“A Lot Happens After Best Supportive Care”—Unbottling the Countertransference of Health-Related Suffering in a Community Cancer Palliative Care Setting: A Qualitative Case Study

Vidya Viswanath[1,2] Ravuru Vamsi Pranai[1] Dolorosa Fernandes[3] Neeharika Alapati[4]
Ketireddi Sirisha[1] Alisha Karim[5] Priyanshu Thakur[1] Samanasi Chaitanya Ram[1] Aaliya Khan[1]
Geddam Bhavani[1] Suroj Shit[1] Duvvada Santha Kumari[1] Ravi Teja Miriyala[6]

[1] Department of Palliative Medicine, Homi Bhabha Cancer Hospital and Research Centre, Visakhapatnam, Andhra Pradesh, India
[2] School of Medicine, Cardiff University, Cardiff, United Kingdom
[3] Department of Preventive Oncology, Homi Bhabha Cancer Hospital and Research Centre, Visakhapatnam, Andhra Pradesh, India
[4] Department of Medical Oncology, Homi Bhabha Cancer Hospital and Research Centre, Visakhapatnam, Andhra Pradesh, India
[5] Department of Clinical Psychology, Homi Bhabha Cancer Hospital and Research Centre, Visakhapatnam, Andhra Pradesh, India
[6] Department of Radiation Oncology, Homi Bhabha Cancer Hospital and Research Centre, Visakhapatnam, Andhra Pradesh, India

Address for correspondence Vidya Viswanath, MD, MSc, Department of Palliative Medicine, Homi Bhabha Cancer Hospital and Research Centre, Visakhapatnam, Andhra Pradesh, India (e-mail: drvidya21@gmail.com).

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Abstract

Introduction The Integrated Hospital-based Continuity of Care project at a government tertiary cancer hospital in the department of palliative medicine aimed to relieve serious health-related suffering and facilitate care along the continuum through home visits by a multidisciplinary team to patients on best supportive care. These patients transitioning through palliative care engender reciprocal feelings of suffering among the team members, impacting their well-being.

Countertransference includes the conscious and unconscious feelings experienced by the health care provider toward the patient. Accepted as appropriate and unavoidable, it is important to understand, recognize, and address the issues related to countertransference of health-related suffering. Following a debriefing session, the feelings documented by a downcast nurse, as a doodle, depicting the abandonment of a patient from her own home, formed the background for this study.

Objectives This study aimed to explore the experiences of the palliative care team caring for patients with cervical cancer in the home care setting.

Materials and Methods This qualitative case study method included the multidisciplinary team in the department of palliative medicine as participants. There were multiple sources of data like four sketches with captions depicting patients with cervical cancer at home drawn by the doctor and its interpretation by the team, reflective journaling notes, and transcripts from the focus group discussion. Following data familiarization and analysis, themes were derived.

Results The first theme described the dejection felt by the participants as they witnessed patients with disfigurement, stigma, and neglect. These memories lingered

Keywords
- countertransference
- home care services
- palliative care
- continuity of patient care
- grief

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and the second theme dealt with their deliberations as they navigated through self-doubt. The realization that home care is an invaluable experience was the third theme. The reflection that “every struggle is unique” and how art could help in training, learning, and catharsis was the fourth theme.

Conclusion The results of our study resonate with the dual process model of grief; moving from the loss-oriented response as they witnessed suffering in patient’s homes toward the restoration-oriented response where they felt gratitude and acknowledged the value of caring for the person at home. Art was the ice breaker in enabling this reflection.

