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Auckland

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15:00 - 15:30 Sustaining Compassion in Nursing

Sustaining compassion in nursing

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- Participation: 1000+ doctors, 600+ nurses, 400+ med students








Overview

- Compassion in professional nursing
- Patient expectations and outcomes
- So what is compassion, really?
- Why does compassion fail?
- Beyond compassion fatigue: three studies
  - Study 1: instrument development
  - Study 2: differences across speciality/age
  - Study 3: all about the patient
- Sustaining compassion in nursing – implications for professional nursing practice

The professional nursing context

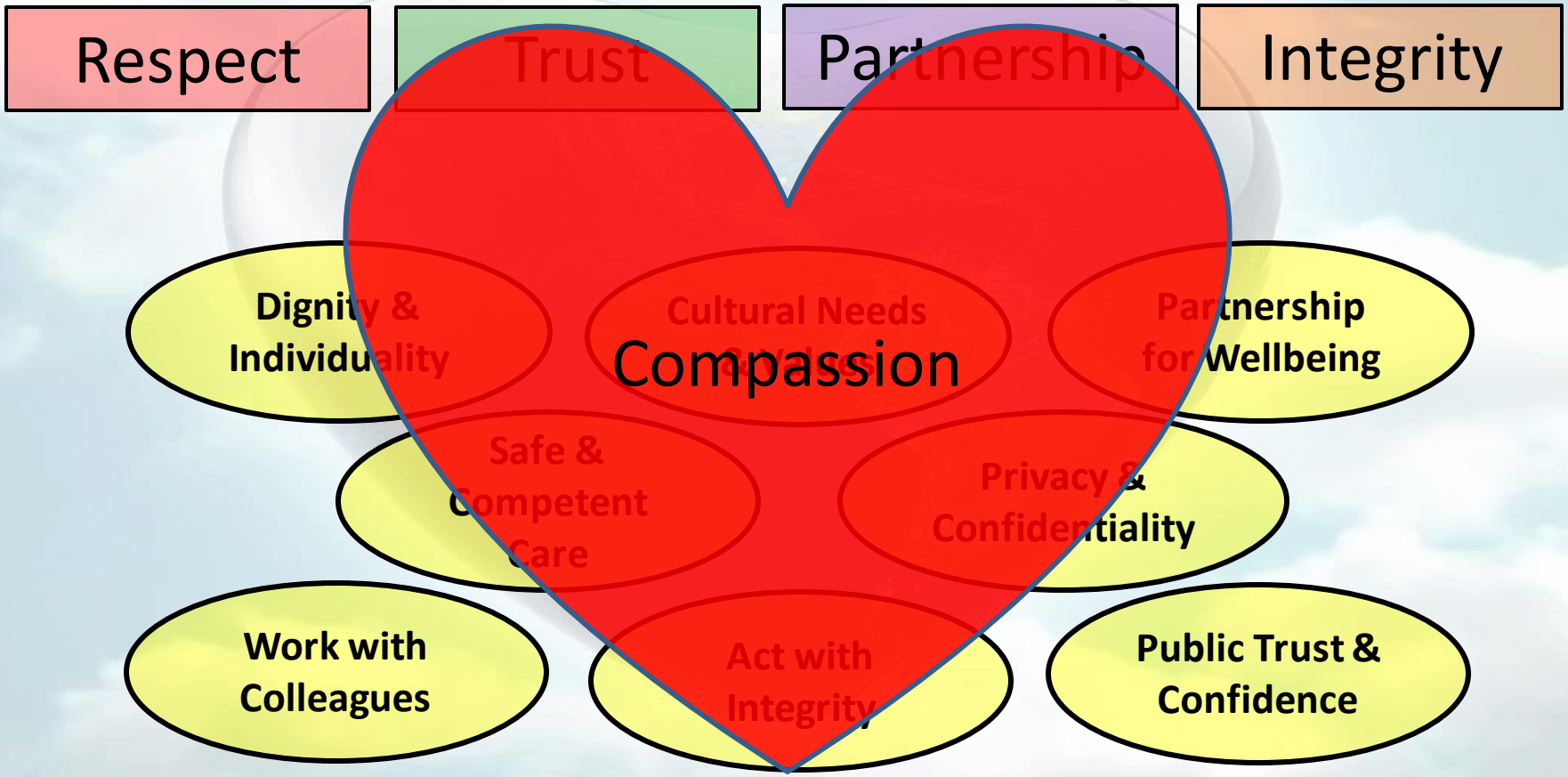


Fig 1: Values and principles of the NZ Nursing Code of Conduct

Patient expectations

- Compassion is among the carer characteristics most valued by patients
- It is ***expected*** by patients
- Compassion is closely linked to patient satisfaction and health outcomes

Why does compassion matter?

- A carer's empathy predicts better patient outcomes (Lelorain, et al., 2012), including:
  - in the common cold (Rakel, et al., 2011)
  - post-treatment QOL in cancer (Neumann, et al., 2011)
  - metabolic complications and control (Del Canale, et al., 2012; Hojat, et al., 2011)
  - following acute surgery (Steinhausen et al., 2014)
- Failures of compassion can lead to poor clinical decisions (Ekstrom, 2012)

Defining compassion

- Latin: *com* (together with) *pati* (to bear or suffer)
- Seems commonsensical and appears near-synonymous with kindness
- But . . . .

