



Compassion Is a Necessity *and* an Individual and Collective Responsibility

Comment on “Why and How Is Compassion Necessary to Provide Good Quality Healthcare?”



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Abstract

Compassion is a complex process that is innate, determined in part by individual traits, and modulated by a myriad of conscious and unconscious factors, immediate context, social structures and expectations, and organizational “culture.” Compassion is an ethical foundation of healthcare and a widely shared value; it is not an optional luxury in the healing process. While the interrelations between individual motivation and social structure are complex, we can choose to act individually and collectively to remove barriers to the innate compassion that most healthcare professionals bring to their work. Doing so will reduce professional burnout, improve the well-being of the healthcare workforce, and facilitate our efforts to achieve the triple aim of improving patients’ experiences of care and health while lowering costs.

Keywords: Compassion, Compassionate Healthcare, Burnout, Organizational Change, Patient-Centered Care

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Compassion is cited as a first principle of medical ethics across the health professions.^{1–3} But what does this mean in today’s healthcare environment? Prof. Fotaki, arguing for the importance of making compassion an ethical foundation of healthcare in her recent editorial, makes the critical point that only an approach that acknowledges the interrelation between individual motivation and social structure can serve as the foundation of compassion-based ethics of care.⁴ We agree and also suggest that we can and must act collectively and individually to tip the scales towards compassion in healthcare.

There are far too many examples in which beliefs and values arising within the context of larger societal forces have led to harm from neglect and lack of compassion (acts of omission), and hatred and violence (acts of commission). As Prof. Fotaki suggests, encouraging and educating individuals to provide compassionate care is insufficient in environments and organizations in which administrators, managers and healthcare professionals are focused on cutting costs, meeting performance targets unrelated to patients’ health and well-being, and sustaining the organization’s productivity rather than focusing on the essential aims of healthcare – promoting health and well-being, curing disease when possible, managing illness, and healing always. We need genuine, widespread commitment to fostering the well-being of the ill and vulnerable, to supporting the primacy of healing relationships, and healthcare workers themselves, as well as patients, families and their communities. Driving healthcare professionals and teams to work faster and harder with fewer resources is not a solution. This will only exacerbate

the epidemic of burnout and drop-out among those drawn to professions based on service to persons.⁵ Compassion involves emotional engagement, human connection and sense of reward, while burnout degrades compassion with emotional exhaustion, depersonalization and low sense of personal accomplishment.⁶ Lack of compassion towards staff, and the burnout this engenders also undermines the “Triple Aim” of improving patients’ experiences of care and health, and reducing costs.⁷ Further, these considerations must be folded into broader conversations about overall societal priorities and policy decisions as we collectively try to allocate resources to meet other social needs in addition to healthcare. Our research suggests that organizations and systems can make commitments that enable rather than impede compassionate, high quality healthcare. These include a commitment by organizational leaders and managers to allocate resources and set policies that focus on the needs of patients, families, and caregivers themselves, for compassion and healing relationships; a commitment to educate healthcare professionals and the public about the characteristics and skills of compassionate care; to value and recognize compassionate caregivers and organizations; to partner with and learn from patients and families; to create flexible performance improvement processes in order to implement and continuously improve compassion in care; to deepen our understanding of the nature of compassion and its impacts through research and measurement; and to support healthcare professionals and staff to manage the psychological and emotional stress of providing care so that they are able to act with compassion rather than experiencing personal or

moral distress, and burnout.^{8,9}

The magnitude of the challenges, however, can be daunting. It is tempting to place responsibility for compassion failures on “the system” or “organizational culture.” But where does the balance lie between collective and organizational responsibility on the one hand, and individual motivation, agency and skill in acting with compassion on the other hand? In fact in my role as educator, I am often asked, “Is compassion innate, or can it be taught, learned and enhanced?” Evidence about brain plasticity and the social neuroscience of empathy and compassion should set these questions to rest. The answer is definitively yes, compassion is both innate and can be learned and enhanced.^{10,11}

Advances in neuroscience have shown us that the human brain has neural networks that are hard-wired with the ability to share the experiences of others, including emotions and sensations. For example, overlapping neural networks are activated whether directly experiencing pain oneself, or observing another person experience pain.¹² This is thought to be the physiologic basis of empathy for others’ pain. How one processes this experience-sharing is modulated by individual traits and momentary states, a myriad of conscious and unconscious factors, immediate context, and organizational “culture.” Human beings are born with the capacity for compassion, and everyone involved in the care of patients and families can learn to deepen their capacity to provide compassionate care in every interaction in which it is called upon.^{13,14} Rather than asking whether empathy and compassion can be motivated and learned, we might be better served by asking how we can eliminate or at least diminish the societal forces that suppress the innate compassion of healthcare professionals who are drawn to this work in the first place.

While we are advocating for such transformative change, we can also learn more about the attributes and skills of compassionate healthcare professionals and teams and develop educational and performance improvement processes to encourage and assess them.¹⁵ It may be daunting to consider one’s individual role and responsibility for transforming uncompassionate organizations and systems into compassionate ones. But as psychiatrist and concentration camp survivor Viktor Frankl, reminded us, “... everything can be taken from a man but one thing: the last of the human freedoms – to choose one’s attitude in any given set of circumstances, to choose one’s own way.”¹⁶ Recognizing the interrelation of individual motivation and social structures, we must fulfill our collective responsibility to advocate for organizational and system change while deepening our own individual capacity for compassion.

Ethical issues

Not applicable.

Competing interests

Author declares that she has no competing interests.

Author’s contribution

BAL is the single author of the manuscript.

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