Introduction

Serious health-related suffering associated with death from cancer is estimated to double over the next four decades. By 2030, 70% of global cancer cases will be in low- and middle-income countries where late presentation and fewer resources lead to poor cure rates compared to high-income countries. More than half of low-income countries do not have palliative care programs. Thus, there is an overwhelming need to expand cancer programs that integrate palliative care.[1]

In addition to symptom control, integrating palliative care early in the trajectory of the disease enables cycling conversations over time and deepens prognostic awareness, thus supporting patients to develop adaptive coping strategies.[2] Timely palliative care delivery in the home care setting allows for structured and systematic follow-up, facilitates anticipatory care planning, and focuses on information sharing and psychosocial elements of care.[3]

With this in mind, an integrated hospital-based continuity of care project to supplement the services within the department of palliative medicine at a government tertiary cancer hospital was initiated with a multidisciplinary team of doctors, nurses, administrative staff, physiotherapist, and clinical psychologist in December 2021 and continues till date. The team provides palliative care services within the hospital outpatient and inpatient departments, through telephonic calls and in the community through home care provision. Home care is provided to patients on “best supportive care”[4,5] where no further disease-directed therapy is being continued and who live within a 100-km radius from the hospital.

Being a hospital-based community program, patients on home care have transitioned through early and/or concurrent palliative care and interacted with the palliative care team during the course of treatment. Clinical relationships built on the feelings and associations generated by the patient toward the team members along the course of illness, transference, can develop.

Countertransference applies to the reciprocal feelings, intuition, and inferences generated by the team members about patients and is important clinical information.[6] The team members recognize suffering and healing as core concerns in patients but it is unclear how patient suffering impacts the team member’s well-being.[7,8]

Following a home care visit, a downcast nurse and a doodle depicting the abandonment of a patient with cervical cancer, from her own home, set the background for this case study. This qualitative case study aimed to explore experiences of the hospital palliative care team caring for patients with cervical cancer in the home care setting.

Materials and Methods

This descriptive qualitative study exploring the experiences of the hospital palliative care team members was reported according to the Consolidated Criteria for Reporting Qualitative Research[9] (►**Supplementary File S1**).

Study Participants

The study participants included all the multidisciplinary team members working in the palliative medicine department, narrating the experience. Hence, no formal sample size estimation was considered. The sample was adequate to narrate the complex and multifaceted phenomenon of patients with cervical cancer in the home care setting. There were six female and three male participants aged between 24 and 33 years. There were three doctors (D1, D2, D3), three nurses (N1, N2, N3), one physiotherapist (P1), one clinical psychologist (C1), and one administrative assistant (A1). Each of them had 6 months to 2 years of working experience in palliative medicine. This team supplemented the hospital palliative care outpatient and inpatient services. They followed up through telephonic calls and provided home care to the patients. These were planned home visits, triaged based on symptoms and psychosocial needs. The visits are usually done by two team members; nurse along with doctor/physiotherapist/clinical psychologist. The administrative staff were trained through the volunteer training program in palliative care and visited patient homes as part of their training protocol. Regular debriefing following the home visits was held.

Study Design and Setting

Qualitative case study method, where the system and people are part of the study, was used as the strategy of inquiry with multiple sources of data for in-depth exploration.[10]

The philosophical framework underpinning the research was the pragmatic model which allowed for the plurality of methods to be part of the research plan. It offered a methodological framework where the situation was first encountered and recognized as a research problem. Then, the researcher reflected on the nature of the problem and reformulated the research question. Then, the choice of methods to best address the problem was decided, thus connecting the process of designing the research to the core research question and the design concerns to the methods.[11]

Data Collection

The palette of methods for data collection included:

(1) Four sketches drawn by the team doctor depicting patients with cervical cancer at home with captions (►**Fig. 1**) and its interpretation by the team. As the doodle was the trigger for this research study, following the debriefing session, four sketches of patients with cervical cancer seen in the home setting were drawn by one of the doctors, who is an amateur artist. This was then captioned and circulated within the participants for their interpretation.

(2) Individual reflective journaling notes (J) of the multidisciplinary palliative care team.

These included their notes relating to the sketches and also from their home care experiences of patients with cervical cancer.