Compassion vs. empathy, sympathy

"When people hear . . . compassion, they tend to think of kindness. But . . . the core of compassion [is] courage"

Compassionate Mind Foundation

- Compassion is related to, but distinct from, empathy, sympathy, pity, and other constructs
- Indeed, some forms of empathy may be a double-edged sword

So what *is* compassion?

"Be kind, for everyone you meet is fighting a harder battle"

Plato

- In our approach, compassion has two aspects:
  1. An ability and willingness to enter into another's situation deeply enough to gain knowledge of the person's experience of suffering; and
  2. The desire to **alleviate the person's suffering** or, if that is not possible, to be of support by living through it vicariously

Compassion fatigue

- Primary framework for study of compassion – impacts (20-70%) of doctors and (likely) a similar proportion of nurses
  - 35% in oncology nurses (Potter, et al., 2010)
  - 78% in hospice nurses (Abendroth, et al., 2006)
- Based in the clinical “knowing” that caring for others is tiring
- Carries a PTSD-like flavour in terms such as “burnout”, “secondary victimization”, “secondary stress”, and “vicarious traumatization”

Compassion fatigue

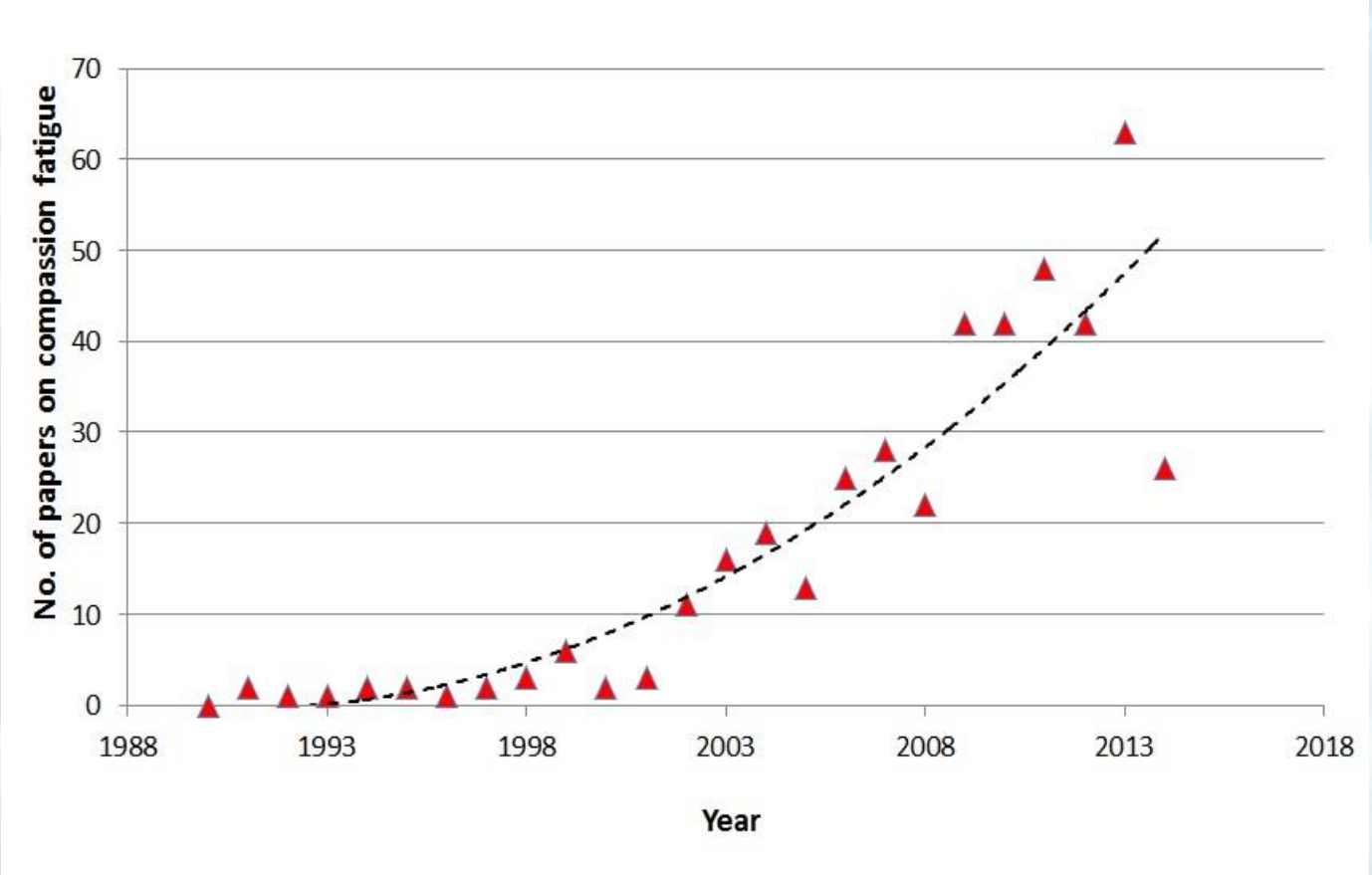
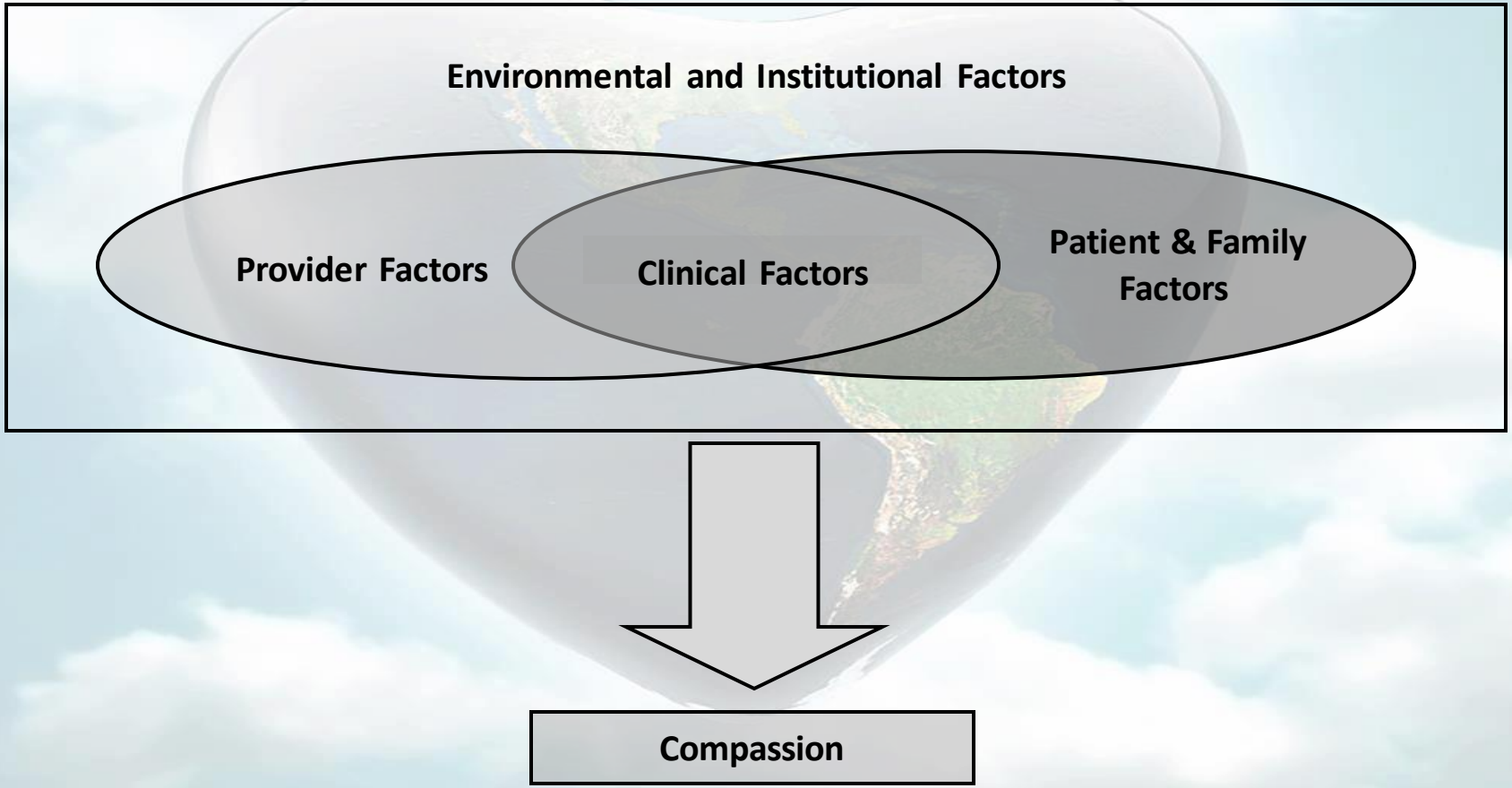


Fig 1: SCOPUS data for number of studies on compassion fatigue

Beyond compassion fatigue

- Compassion fatigue is the product of a process (an end point) and ill-suited to illuminating its own causes (Fernando & Consedine, 2014)
- Four key problems:
  1. Monolithic focus on the carer and ignores the person-environment transaction
  2. The unacknowledged tautology
  3. The fact that it is typically lower in more senior providers
  4. Conflated with burnout
  5. Fails to capacitate interventions

The Transactional Model of (Physician) Compassion



Fernando, A. T., & Consedine, N. S. (2014). Beyond compassion fatigue: a transactional model of physician compassion. *Journal of Pain and Symptom Management.* DOI: 10.1016/j.jpainsymman.2013.09.014

Original article

Development and initial psychometric properties of the Barriers to Physician Compassion questionnaire

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ABSTRACT

Objective Physicians are expected to be compassionate. However, most compassion research focuses on compassion fatigue—an outcome variable—rather than examining the specific factors that may interfere with compassion in a physician's practice. This report describes the development and early psychometric data for a self-report questionnaire assessing barriers to compassion among physicians.

