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Auckland

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11:00 - 11:25 It's Not All About the Doctor - Barriers to Compassion

It’s not all about the doctor:

Barriers to compassion

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Acknowledgements

- Faculty: Dr. Tony Fernando, Profs. Bruce Arroll and Andrew Hill
- Students : James Cameron, Tobias Barker, Sigourney Taylor, Harry Yoon, Kat Skinner, Lauren Barker, Amy Clucas
- Funding: UoA Summer Studentship Program
- Participation: 1000+ doctors, 600+ nurses, 400+ med students








Overview

- So what is compassion, really?
- Why does compassion fail in medicine – fatigue?
- It's not all about the doctor: a research program
  - Background
  - Study 1: don't lose sight of the patient
  - Study 2: the work environment
- Implications for CME and professional practice

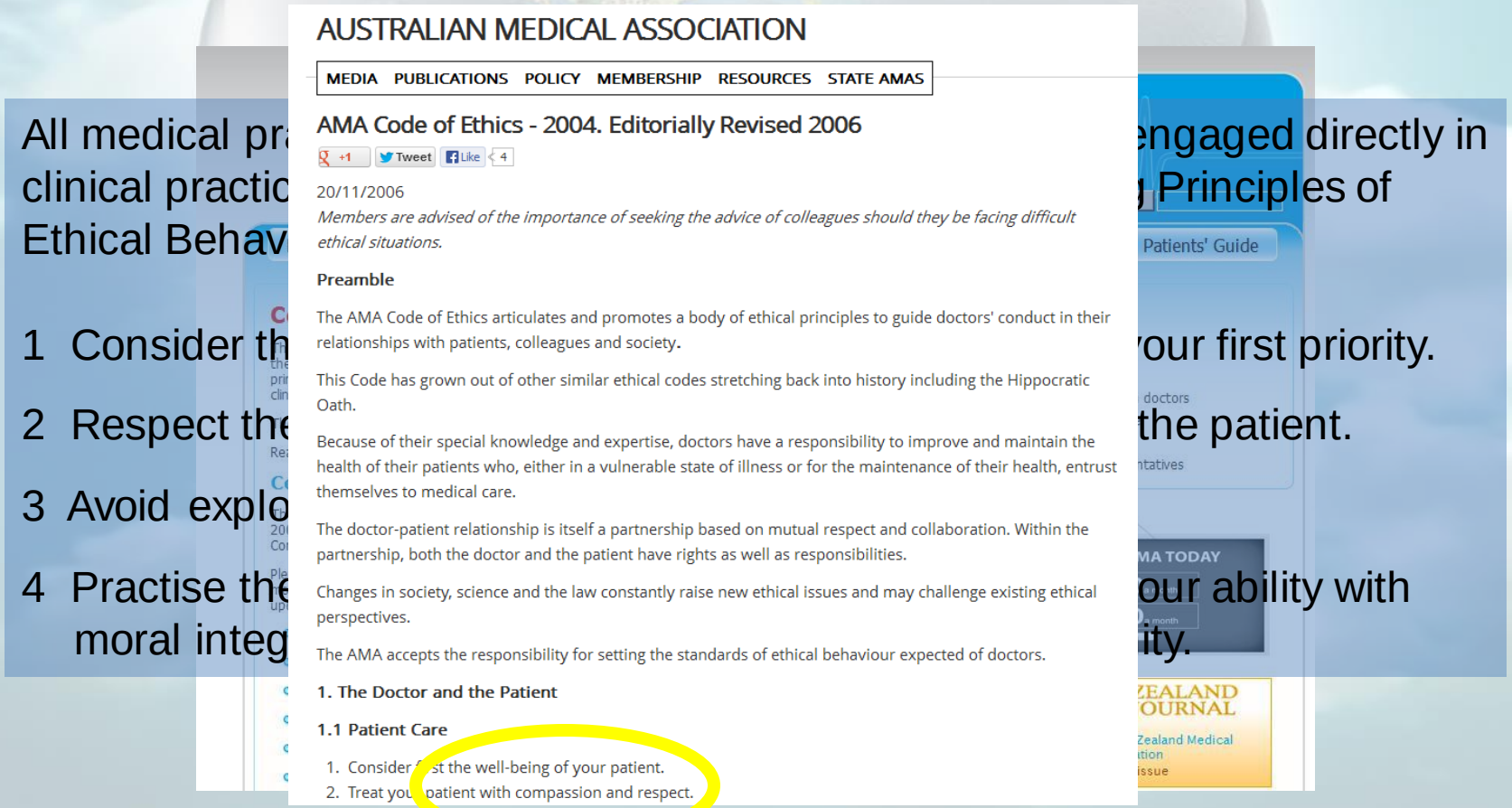
So what is compassion?

- In our approach, compassion has two (necessary) aspects (per Dougherty & Purtilo, 1995):

  1. An ability/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

Professional expectations

- Codes of practice in most healthcare environments ***require*** that physicians practice compassionately



Patient expectations

- Compassion is valued and expected by patients
- Linked to patient values, satisfaction, and, increasingly, to health outcomes

Why does compassion matter?