(3) Focus group discussion was conducted, undisturbed, with all the participants in a meeting room in the hospital. It was around a table so that all the participants and the researcher were facing each other. Focus group was advantageous here as the participants were familiar with each other and the interaction could yield the best results. After participant consent, the discussion was video recorded for a total period of 1 hour. Care was taken to ensure that all participants could express their thoughts and share what they felt, saw, and heard. Those who dominated the conversation were monitored. The questions were broad and open-ended and focused on the experiences while visiting patients with cervical cancer in the home care setting and the reactions to the art.

The primary researcher was aware of her multiple roles as a complete participant engaging with the team, as an observer and also the person the team reported to. Descriptive and reflective field notes were made by her. She refrained from sharing personal experiences, which could have limited participant information and thus ensured bracketing.[10]

Qualitative Data Analysis

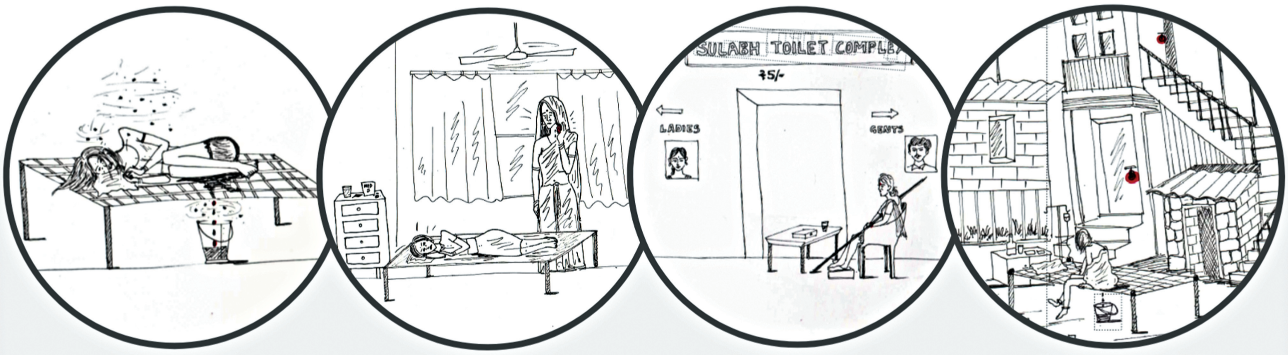
The focus group discussion was recorded and transcribed verbatim within 24 hours to ensure quality and reliability. The discussion was in English with some words in the local language, which were translated and transcribed. The transcript of the focus group discussion (T) and the journaling notes (J) from the individual participants were read and reread for familiarization of the data. The recording was also heard along with the transcript. This enabled the researcher to recreate the setting and engage in both the verbal and nonverbal data. The participants also reviewed the transcripts and provided feedback.

Validity

The validity of the study was determined using Yardley's criteria by demonstrating contextual sensitivity, commitment and rigor, transparency, coherence, and impact.[12]

The recording was heard and the transcript and journaling notes were examined by two colleagues (coauthors 3 and 13) of whom one was proficient in the local language to ensure trustworthiness of the data (coauthor 13).

After data familiarization and saturation, the process of coding was done by categorical aggregation. This was then collapsed to derive the subthemes and themes. The data



A woman on a bed, the bed with a hole, a swarm of flies, the stench of secretions, the shame of cancer, the stigma of the fistula.... **The reality of the morbidity of cervical cancer**

A mother watched as her daughter wilted, burdened by cervical cancer Between her dying daughter, her paraplegic husband, deserted son-in-law and young grandchild, **how could we convince her to start therapy** for the cervical cancer that had already scarred her lymph nodes too?

From afar, she is a worker in the Sulabh complex, going through her daily grind. Come closer and she is our **patient with Stage 4 cervical cancer on best supportive care working to support her abusive husband and young children.**

Her toil and sweat had built her house, a space called home and a place for her family ! But when cervical cancer mutilated her, home deserted her. **We wonder what was worse, the cancer ravaging her body or the abandonment scarring her soul...**

Fig. 1 Four sketches with captions depicting patients with cervical cancer at home. Original artwork created by coauthor 2.

analysis and interpretation were also examined by the coauthors 3 and 13.