Methods In 2011, a pilot sample of 75 physicians helped to generate an initial list of barriers to compassion. A final 34 item Barriers to Physician Compassion (BPC) questionnaire was administered to 372 convenience-sampled physicians together with measures of demographics, practice-related variables, stress, locus of control and trait compassion.

Results The barriers to physician compassion were not one-dimensional. Principal component analysis revealed the presence of four distinct, face-valid and discriminable factors—physician burnout/overload, external distractions, difficult patient/family and complex clinical situation. All barrier components had adequate internal

behind. Unsurprisingly, patients expect their doctor to be compassionate.[4–8] In addition to fulfilling a professional duty, research is increasingly suggesting that physician compassion is associated with better outcomes, including patient satisfaction, better quality doctor-patient interactions and improved long-term adjustment.[6] Considering how central compassion is to professional ethics and patient wishes, there are few studies on the subject. There are more studies examining empathy (an aspect of compassion) with patient outcomes.[9 10]

While compassion is often confused with empathy, the terms are distinct. Linguistically, the term compassion is derived from the Latin words *com*, which means 'together with', and *pati*, which is 'to bear or suffer'.[3] According to some,[3] the two key elements of compassion are

1. an ability and willingness to enter into another's situation deeply enough to gain knowledge of the person's experience of suffering;
2. the desire to alleviate the person's suffering or, if that is not possible, to be of support by living

Fernando, A. T. & Consedine, N. S. (2014b). Beyond compassion fatigue: Development and preliminary validation of the Barriers to Physician Compassion Questionnaire. *Postgraduate Medical Journal, 90,* 388-395.

Original Article

Barriers to Medical Compassion as a Function of Experience and Specialization: Psychiatry, Pediatrics, Internal Medicine, Surgery, and General Practice

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Abstract

Context. Compassion is an expectation of patients, regulatory bodies, and physicians themselves. Most research has, however, studied compassion fatigue rather than compassion itself and has concentrated on the role of the physician. The Transactional Model of Physician Compassion suggests that physician, patient, external environment, and clinical factors are all relevant. Because these factors vary both across different specialities and among physicians with differing degrees of experience, barriers to compassion are also likely to vary.

Objectives. We describe barriers to physician compassion as a function of specialization (psychiatry, general practice, surgery, internal medicine, and pediatrics) and physician experience.

Fernando, A. T. & Consedine, N. S. (2017). Barriers to medical compassion in psychiatry, pediatrics, internal medicine, surgery and general practice. *Pain & Symptom Management*. E-pub: 3rd January, 2017.

Beyond the carer . . . .

"Patients who are rude, demanding or difficult suck the oxygen from our compassion"

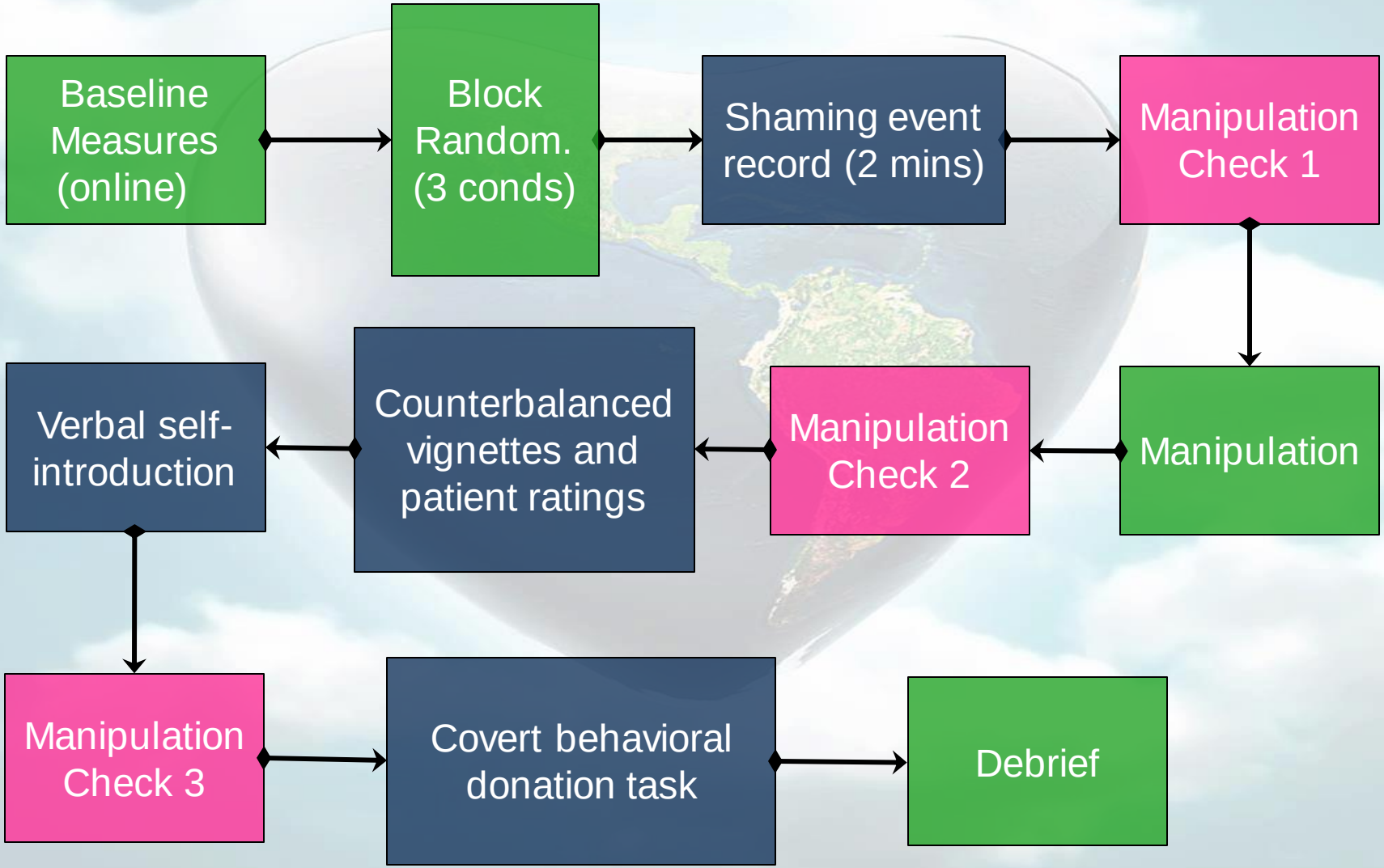
Fernando, Arroll, & Consedine (2016)