- 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)
  - acute surgery (Steinhausen et al., 2014)
- Failures of compassion can lead to poor decisions (Ekstrom, 2012)

Research myopia

- Compassion fatigue is the most common framework for the study of physician compassion (20-70%)
- Based in the clinical “knowing” that caring for others is tiring

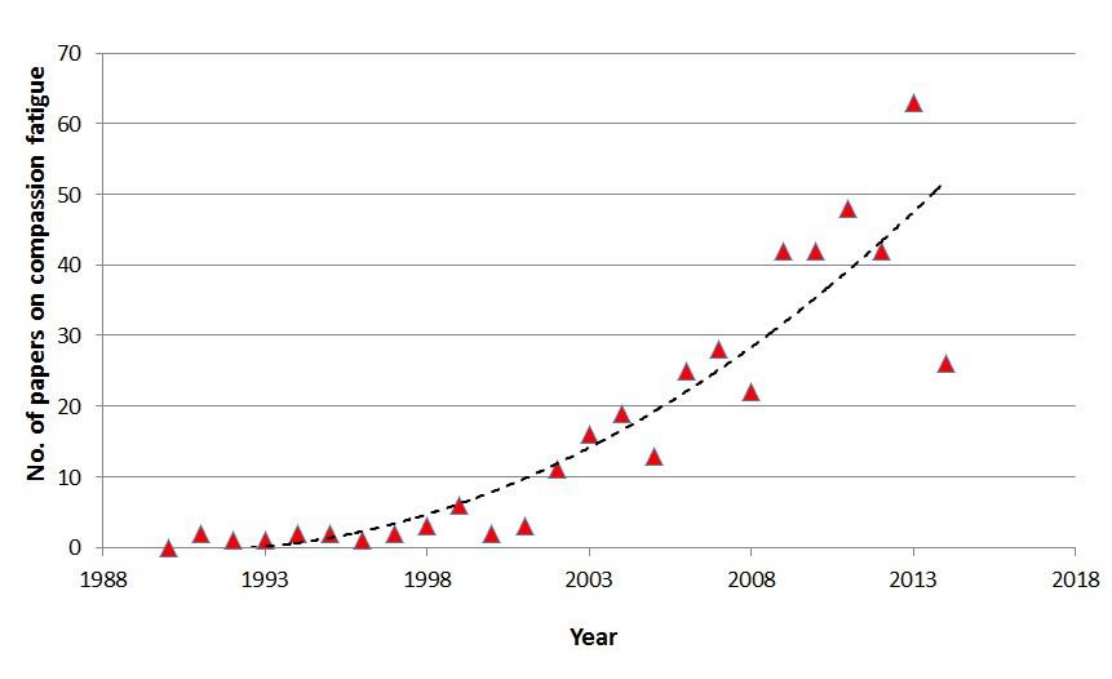
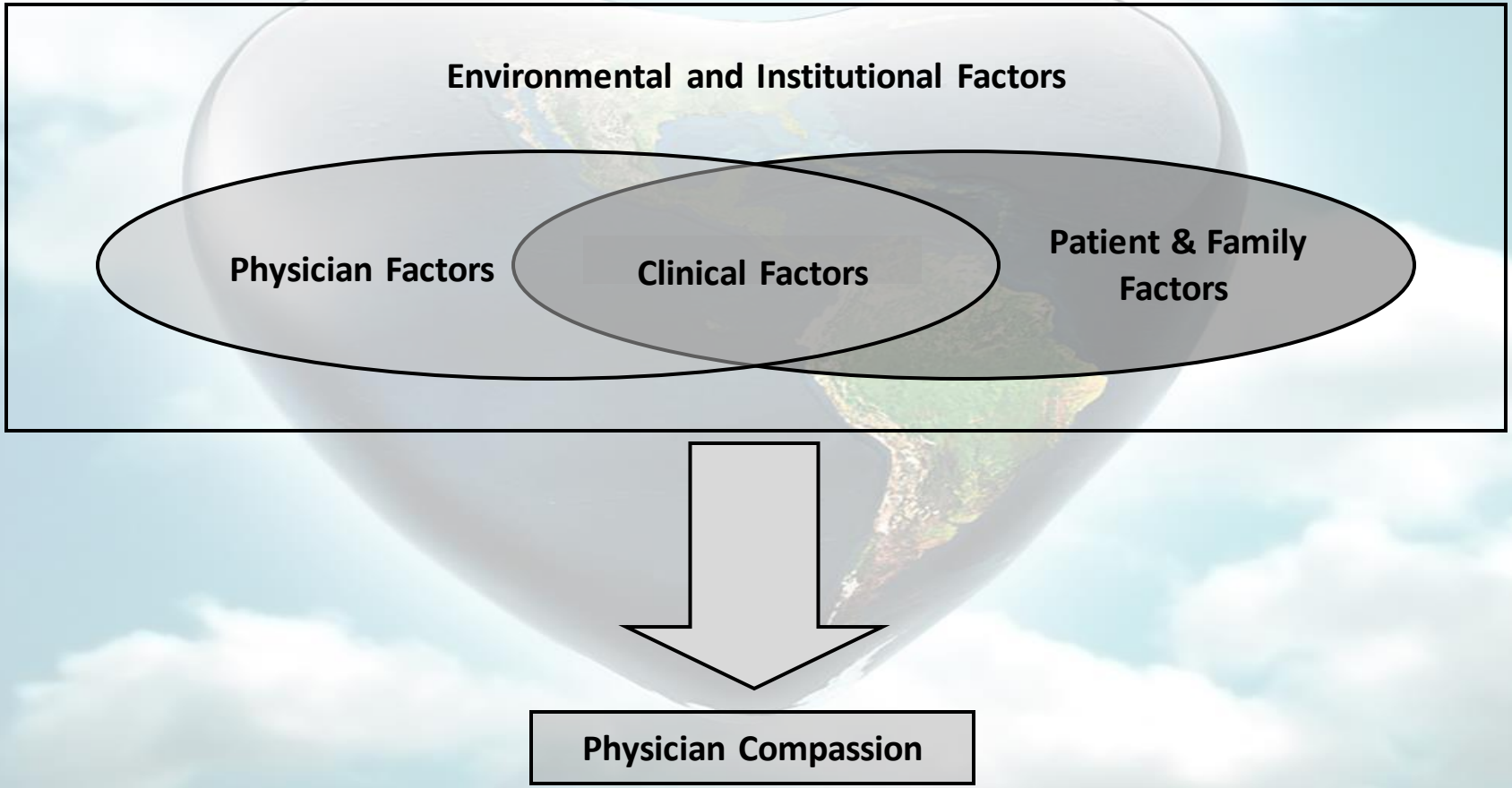


