

Complexities Concerned With End-Of-Life Care: Learning from Experience

Brief Note

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Abstract

This brief report discusses some psychological and cultural aspects of treatment and care at end-of-life, along with suggesting that clinical supervision, along with similar forums, provides protection and development to health care. Beyond technical aspects of treatment and care, clinicians are exposed to existential realities and moral complexities that require cultural sensitivity and test resilience. A concise case example illustrates the emotional resonance of clinical work and risks of identification when working with the seriously ill and the dying. This discussion makes a case for organizational support for formal work discussions, in clinical supervision, throughout oncology and palliative care.

Introduction

Working with the seriously ill, the dying and bereaved is a challenging specialty of health care. Among other areas of professional competency; pain management, complex clinical diagnosis, and working with families, in often distressing circumstances, can deplete the resources of the most experienced professional.

Consequently, an important aspect of the overall delivery of care is support for healthcare professionals - who themselves are documented as experiencing personal challenges because of their work. Striving to fashion safe and helpful professional relationships, while at once preparing for enforced and often untimely separations through death, is a feature of end-of-life and requires meaningful and appropriate support.

There are various ways of supporting professionals working in end-of-life care, including reflective forums, Balint-style discussions, Schwartz rounds, restorative peer groups, and related to this discussion, clinical supervision. Each offers a structured space for professionals to explore relational dynamics, address the emotional impact of providing health care, and share ethical concerns - while

maintaining a grounded and compassionate and grounded presence in the face of recurrent losses.

End-of Life Care: An Existential Mirror

Listening with care to patients' stories is arguably a concern for all involved with end-of-life care. Allowing patients and families to speak, in safety, about their suffering, can permit a voice for hidden pain. Professionals may absorb both spoken and unspoken elements of conversations - impacting their internal landscape and influencing how treatment and care are delivered. Opportunities for reflection can potentially bring about beneficial changes in a person's thinking, feelings and attitudes - treatment and care can be managed appropriately.

Cultural Awareness

Cultural sensitivity is also important - being attentive to diverse identities and microcultures of others, including colleagues. This goes beyond an awareness of ethnicity or religious faith. Hidden cultural norms that shape our identities and the experience of serious illness, dying and bereavement might also impact the course of illness, along

with treatment and care. Sexual orientation and gender, family dynamics, social class, disability, neurodiversity, and a person's microcommunity are concerns that typically surface when meaning is sought in response to illness - and can challenge professionals' personal resources.

Carrying Emotional Burdens

Acknowledge existential realities, are recurrent concerns for those who work in end-of-life care and are related to the psychological idea of containment. Personal fears, values along with other life challenges, can arouse as a result of being emotionally available to others in times of crisis.

The following exchange concerns a palliative care nurse's experiences with Sally (pseudonym), who died because of bilateral carcinomas in her breasts. The account, while brief illustrates how psychological concerns can be aroused and some complexities of end-of-life work:

Nurse: 'Sally was a fighter (pause) - yes, a real fighter to the end. She made sure her family stayed together, and towards the end she protected them from the pain of her death (heavy sigh). 'I liked her, yes I did - and I'm going to her funeral. She reminded me of... (break off and pause) me! She reminded me of me, that's the way I would have dealt with it.'

In this instance, the nurse strongly identified with Sally's sufferings, and required an emotionally literate forum to make sense of her experiences.

The Role of Clinical Supervision

Clinical supervision is recognised across healthcare, as offering a developmental space for reflecting on professional practice. It is concerned with work related discussions and safety of professional practice. It is not a therapy, yet the confiding nature of supervisory relationships can evoke discomfort from previously unexamined feelings.

Relaxing our guards can effectively arouse forgotten and deep-seated feelings. Providing safeguards and ethics to direct discussions, clinical supervision allows a deeper reflection on clinical work. Establishing supervision as a part of the overall provision of treatment and care, rests with balancing measurable outcomes and valuing time to think.

There is the additional consideration of securing supervisors with the necessary competencies to offer support that fits with professionals' developmental levels, clinical values, and learning styles. Supervision should be aligned with real-world professional practice.

These ideas have particular relevance to end-of-life care that are often involved and emotionally charged clinical encounters. Some research challenges ideas that strong anxiety and emotional unease are universal responses to serious illness - suggesting a danger of clinical interventions based on assumptions. It has also been suggested that patients' perceptions of their emotional responses are sometimes at variance with the observations of healthcare professionals.

Nevertheless, psychological trauma, and emotional distress linked to serious illness are widely documented. It may be helpful to keep in mind that wherever anxiety and fears appear absent, some level of psychological management is likely operative. That is to say, feelings of concern or fear are kept enclosed rather than experienced openly - yet the person (patient, family, team or practitioner) is troubled. For these reasons, clinical treatment and care require formal and carefully planned work discussions.

Conclusion

Clinical supervision, therefore, seems essential to safe practice. Organizational commitment to supervision is furthermore critical to success. If clinical supervision is to provide some measure of safety and security, for healthcare professionals, patients, families and organizations, it must be integrated thoughtfully with protected time and skilled facilitation.

Clinical supervision, can allow professionals to share knowledge, acknowledge limits, maintain cultural sensitivity, and learn from experience. Showing respect for colleagues, developing emotional strength and awareness, addressing senses of shortcoming, inevitably arising in health care, while affirming achievements, can also foster professional unity, providing a strong sense of common purpose in teams.