- In medicine, compassion happens (and doesn't happen) when we are with particular patients
- Caring for "difficult" patients is demanding. Why?
  - "Checks and balances" in the compassion system
  - Characterising the relevant patient factors

The power of the patient

- ***Participants***: 85 medical students (34% male, 50% Pakeha) from the University of Auckland; most in 2nd/3rd year of their MBChB
- ***Design***: Experimental – gender block-randomized to self-compassion, self-criticism, or control conditions before completing vignettes
- ***Baseline Measures:*** demographics, physician empathy, social desirability, mindfulness, fear of compassion, trait self-compassion, and attachment
- ***Analysis:*** Simultaneously assessing patient and physician factors

Design summary



Patient vignettes

- Gender matched vignettes tested to high/low responsibility and positive/negative presentation

Low responsibility/Positive presentation		High responsibility/Positive presentation	
DAVID: teacher, IBS following chemo for lymphoma, grateful		ALAN: asthmatic smoker, well-dressed and pleasant	
Low responsibility/Negative presentation		**High responsibility/Negative presentation**	
BRENDAN: pain patient, tried rehab, wants more Tramadol; angry		ERIC: obese, BP, dirty, smelly, non-adherent; has genital warts	

Results – patient factors

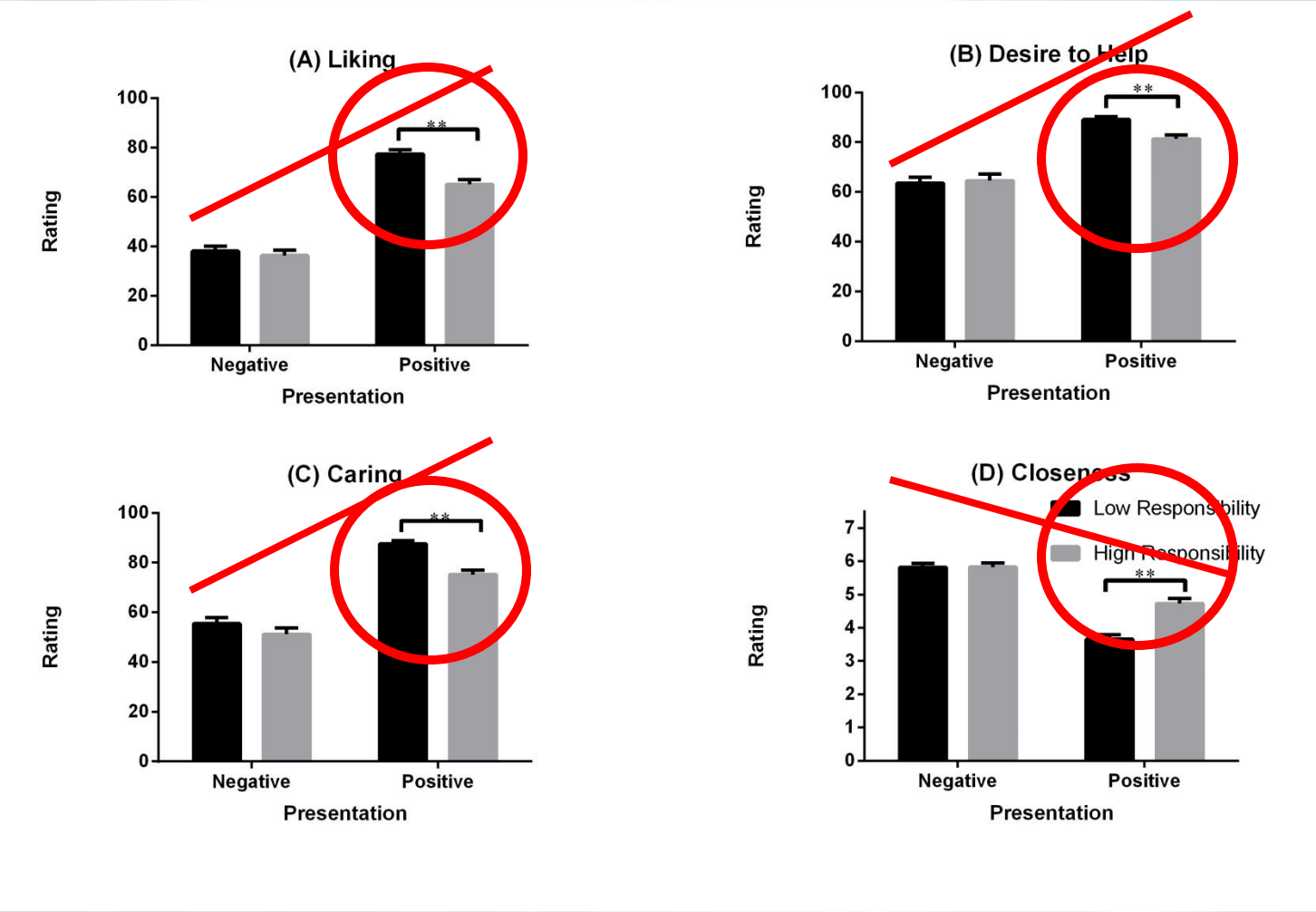


Fig 2: Patient liking, desire to help, care, and closeness as a function of patient presentation and responsibility