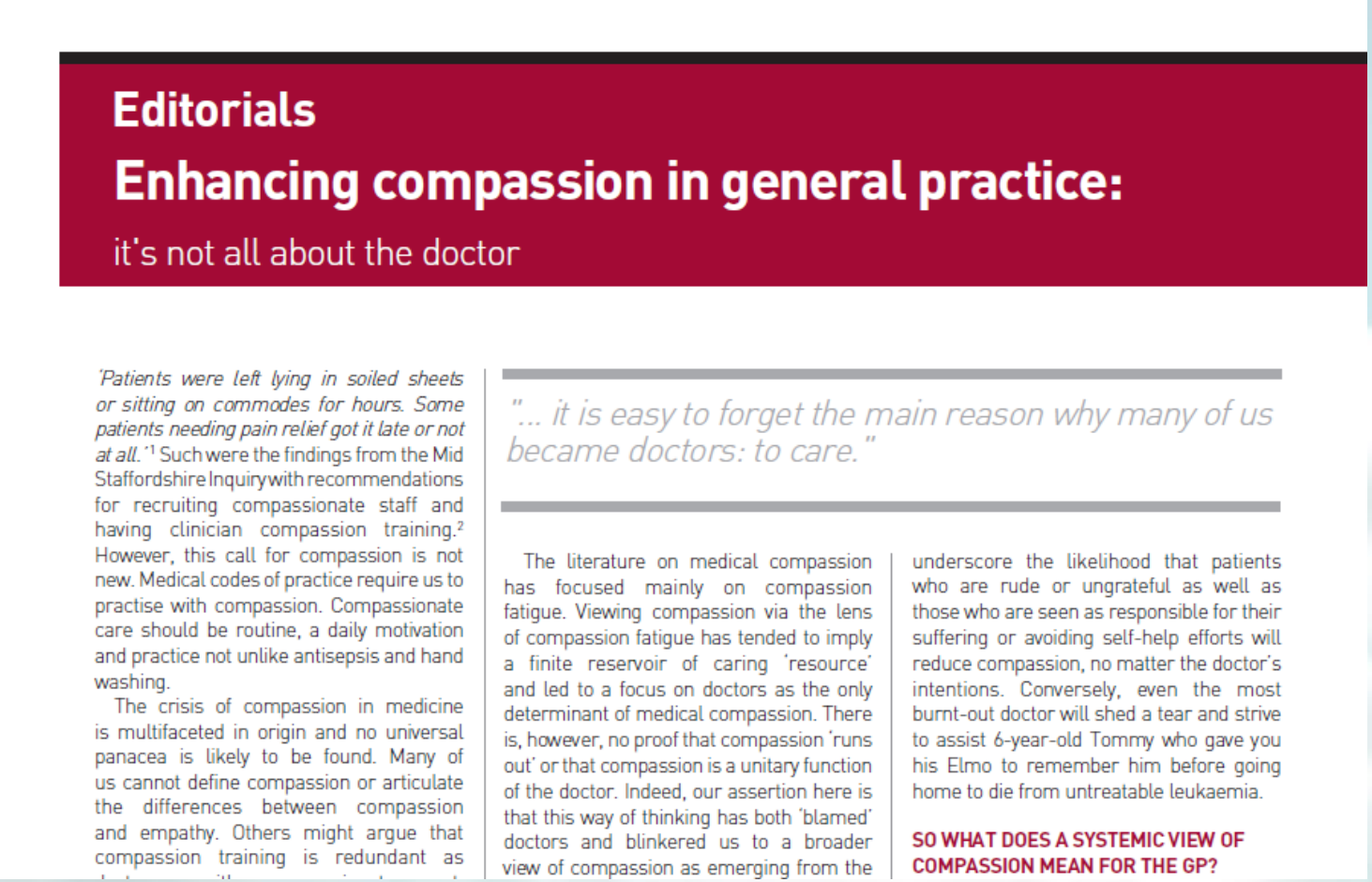
Fig 1: SCOPUS data for number of studies on compassion fatigue