Ethical Approval

The study protocol was submitted to the Institutional Ethics Committee and granted exemption from review IEC/0224/12000065/001.

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

Results

There were nine study participants including three doctors, three nurses, and one physiotherapist, clinical psychologist, and administrative assistant each. Ten subthemes and four themes were generated as described (►**Tables 1**–**4**).

Dejection

The team expressed their disappointment, sadness, and helplessness when they witnessed patients in the community; neglected, living in hiding with distorted body images, and living with shame and stigma. It is the bad memories that are haunting, they voiced. As professionals trained to relieve suffering and having decreased the symptom burden in the outpatient department, they were concerned if they were doing enough and wondered what more they could do. They brought forth the irony that those who needed looking after were being neglected. They also dwelled upon the inadequacies and inequity in health care provision especially when patients were only on best supportive care. This led to an agitated discussion on why newer modalities and interventions to bring down symptom burden and ease caregiver burden was not a priority (►**Table 1**).

Deliberations

As the team navigated through self-doubt and deliberated on the innovations needed, they also expressed regard for the courage of these women patients, who strived and worked with disease to support their homes. They admired the patients' willpower to stay alive in the midst of suffering and abandonment. This reminded them of why they worked and how they needed to keep "*knocking on doors*" (C1J) without losing hope.

The team spoke about some caregivers neglecting patients and others struggling to manage their responsibilities and caregiving. They recognized how important it was to be nonjudgmental as they had limited insight about the families' past and relationship dynamics. Acknowledging and supporting the caregiver was important, they agreed. They were concerned about whether it was imposing on the caregiver when they had to continue their activity alongside caregiving. Recognizing compassion fatigue, the team broached on the challenges of dealing with the concerns and fielding questions from different caregivers especially when they faced them at home. They spoke about societal norms, which contributed to caregiver conundrums and how fear, uncertainty, and stress added to caregiver distress. In

Table 1 Dejection

Quotes	Subthemes
"*I have seen patients come and whisper in my ear that they have white discharge because they are shy … because of society. They don't show if they have a huge ulcer, they don't tell unless it is infected, foul smell maggots. I have seen, opened it and been told the family was not willing to show because of stigma. How can I show this to my sons? How can I explain this to the others? (D3T)*	Women in hiding
"*So when we talk about cervical cancer per se, all patients will have similar symptoms – vaginal discharge, smell, fistula, stool p/v but the way they are treated in terms of hygiene and symptom burden that stays in our mind*" "We *must have visited more than 100 patients with cervical cancer in a period of 2 years. But the way they are treated is different from patient to patient. What stays in our mind are the patients who are being neglected, something similar to the pictures, patients kept outside, that stayed in our mind (P1T)*	Haunting memories
"*Am excited to see her on a home visit. On entering home, we get to know she is not taking medicines she is not seen by caregiver properly, stigma, and she has so many psychological concerns that she cannot open up in front of the caregiver. So being a professional, I am grateful that I did this service but also feel very helpless" (D2T)*	Helplessness
"Felt very bad 2 houses but she is outside the house"(N1T)	
"When palliative intent is starting, more research should come because as humans we are very responsible that fellow humans should not suffer. They should have better life, there will be end, suffering decreased or minimalised as much as possible." So, more modalities and innovations for the person with the disease and those taking care." *(D1T)*	
"Is the research and studies enough for us to answer this ladies distress, who was lying on the cot with the most terrifying environment (flies around her) leaves us speechless" (P1J)	
"Being a health care provider, we need to find some other way …"(N3J),	

Note: D1, D2, D3 are doctors 1, 2, and 3; N1 and N3 are nurses 1 and 3; P denotes physiotherapist; T means transcript quotes; J means journaling notes.