Results – provider factors

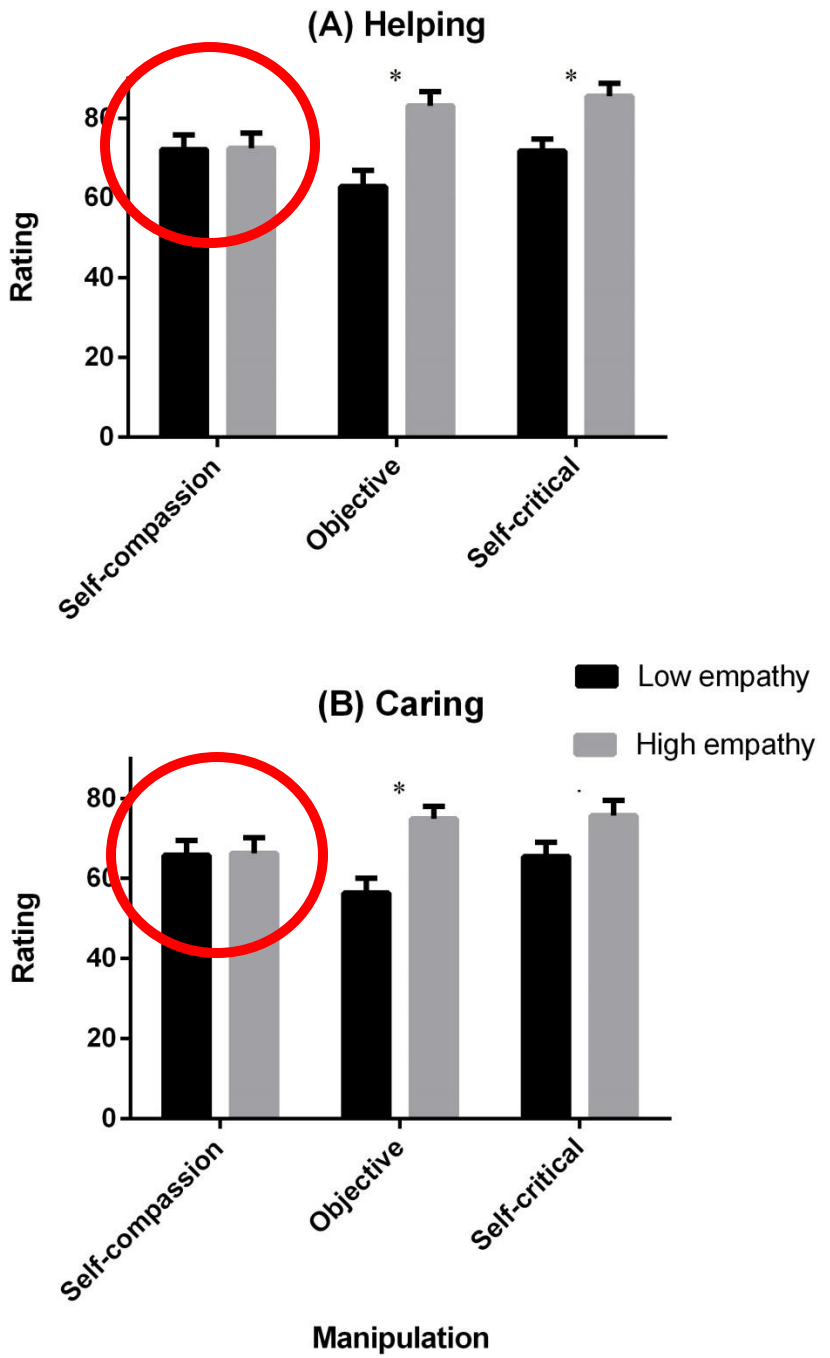


Fig 3: Desire to help and care as a function of manipulation and trait empathy