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

It’s not all about the doctor . . .



Editorials

Enhancing compassion in general practice:

it's not all about the doctor

'Patients were left lying in soiled sheets or sitting on commodes for hours. Some patients needing pain relief got it late or not at all.'[1] Such were the findings from the Mid Staffordshire Inquiry with recommendations for recruiting compassionate staff and having clinician compassion training.[2] However, this call for compassion is not new. Medical codes of practice require us to practise with compassion. Compassionate care should be routine, a daily motivation and practice not unlike antisepsis and hand washing.

The crisis of compassion in medicine is multifaceted in origin and no universal panacea is likely to be found. Many of us cannot define compassion or articulate the differences between compassion and empathy. Others might argue that compassion training is redundant as

"... it is easy to forget the main reason why many of us became doctors: to care."

The literature on medical compassion has focused mainly on compassion fatigue. Viewing compassion via the lens of compassion fatigue has tended to imply a finite reservoir of caring 'resource' and led to a focus on doctors as the only determinant of medical compassion. There is, however, no proof that compassion 'runs out' or that compassion is a unitary function of the doctor. Indeed, our assertion here is that this way of thinking has both 'blamed' doctors and blinkered us to a broader view of compassion as emerging from the

underscore the likelihood that patients who are rude or ungrateful as well as those who are seen as responsible for their suffering or avoiding self-help efforts will reduce compassion, no matter the doctor's intentions. Conversely, even the most burnt-out doctor will shed a tear and strive to assist 6-year-old Tommy who gave you his Elmo to remember him before going home to die from untreatable leukaemia.

SO WHAT DOES A SYSTEMIC VIEW OF COMPASSION MEAN FOR THE GP?

Fernando, A. T., Arroll, B., & Consedine, N. S. (2016). It’s not all about the doctor: enhancing compassion in general practice. *British Journal of General Practice, 66 (648),* 340-341.

Study 1

- ***Participants***: 85 medical students (34% male, 50% Pakeha) from the University of Auckland; most in 2nd/3rd year MBChB
- ***Design***: Experimental – gender block-randomized participants 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

Patient vignettes

- Gender matched vignettes describe high/low responsibility and positive/negative patients

