape le pouce avec un marteau et que vous en êtes témoin, le même chemin neural est stimulé en même temps chez nous deux.



LA COMPASSION POUR TOUS



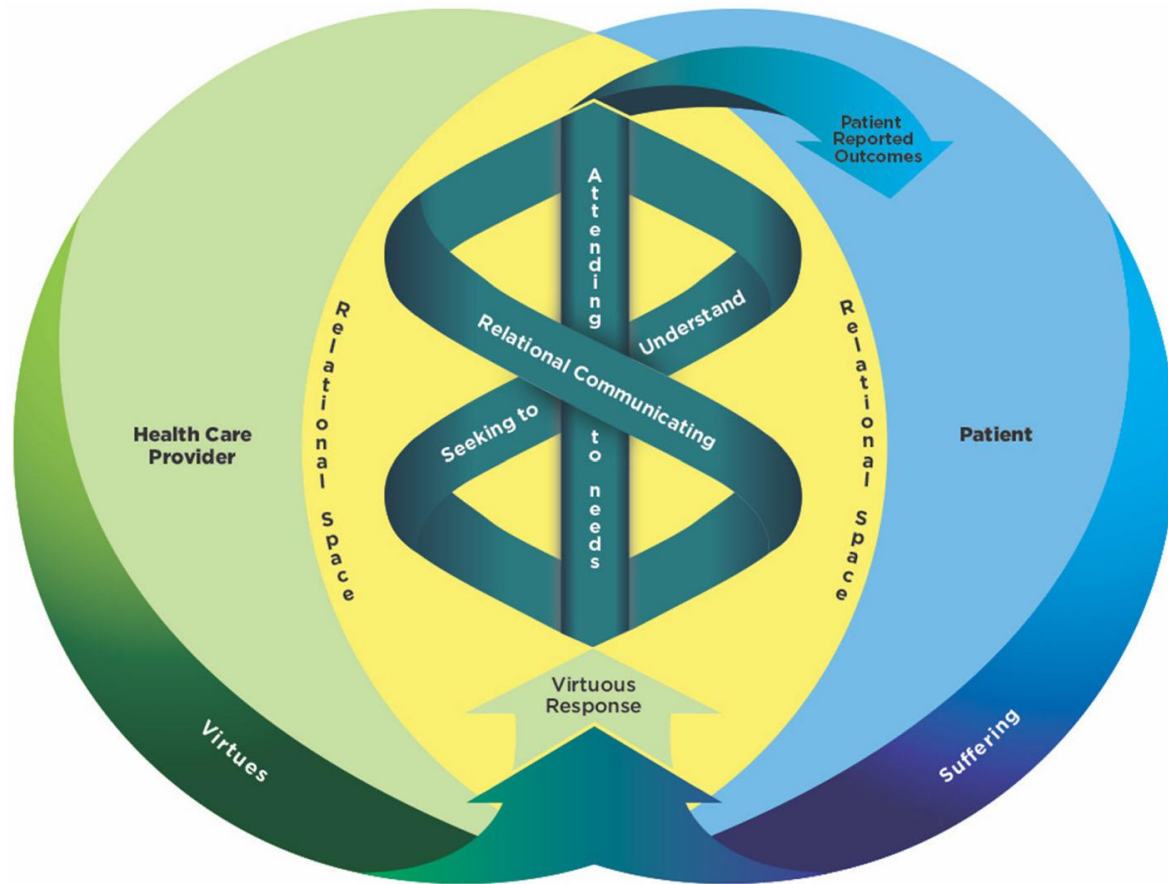
«Les adeptes» et «les novices». (*‘meditation-naïve*)

Compassion meditation en silence avec la neuro-imagerie des deux groupes.

Augmentation de l'activité positive du réseau neuronal des deux groupes.