Results – provider-patient effects

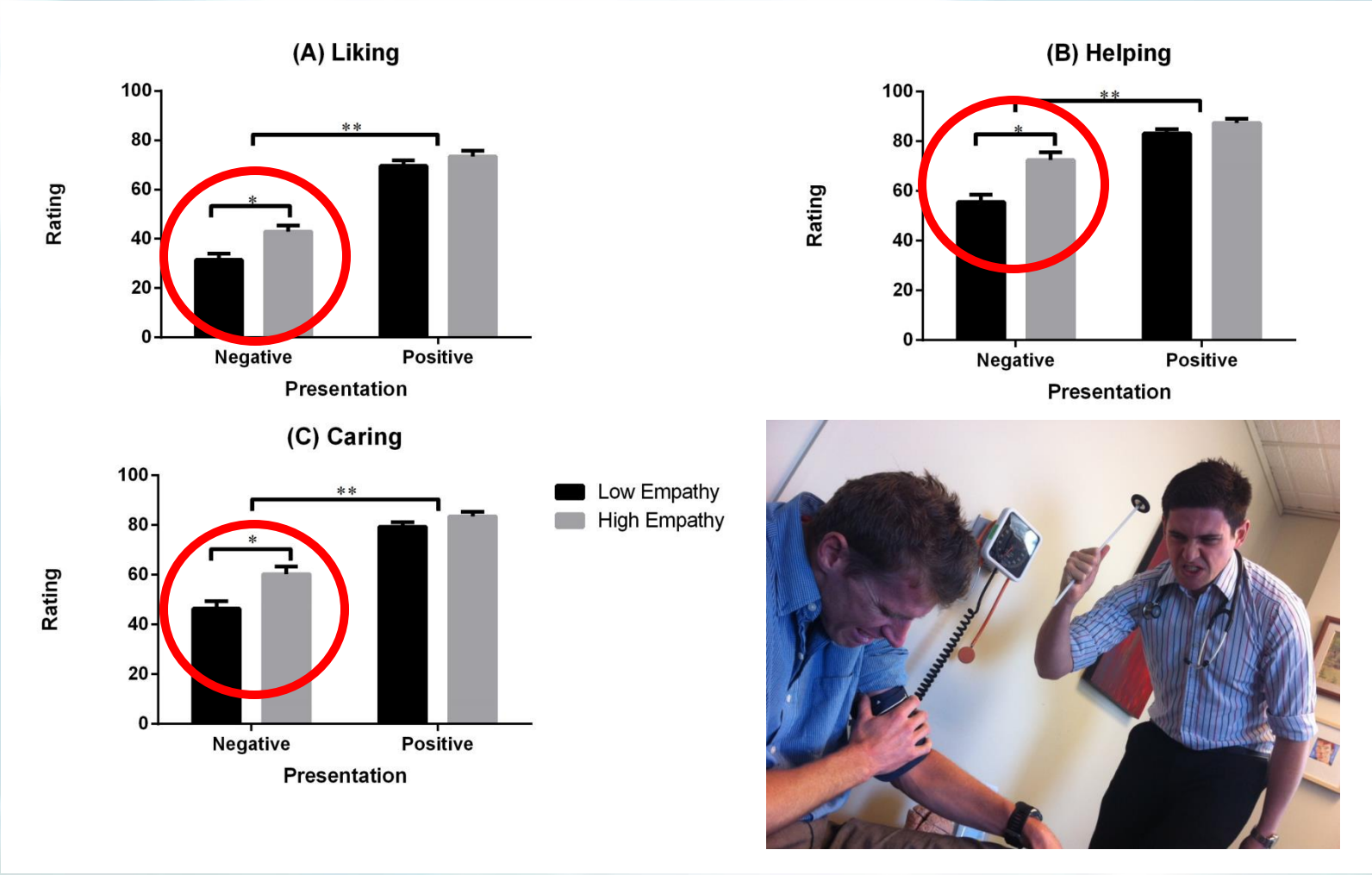
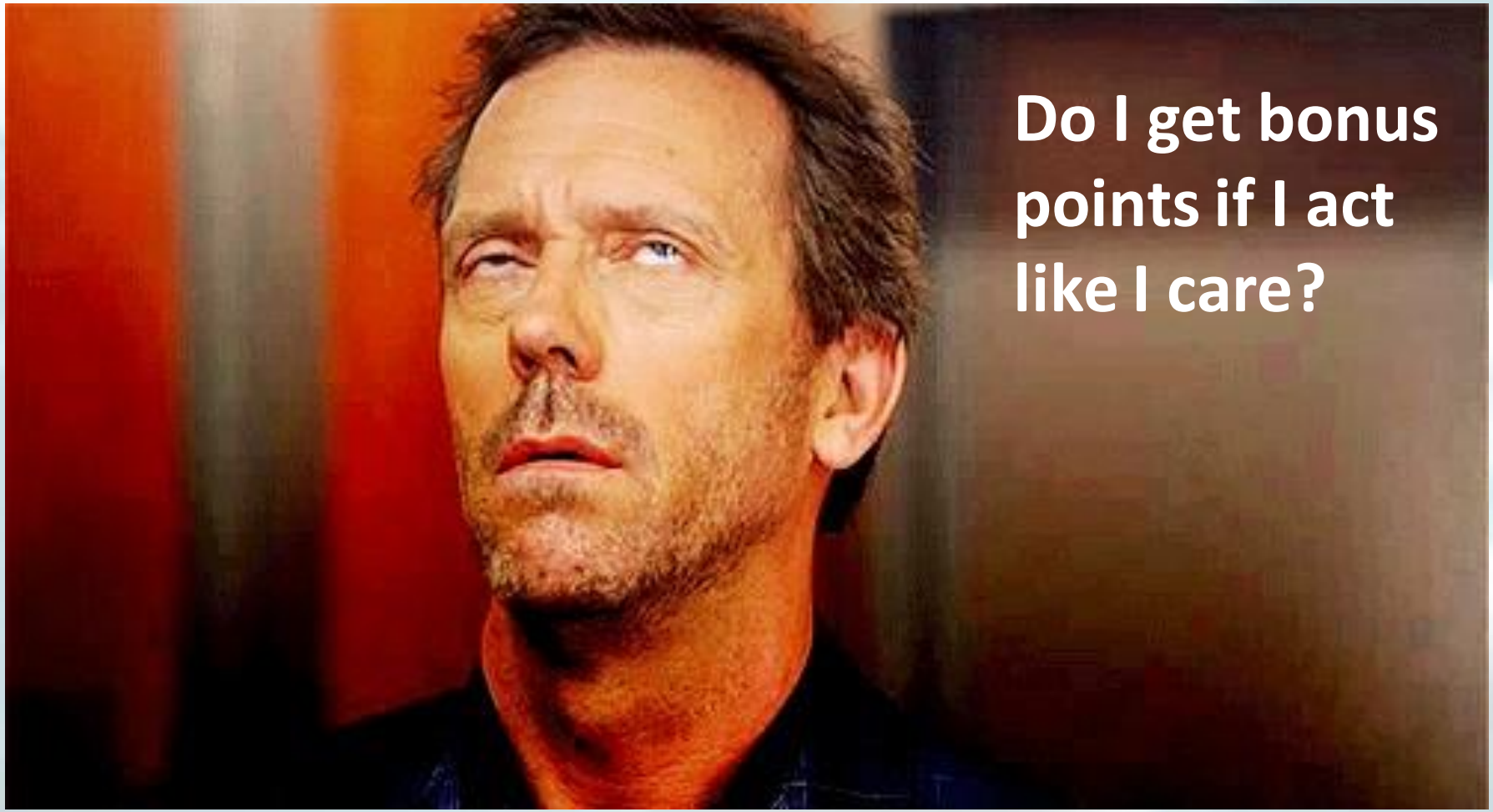