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

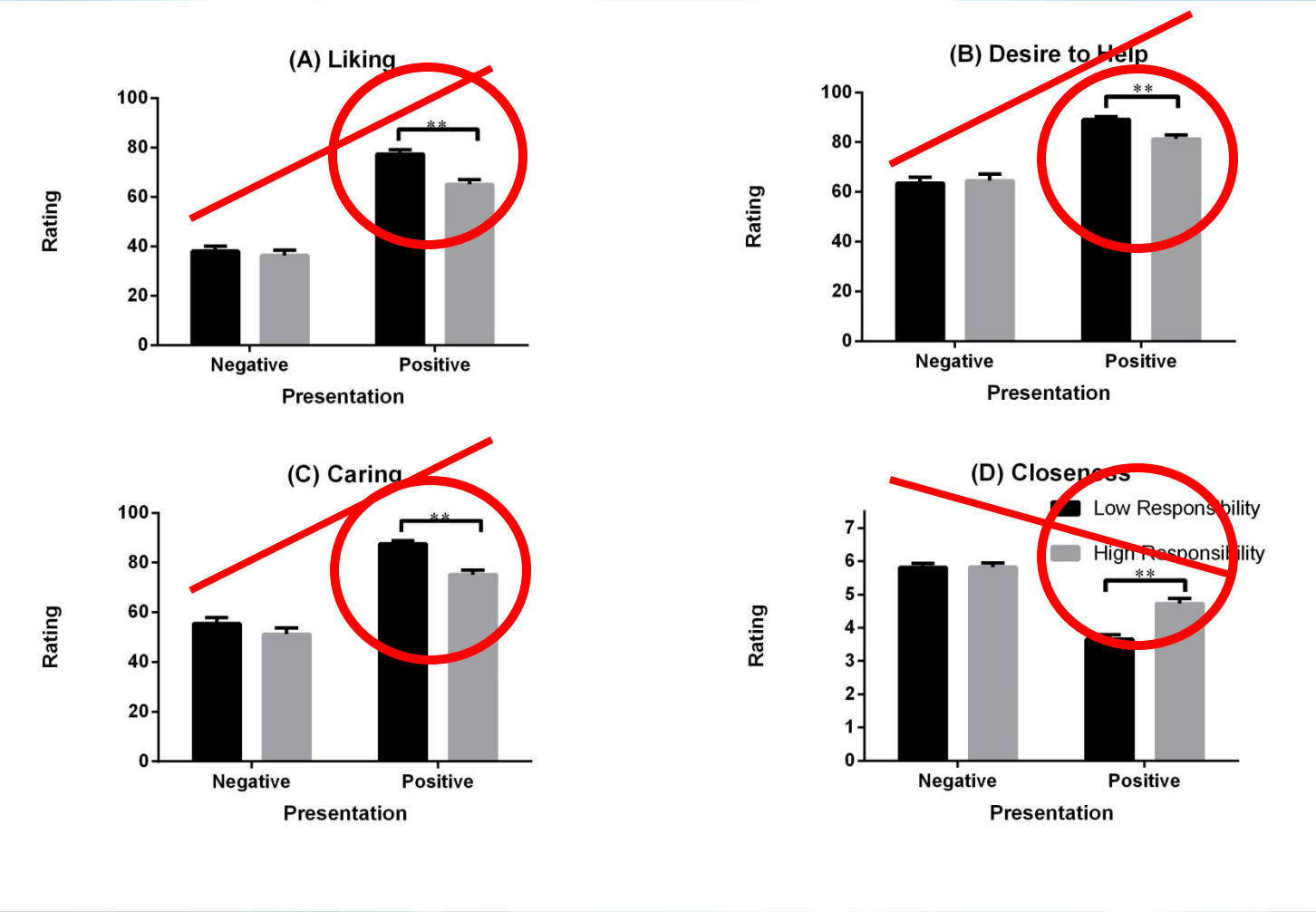


Fig 1: Patient liking, desire to help, care, and closeness as a function of patient presentation and responsibility