Table 2 Deliberation

Quotes	Subthemes
"*I observed in the picture that in the position also, she is giving a message to us – she is so brave, she is fighting with disease, even though she don't have that much love and affection and care from others but she is still fighting with the disease. (A1T)*	Resilience
"*And also when we see patients with disease working in toilets, (*this patient worked in a public toilet*) it encourages us to do more and support them …strong bold women" (C1T*)	
"You should go for work, you should earn money, you should take care …adds to the burden."(D1T).	Caregiver conundrums
"What becomes cumbersome is changing the diapers, changing the under sheets daily. If we see a patient, or even if it is our own father or mother, at one point; compassion fatigue" (P1T).	
"*The kind of questions they ask changes, at the Out-Patient Department*, *will the pain reduce? I want this to come down. But when we go for home visit, how long will the patient live?" (C1T).*	
"Most important, when patient is in hospital and visiting OPD, they have set the trust on us that something they will do to decrease the pain or decrease the symptom burden. When they are with the caregiver at home, they always have the distress that if some bigger symptom like shortness of breath or something happens, can they manage it alone or what and because of that fear, what they want …I always believe that the question how long the patient will live arises from this distress only that we can't manage, the fear of managing the patient is something happens suddenly, what we have to do?"(D1T)	
"We should not be judgmental to caregivers also…, because I feel that no one wants to lose their loved one so as I mentioned; some caregivers are taking care very nicely and some; neglect. The reason why they don't want them to suffer question arises How long? (N3T)	
"If we keep at home, they will repeatedly ask, why are you not getting admitted in hospital …. neighbors will question.". (D1T.)"	
"*Even caregivers have sleepless nights along with patients." (D3T)*	

Abbreviation: OPD, outpatient department.
Note: D1 and D3 are doctors 1 and 3; N3 is nurse 3; C1 is clinical psychologist; P1 is physiotherapist; A1 is administrative assistant; T means transcript quotes.

Table 3 Realization

Quotes	Subthemes
"How the patient is actually being treated; so the onion peeling we call in palliative care, I think home visit is the way of finding out more" (P1T)	Value of home care
"the real time situation, and the level of suffering our patients are going through" (D3T,D3J)	
"*but during home visits symptoms can deteriorate or alleviate or decrease. So the plan will be when we saw the patient last versus what we see real time". (P1T)*	
"*When we go to home visit, we realize what they are suffering. Sitting in the Outpatient Department, we think it is routine" (D3T)*	Challenges with routinization of symptoms
"When we go for Home Visit, main thing in our head is symptom control, plan in the mind – This patient has a wound …When we go and see, symptom stuff we are able to manage, but there is a lot beyond that we see. We start thinking, we are helping this patient, what more can we do? (C1T)	
"Cervical cancer, house (hesitatingly); daughter ladies help even without stigma. But if they are male, you find it difficult to counsel" (N2T).	

Note: D3 is doctor 3; N2 is nurse 2; P1 is physiotherapist; C1 is clinical psychologist; T means transcript quotes; J means journaling notes.

spite of the challenges they witnessed and faced, the team unanimously expressed that it was the home care visits that enabled them to realize the illness experience (►**Table 2**).

Realization

The team remarked that though comprehensive care plans are made when patients left the outpatient department, they witnessed the real situation only in the home care setting.

Symptoms which were considered routine in the outpatient setting were challenging to manage at home. Though they were comfortable with physical symptom management, it was the unforeseen societal and psychological distress that was visible during home care visits.