Fig 4: Patient liking, desire to help, care, and closeness as a function of patient presentation and trait physician empathy

You shall not pass!

- The best predictors of compassion were not in the carer, but were in the patient
- Effect size at least 4X that of the carer's empathy
- Judgments of responsibility only relevant for positive patients – emotion as a gatekeeper?

The question . . . .



1. Cultivate self-compassion

If you are continually judging and criticizing yourself while trying to be kind to others, you are drawing artificial boundaries and distinctions that only lead to feelings of separation and isolation

Kristen Neff

- In Buddhist approaches, self-compassion is the seed from which all compassion grows
- See self-care as necessary rather than soft, self-indulgent, and narcissistic
- Keep an ear out for your inner critic but don't become their slave

2. Remember your motivations

- Ask yourself: why did I become a nurse?
- Simple self-reminders reinforce the desire to care
- Try repeating "May I be of benefit" before opening the door, touching a patient, or sanitising
- Remember what your care **means** to the patient

3. Remember that being compassionate is also for *you*

- Compassion is good for carers and a key source of work satisfaction
- Compassion has deep evolutionary origins. When we are compassionate:
  - Our HR slows down, oxytocin is secreted
  - Brain regions linked to caregiving (and pleasure!) active
  - Compassion training leads to lower stress reactivity, reduced rumination, better relationships
  - We improve our work environments

4. Remember that compassion is challenged by the patients that need it most

- Compassion is based in biological caregiving systems that have in-built "checks and balances"
- In some senses, we are "designed" to care less for:
  - Persons that are responsible for their suffering
  - Persons that treat us poorly – the difficult patient
- The impact of such factors can be very large
- BUT: people behave poorly *because* they suffer

5. Remember that compassion fades when we are stressed or anxious

- The response we call “stress” is a psychological signal that coping capacities are being exceeded
- Anxiety is a response to threat and evolved to promote avoidance
- Clinicians becomes concentrated on their own emotional needs and/or become distant

6. Consider the work environment

- All behaviours happen (and don't happen) in particular contexts; contexts impact behaviour
- Look for things that interrupt rapport building – interruptions, phone calls, computer notifications
- Minimize interruptions
- Block time for administrative tasks
- Provide training for support staff – team dynamics set tone within the practice

Treat compassion as a skill that must be “worked at”

- Compassion is more than the ‘soft’ side of practice
- It is a professional responsibility that benefits patients and clinicians alike
- Things to look for and do:
  - Manage caseloads and recharge batteries
  - Think systemically
  - Structure work environment to minimise interruptions
  - Remember that compassion fades in complex cases and for patients that are less easily liked
  - Look for irritability, impatience, (self) judgment, and dislike