Results – physician factors

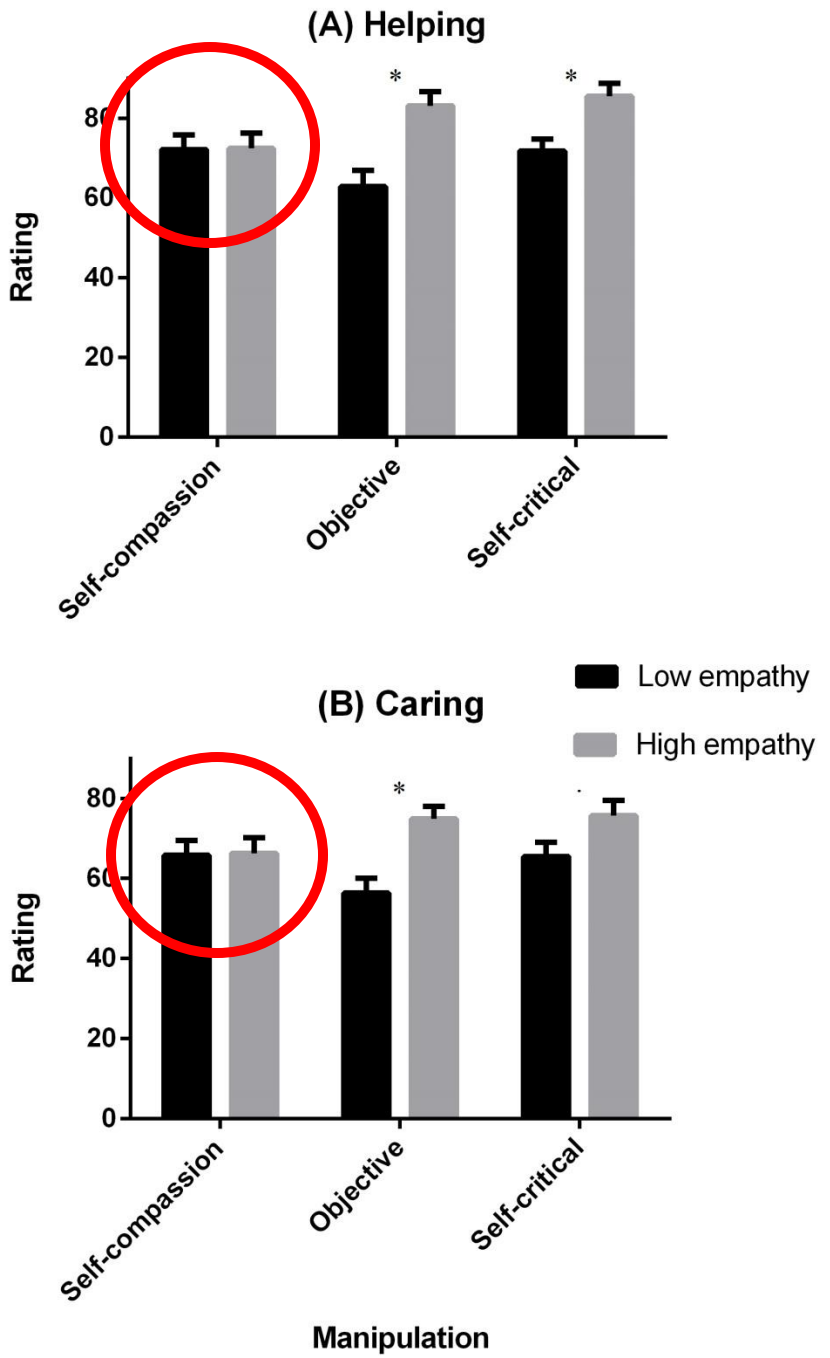


Fig 2: Desire to help and care as a function of manipulation and trait empathy

Results – physician-patient effects

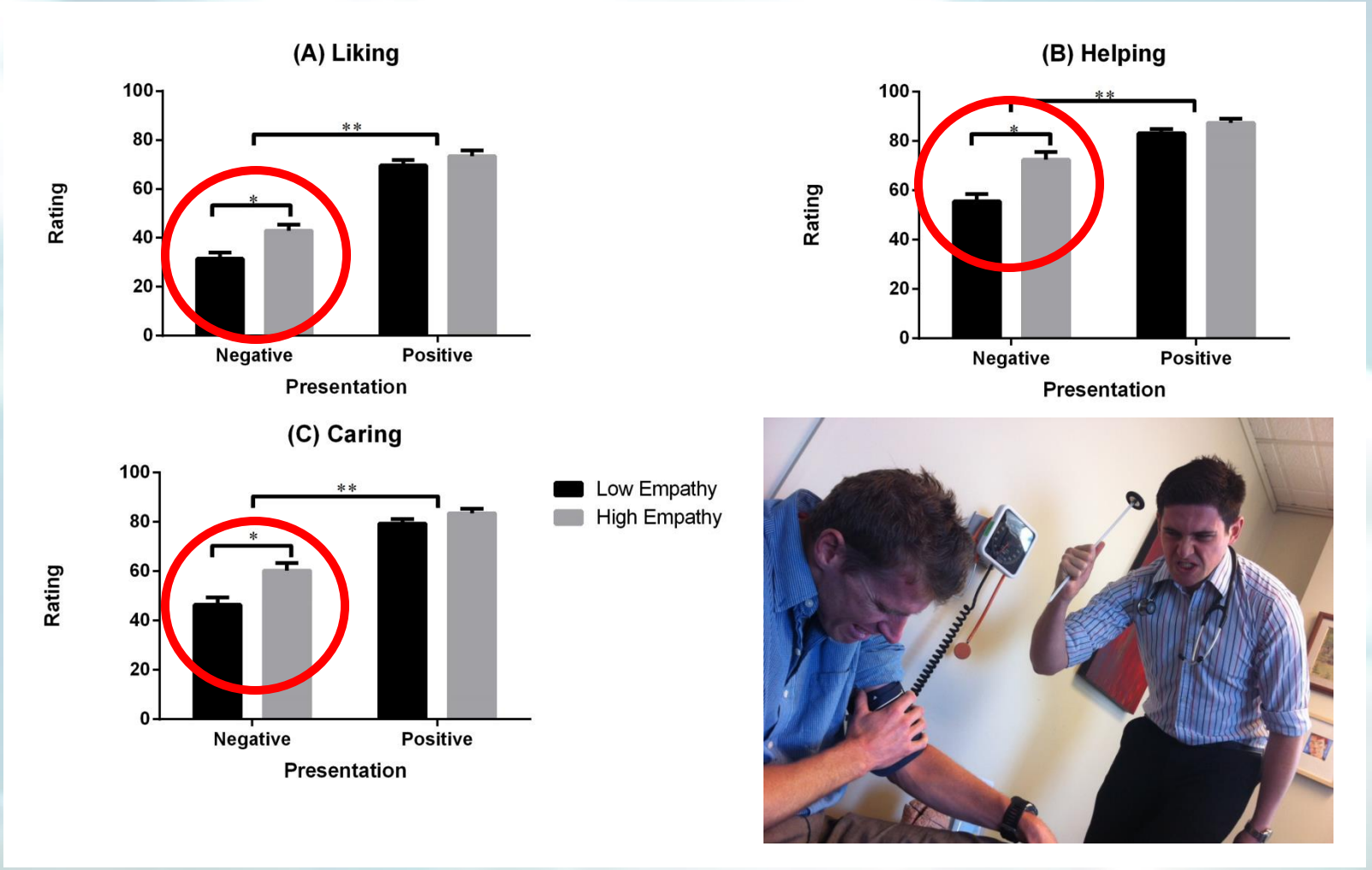


Fig 3: Patient liking, desire to help, care, and closeness as a function of patient presentation and trait physician empathy