Female team members spoke about patients who whispered in their ears during home visits regarding discharge, ulceration, and maggots and were shy to reveal it to the males

Table 4 Reflection

Quotes	Subthemes
"*We did our best what and when we did; appreciate ourselves" .More self- growth for me ....self-learning as well(C1T)*	Introspection leading to growth
We have to fight with our problems, whatever we are facing with our life." *(A1T)*	
"*Grateful for a proper meal, grateful to enjoy the taste of food. At one point everything will end but till then, appreciate the sensations for myself. I realised that living a normal life is a blessing" (D1T).*	
"It doesn't take any time for the tables to turn we can be in this position, can you say that? One of us can be in this situation. This applies to everyone including health care provider and the caregiver" (P1T)	
"Every tear has a story, every struggle is unique but one thing in common is the resilience and the strength to cope" (C1J)	Every tear has a story
"*Depicts the true picture*" (*N3T*)*"And it connects and connects very easily*	
and even it is non-verbal and the person is not saying anything it will still connect. There is no language barrier" (C1T)	
"*We as Health Care Professionals can educate through these pictures and .... tell you what you don't have to do. You don't have to put the patient outside. Don't have stigma. Treat her like a normal human being What not to do." (D2T)*	Art as an enabler
"When we read, the diagrams stay with us. When it is a labelled diagram, it stays longer – picture of a memory. Experience we are trying to portray through art and take it forward for learning – experience learning and pictorial learning. So based on that, it is the best way of learning and can be incomparable and with words(captions)*-makes even more sense." "Actions speak louder than words but here it was the pictures speaking more than the memories because it was his memory and her memory but all of us could replicate or feel what was going on there" (P1T)*	
"It is the strength we all have...The strength of the team is in each individual and the strength of the individual is the team" (C1T)	

Note: D1 and D2 are doctors 1 and 2; C1 is clinical psychologist; P1 is physiotherapist; A1 is administrative assistant; T means transcript quotes; J means journaling notes.

in the family. Counseling was difficult too when there were only male caregivers. They realized how holistic care provision was facilitated by home care (►**Table 3**).

Reflection

Even with a similar disease, they contemplated how the illness experience was distinctive. The focus group discussion also brought forth the importance of family support being even more than wealth. They introspected and felt gratitude for what they had.

They surmised that art was the enabler which drew from the experiential and enabled them to connect and converse. They were confident that they could educate through art. For the artist, he drew from the memories; "*What it made me feel, I didn't think while drawing*" (D2T).The focus group discussion concluded with identifying the strength as individuals and as a team (►**Table 4**).

Reflexivity

The primary researcher, a female postgraduate, who conducted the study and the focus group discussion leads the palliative care department and has over a decade's experience in palliative care. The study was conducted keeping in mind the morbidity of cervical cancer witnessed by the researcher in her practice in palliative medicine for over a decade. The researcher was also conscious that the participants reported to her. This reflexive approach allowed for the researcher's subjectivity as a resource during data analysis.[10] It enabled the researcher to use her experience while exploring the phenomenon and maintaining an active role in the knowledge creation process. Thus, themes are meaning-based patterns, conceptualized and analyzed by the researcher, and not merely a superficial summary of the data. It involves significant critical engagement of the researcher with the data set, where the researcher is actively interpreting the data through the lens of her scholarly knowledge, sociocultural view, ideology, and theoretical suppositions.

To facilitate the focus group discussion, the researcher sat with the participants around a table to enable eye contact and ease conversations with each other. She ensured bracketing and could relate closely with the sketches, the focus group discussions, and the feelings, from angst to hope, which the participants went through. She could also relate to the gender dynamics when female participants expressed their difficulty in counseling male caregivers. She, through her field notes,[13] documented the silences when they related about the suffering witnessed. She noted the animated discussions regarding the need for more research in palliative care. She also observed how through deliberations the participants reflected on gratitude and their strength as a team.

Validity

Contextual Sensitivity

The six female and three male study participants were in the age group of 24 to 33 years and had an experience ranging from 6 months to over 24 months in palliative medicine. Home care was a core area of their work. The morbidity and mortality of cervical cancer in India is significant and the debriefing revealed that there was exploration needed to understand the countertransference of suffering experienced by the team. Hence, this study was designed with pragmatism as the framework with multiple sources of data collection.