UN MODÈLE POUR COMPRENDRE LA COMPASSION

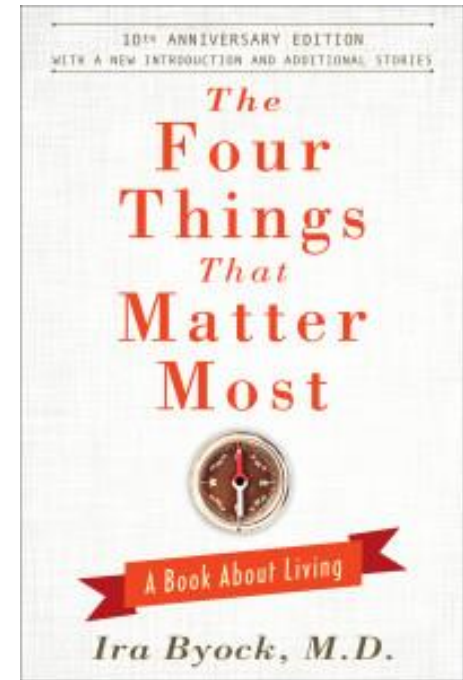


COMPASSION: POURQUOI EST-CE IMPORTANT DANS LA PRISE EN CHARGE DES PERSONNES EN FIN DE VIE?





‘S'il te plaît, pardonne-moi’
‘Je te pardonne’
‘Merci’
‘Je t'aime’
(Adieu)



LA RECONSTRUCTION DE VIES QUI NE SERONT PLUS JAMAIS LES MÊMES



APPRENDRE À PARLER AVEC COMPASSION



MESSAGE CLÉ 3 – L'AUTOCOMPASSION



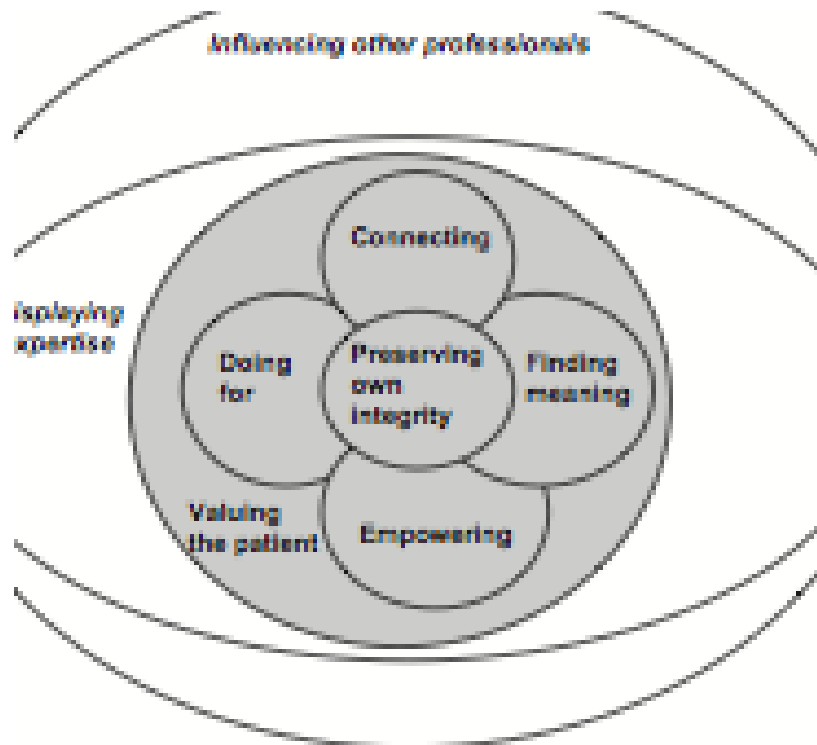
*In order to have
compassion for others,
we need to have
compassion for
ourselves'*
Pema Chödrön



COMPASSION: EST-CE IMPORTANT POUR LES SOINS PALLIATIFS INFIRMIERS ?

QUI SOMMES-NOUS ?

Davies et Oberle (1990)



Newton et McVicar (2014)

JCN Journal of Clinical Nursing

Journal of Clinical Nursing

ORIGINAL ARTICLE

Evaluation of the currency of the Davies and Oberle (1990) model of supportive care in specialist and specialised palliative care settings in England

Jenni Newton and Andrew McVicar

Aims and objectives. To evaluate the extent to which the Davies and Oberle (1990) model of supportive nursing has currency across specialist and specialised care settings in England.

Background. The model describes attributes of palliative nursing for practice and associated educational curricula. It is influential but prevents introduction of specialist/specialised care. Its applicability in contemporary care settings has not been evaluated.

Design. Evaluation was undertaken using sequential mixed methods, predominantly qualitative. Data collected during 2008–2009.