Compassion killers

- The best predictors of compassion were not found in the physician – they were in the patient
  - Less compassion for more negative patients
  - Less compassion for more blameworthy patients
  - Negativity “trumps” responsibility
- Negative patient presentation is what Dr. Tony Fernando calls a “compassion killer”

Mimicking the office environment

- Compassion (fails to) happen in particular contexts
- Environmental factors – noise, distractions, interruptions – may interfere with compassion
- We mimicked typical practice by **interrupting** participants while they were reading vignettes
- A phone call asked a single question about an unrelated patient (files were on the desk)
- Participants then made the same ratings as in Study 1 before trying to recall patient data

Study 2

- ***Participants***: 31 medical students (49% male, mean age 21 yrs) from the University of Auckland from MBChB years 3-6; prior participants excluded.
- ***Design***: Experimental – gender block-randomized participants to study as well as control v. interruption conditions
- ***Baseline Measures:*** demographics, physician empathy, social desirability, mindfulness, fear of compassion, trait self-compassion, values, and attachment
- ***Analysis:*** Simultaneously assessing patient and physician factors

Patient vignettes (per Study 1)

- 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	
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Results – impact on recall and care

- As expected, those in the interruption condition had lower recall of patient information

- More telling, however, are the effects of the interruption on compassion ratings
  - As in Study 1, care, liking, and desire to help were lower for negatively presenting or high responsibility patients
  - In addition, the negative effect of patient factors on care ratings was **exacerbated** by the interruptions

Impact on recall and care (cont)