Commitment and Rigor

The investigator was committed to executing every part of the study meticulously and carefully. Care was taken to respectfully engage the participants, conduct the focus group discussion, analyze the journaling notes and transcripts, and extract the essence of the study. The data was handled responsibly and diligently.

Transparency and Coherence

A detailed description of the process and methods of research has been made to ensure transparency. A rational association of the research question, the methodology, and the philosophical framework and data analysis has been made to achieve coherence. The documentation and maintained records have been examined by colleague researchers and analyzed.

Impact

The research process and outcomes will contribute to the impact the research has made. A good audit trail has been maintained. Adding to the quality of the research was also how the data shaped the conclusions. The study, though not generalizable, may be transferable.[14]

Discussion

Critical to the success of a therapeutic relationship, is the space between the patient and the clinician with the interplay of verbal and nonverbal interactions.[15] Transference and countertransference apply to the feelings and associations felt by the patient toward the clinician and the reciprocal ones generated by the clinician toward the patient. Countertransference is the inevitable emotional response, conscious and unconscious, of a health care professional toward the patient. When utilized correctly, it can help the physician to understand how patients relate to others and experience the world around them.[16,17] It is ubiquitous in a clinical encounter especially during exploration of psychological concerns and information gathering.[6,7] “How we experience countertransference varies; that we experience it does not.”[15]

The basis of palliative care is a successful interpersonal and empathetic relationship that is built along the disease trajectory and transitions in care.[6] This is enabled in our hospital setting; as home care provision is integrated into the services and follows early/concurrent palliative care. It works as a continuum, thus enabling the team which interacts with the patient and caregivers in the outpatient unit to also follow them up at home. For those beyond the hospital home care radius, provision of care continues through collaboration and timely exchange of information and decisions.[18]

All the participant health care workers in the study were in the age group of 24 to 33 years with about 6 months to 24 months experience in palliative care. They were being trained to help those who suffer and also learning about their own responses to the suffering they witnessed. “*The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet!*”[19] The team members were young and yet to metamorphose[20] in their palliative care journey. The daily exposure to suffering and death, working as a unit with patients and families, and interacting with other health care professionals meant coping and finding a balance between the cost of care and the satisfaction of caring.[20]

In a study by Rowe,[21] some of the threats that lead to suffering of the healer are dealing with the vulnerable patient population, the high cost of empathy, and silence. Our home care visits involve caring for the most vulnerable and caring for many patients with different needs simultaneously.[21] It involves entering patients’ spaces and conveying an understanding of their emotional response. The demands are significant and understanding responses to suffering is one way to ensure that team members are able to continue in the profession.

The phases[21] described in response to suffering from being mute to lamenting and then finding solidarity and support requires assistance. The need is to recognize, acknowledge, and discuss these feelings, in supervision or consultation, if necessary.[7,16,17]

It needs a place built into the work setting where they can talk to others who can empathize.

A healthy work environment[22] and debriefing sessions play a key role in providing intellectual and emotional support and helps maintain team efficiency.[21] Our study too, took root after a debriefing session following home care. The themes drawn from the study resonated with the dual process model of grief.[23] Dejection and deliberation dwelled on the loss-oriented response which was the sadness, angst, and self-doubt the team felt as they witnessed suffering in patient’s homes. This then moved toward realization and reflection—the restoration-oriented response. Here, they felt gratitude and acknowledged the value of caring for the person at home. They reflected on how home-based palliative care is a direct look into the reality, on how it plays a unique and crucial role in providing a more personalized and holistic approach to managing serious health-related suffering in the patient’s own environment. Though it could be challenging, it is also essential to mitigate suffering and offer home care to patients who are in need. Though spirituality was not explicitly discussed in our study, there were implicit references by participants who experienced a transformative process, felt useful, reaffirmed their love for life, and developed flexibility and resilience.[20] One team member expressed how her own adaptive capacity had improved and others vocalized feeling grounded, grateful, and more courageous in their own lives.