Methods. Four stages: (1) focus groups involving hospital and community palliative clinical nurse specialists and nurses from three hospital settings (total = 23) to identify setting-specific characteristics, (2) survey of nurses (n = 48 respondents/53%) with follow-up interviews (n = 23) to identify congruence with the model, (3) interviews with patients (n = 6) and carers (n = 13) for patient evidence and (4) reconvened focus groups (n = 15 nurses) for confirmation.

Results. All major dimensions were reinforced. 'Connecting' had reduced emphasis in the hospital setting where specialist nurses spend limited time with patients, but dedicating time to 'connect' with patients and carers as service develops could potentially become problematic across all settings. Two new dimensions ('Displaying expertise' and 'Influencing other professionals') with subdimensions (e.g. 'Advanced communication skills') are proposed as additions to reflect advanced practice. Further care subdimensions ('Making the assessment', 'Orientating', 'Agreeing the plan') are suggested to be best aligned with the existing dimension 'Connecting'.

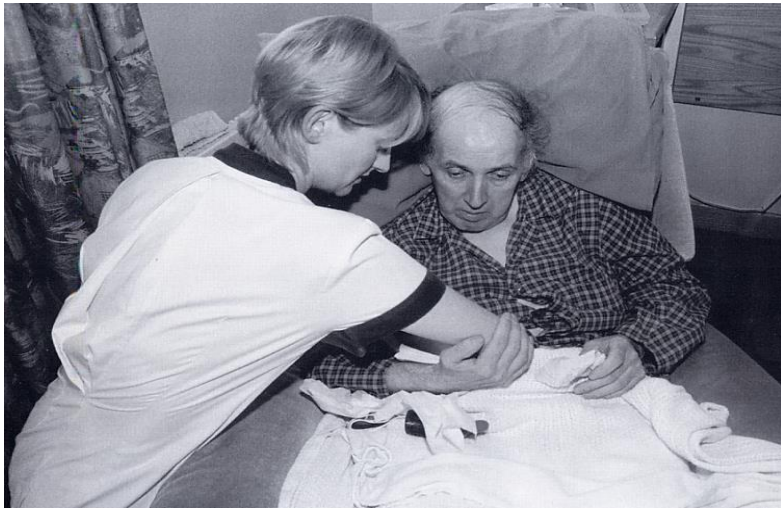
Conclusions. A revised model of supportive care incorporating dimensions of advanced nursing has currency in contemporary specialist/specialised care settings, although evaluation is required as to the actual impact of the model on care outcomes. 'Connecting' is currently being affected by pace of work and features of referrals.

Implications for practice. 'Spending time' is increasingly difficult to sustain so challenging nurses as to how they may continue to 'connect' with patients as service delivery continues to change.

Key words: advanced practice, clinical nurse specialist, evaluation research, models of nursing, nurses, nursing, palliative care, supportive care

Accepted for publication: 30 January 2013

TRAVAILLER À UN RYTHME DIFFÉRENT - ATTENTION MÉTICULEUSE AUX DÉTAILS



CE QUE SIGNIFIE PRENDRE SOIN DES AUTRES

PERSPECTIVES ON CARE
AT THE CLOSE OF LIFE

CLINICIAN'S CORNER

Self-care of Physicians Caring for Patients at the End of Life

"Being Connected . . . A Key to My Survival"

Michael K. Reutter, MD
Paula D. Wenzler, MD, PhD
Mary E. Vaughan, RN, PhD
Richard S. Sherman, PhD
Juliana M. Moss, MD

THE CLINICIAN'S STORY

Dr C, a 45-year-old hematologist-oncologist in private practice for 12 years at a large, urban, community hospital. Dr C, a male, has completed clinical research in progress oncology and has an appointment at the nationally ranked medical school institution. He sees about 300 patients a month, 6000 patients a year, of whom 60 to 120 require end-of-life care. Dr C is married, with 2 school-age children, 2 dogs, 2 cats, 2 horses, and good food with friends. Dr C shared stories of Mr J and Mr B, 2 patients who had recently died on the same day. He had very different relationships with each.