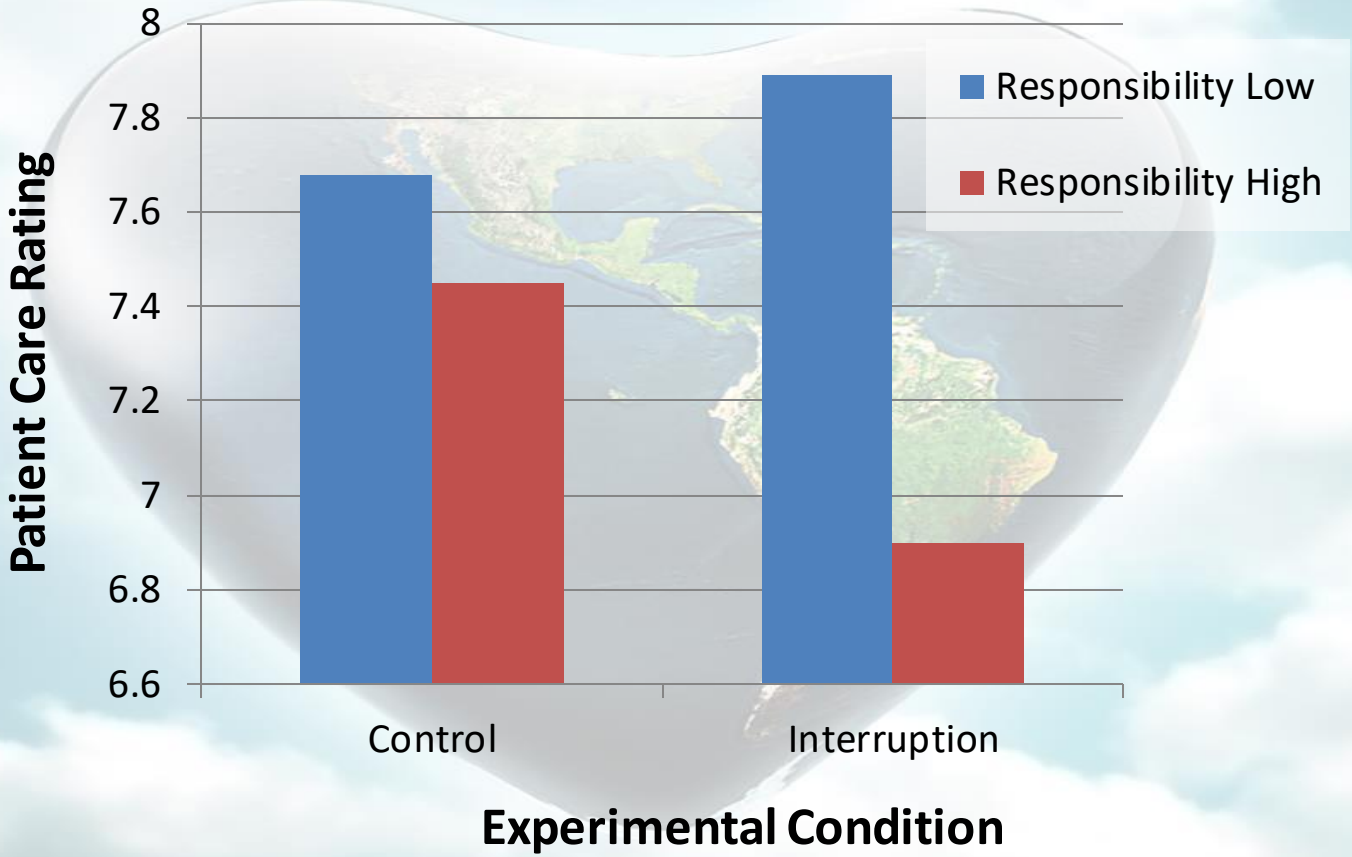
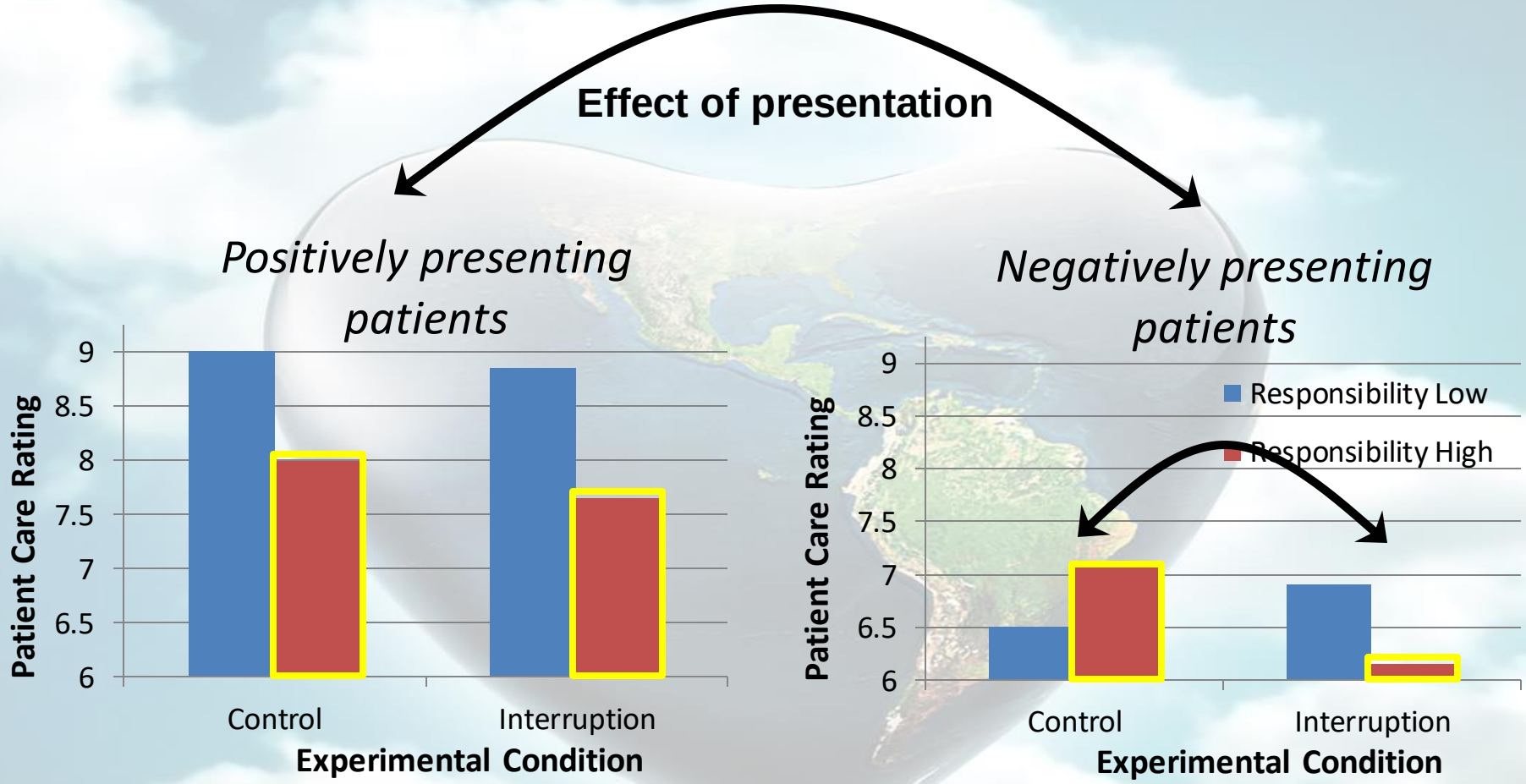


Fig 4: Patient care as a function of experimental condition and patient responsibility



Figs 5 and 6: Patient care as a function of experimental condition, patient responsibility, and patient presentation

It’s not all about the doctor

- Compassion is more than the ‘soft’ side of practice – it’s a responsibility that benefits patients and GPs
- But the origins of compassion are not **only** found with the doctor
- So how to sustain compassion?
  - Think **systemically**
  - The Physician: manage caseloads, recharge batteries, train for compassion, look for markers of compassion fade
  - The Patient: compassion fades for some patient types
  - The Clinical Picture: uncertainty makes it hard
  - The Work Environment: minimize interruptions, screens