Our participants also acknowledged that the support of the team members contributed to their work and each member drew strength from the team. Systemic countertransference[24] extends beyond the person into the shared space incorporating the team and culture of the organization. A dedicated means of processing the emotional experiences without marginalizing it, even if it takes time, can build team capacity and cohesiveness.[25] Thus, organizational culture should expect and acknowledge countertransference and encourage self-reflection, self-analysis, supervision, and psychotherapy.[7,15,20] Supervision and group support enlivens efficacy, well-being, and commitment to work. Along with working with whole patient care, the future of hospital-based care lies within the hospital system, its people, and the interactions between them.[25]

There is a need for ongoing reflective assessment, informal and formal personnel support, and pursuit of opportunities for healing.[7] This study was one such opportunity, and for our participants, art was the ice breaker.

The strength of arts-based research, using artistic process as a way of inquiry,[26] is its holistic and transdisciplinary approach.[27] This was also echoed by our participants. The sketches, drawn from memories, were impactful and able to capture the ineffable. Described as a metacognitive experience,[28] the art evoked empathy, deepened reflexivity, and triggered transformative understanding. The esthetic force can garner community engagement in academia and lead to wider dissemination of findings.[27] Individuals do vary in graphic aptitude, it could make some uncomfortable and can become ineffective when inquiries lose focus of the purpose. Our art focused on women living with cervical cancer in their homes seen during home care visits. It was sketched by the team doctor who is an amateur artist and the sketches were open to interpretation by all the participants.[29] The combination of the visual and the verbal allowed our participants a multifaceted understanding of women living with cervical cancers in their homes and resulted in an engaging, valuable, and cathartic interaction.

Art-based educational approaches have been applied to improve communication skills among oncology fellows.[30] Key competencies in oncology practice include interprofessional collaboration, lived experiences of people with cancer, person-centered care, understanding one's own limits, and self-care practices.[31]

Limitations of the Study

This study was conducted in a rural setting with constrained economic resources. It is context-specific to patients in the community with cervical cancer on best supportive care; a cancer predominantly seen in the lower socioeconomic strata in India. Our study team had young participants with experience in palliative care ranging from 6 months to 2 years. Thus, the results of the study though reliable, may not be generalizable.

Strengths of the Study

Our oncologists commented on how this could be an educational tool. In the "chain of education" proposed for oncology professionals, the important final key is "how" to educate, optimize, and enhance teaching and knowledge-sharing skills for impactful learning.[32]

We hope that this arts-based approach study would help oncologists introspect regarding countertransference, reflect on their patients who are now unable to come to the hospital, and create pathways to meaningfully integrate palliative care and facilitate home care services at their centers.

This study reprises the importance of debriefing in multidisciplinary teams and demonstrates the use of art as an enabler in unbottling the countertransference of suffering among the health care providers. The themes from the study have been interpreted with a theoretical lens; the dual process model of grief moving from the loss-oriented response to the restoration-oriented response as they introspected and realized the value of the home care service they were providing and the privilege of palliative care.

Conclusion

Timely palliative care in the home care setting can facilitate holistic care. For the health care providers addressing the needs of a vulnerable population, countertransference of serious health-related suffering is ubiquitous and unavoidable. This study reiterates the value of team debriefing and using artistic process as a way of inquiry. Art can be an engaging and an impactful tool for self-reflection and team building in addition to being a powerful aid in providing education and training.

Authors' Contributions

V.V. designed the study, conducted the research, analyzed the data, and wrote the manuscript. R.V.P., K.S., A.K., P.T., S.C.R., A.K., G.B., S.S., and D.S.K. participated in the study and reviewed and approved the data. D.F. and R.M. examined the data and assisted with the interpretation. D.F. and N.A. refined the final narrative and made critical contributions to the manuscript. All authors approved the final version. V.V. is the guarantor and corresponding author for this study. This manuscript is honest work which has been read and approved by all the authors.

Patient Consent

Patient consent is not required.

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Conflict of Interest

None declared.

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