Mr J, a 35-year-old woman, presented in 2003 with lymphadenopathy in the groin that proved on biopsy to be poorly differentiated adenocarcinoma. Further workup revealed an ovarian mass, liver metastases, and a CA 125 level of more than 1000 units, leading to a diagnosis of ovarian cancer. She did not smoke or drink alcohol. Mr J was single and was raped for roughly 10 years before Mr J underwent surgery for debulking and then received 4 cycles of chemotherapy with carboplatin and paclitaxel, achieving good response. After approximately 12 months of remission, her tumor progressed, at which point she received capecitabine and gemtuzumab, initially with good response. Subsequently, she developed symptomatic liver metastases. Several chemotherapy included docetaxel, then irinotecan, neither achieving a response, and radiation therapy was given for the liver metastases.

When Mr J had cancer to see Dr C, in his words, "she was smiling and cheerful and so full of life and joy." Under his care she was able to work, travel, and enjoy her life for 4 years, at which point she had significant worsening of dis-

ease. Physicians providing end-of-life care are subject to a variety of stresses that may lead to burnout and compassion fatigue at both individual and team levels. Through the story of an oncologist, we discuss the potential symptoms and signs leading to burnout and compassion fatigue and present the evidence for prevention. We define and discuss factors that contribute to burnout and compassion fatigue and consider factors that may mitigate burnout. We explore the practice of empathy and discuss an approach for physicians to maximize well-being through self-awareness in the setting of caring for patients with end-stage illness. Finally, we discuss some practical applications of self-care in the workplace.

DOI: 10.1093/jama.294.10.1311

Mr J was a 35-year-old single woman with recurrent B-cell follicular lymphoma. Mr B had stage 2 colorectal cancer, hypoparathyroidism, and previous surgical resection of lung cancer. He smoked 1 pack of cigarettes a day but did not drink alcohol. Mr B was married, worked hard, but it could be after social drinks. He presented with paronychia, documented intracranial papilloedema, breast, weight loss, and diffuse lymphadenopathy. A lymph node biopsy confirmed a diagnosis of diffuse large-cell lymphoma. Mr B received rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone and had an in-

crease in hemoglobin and, cared for by her mother, died at home.

Mr B was a 50-year-old single man with recurrent B-cell follicular lymphoma. Mr B had stage 2 colorectal cancer, hypoparathyroidism, and previous surgical resection of lung cancer. He smoked 1 pack of cigarettes a day but did not drink alcohol. Mr B was married, worked hard, but it could be after social drinks. He presented with paronychia, documented intracranial papilloedema, breast, weight loss, and diffuse lymphadenopathy. A lymph node biopsy confirmed a diagnosis of diffuse large-cell lymphoma. Mr B received rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone and had an in-

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'Our [palliative] identity is primarily shaped by the quality of the care we offer, rather than by proficiency with a demanding new knowledge base and skills set

"Our knowledge and skills as caregivers determine our clinical effectiveness. Through competent curative and palliative interventions we lessen fear, offer comfort and build trust. We facilitate letting go"

'Who we are as persons determines the quality of our relationships and is the most potent medicine we give our patients'

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'ÊTRE À L'ÉCOUTE'

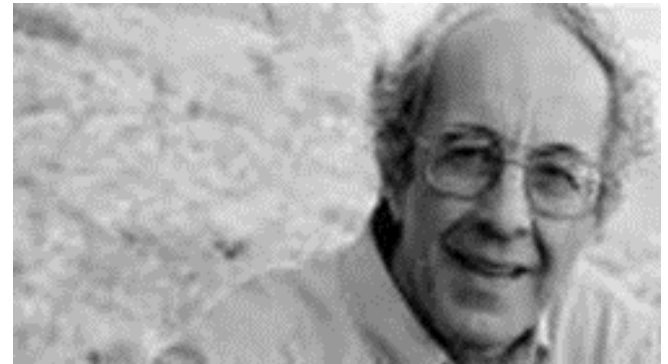


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- Kenneth Schwartz, médecin, cancer du poumon en phase terminale
- Aider le personnel de santé à dispenser des soins empreints de compassion en les aidant à **réfléchir à leur travail**.
- **Réunions mensuelles de groupe** pour discuter des défis émotionnels, sociaux et éthiques des soins dans l'environnement clinique.

' Chercher les petits actes de gentillesse' (Schwartz)





‘YOU ARE THE DIFFERENCE YOU MAKE’
‘VOUS ÊTES LA DIFFÉRENCE’
HENRI NOUWEN’



MERCI BEAUCOUP POUR VOTRE ATTENTION

*Trouvez la compassion
en vous pour pouvoir
la trouver chez les
autres*

