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Commentary

Toward more compassionate healthcare systems

Comment on "Enabling compassionate healthcare: perils, prospects and perspectives"

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Abstract

Compassion is central to the purpose of medicine and the care of patients and their families. Compassionate healthcare begins with compassionate people, but cannot be consistently provided without systemic changes that enable clinicians and staff to collaborate and to care. We propose seven essential commitments to foster more compassionate healthcare organizations and systems: a commitment to compassionate leadership, to teach compassion, to value and reward compassionate care, to support clinical caregivers, to involve and partner with patients and families, to build compassion into the organization of healthcare delivery, and a commitment to deepen our understanding of compassion and its impact through research. Acting on these commitments will help us attend with care to the ill, injured, and vulnerable in every interaction.

Keywords: Compassion, Healthcare Quality, Professional-Patient Relations

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Compassion, the recognition and validation of the needs, concerns and distress of others, coupled with actions to ameliorate them, is central to the purpose of medicine. Yet, health professionals around the globe face numerous challenges that impede their ability to form meaningful connections and relationships with patients. These include administrative demands, cost pressures and resource shortages, fragmentation and discontinuity of care, and technologies that both help and hinder communication and relationship-building. Hospital physicians in the United States now spend more time interacting with computers than they do with patients (1). More than half of primary care physicians in the U.S. report needing more time with patients than they are allotted (2). Meanwhile, work-related stress has contributed to disproportionate levels of burnout among U.S. physicians, while also negatively affecting patient care and health system performance (3).

What does it take for a clinician to provide compassionate healthcare? It requires focusing one's full attention on the patient, which is often difficult to do in the fast paced, high-pressure environments in which most of us work. It then requires empathy, respect, a genuine interest in patients' lives and perspectives in addition to their symptoms, a willingness to learn with and from patients and their families, and the ability to constantly monitor one's own biases and assumptions. At its core, it means caring deeply about the well-being of our patients and their families and being committed to alleviating their distress and suffering.

While compassion can be expressed in a matter of minutes, it takes time to provide compassionate care on an ongoing basis to patients with complex or chronic illnesses, the elderly, patients who come from diverse cultural or ethnic backgrounds or are nearing the end of life, and so many others. Caring for them requires not only expert clinical knowledge, but also strong interpersonal, listening, and communication skills.

While compassionate care begins with compassionate people, the organizations in which they train and work must support the inherent compassion that most clinical caregivers bring to their jobs. As Russell Mannion notes in his perspective piece on enabling compassionate healthcare, the answer lies not in exhorting caregivers to be more compassionate, but in creating more compassionate healthcare systems (4).

In the fall of 2012, the Schwartz Center for Compassionate Healthcare, a Boston, Massachusetts-based non-profit with programs in the U.S. and U.K., convened a meeting of patients, family members, multidisciplinary healthcare professionals, educators, researchers, and health policy experts to reach consensus on an agenda to advance compassionate healthcare. We agreed that compassionate care is not separate from other kinds of care, nor is it reserved for the end of life. Instead, it is fundamental to all patient-clinician relationships and interactions. Without it, care may be technically excellent but depersonalized and cannot address the unique cultures, concerns, and distress of patients and their families.

Over two days of discussion, seven guiding commitments emerged from thematic analysis of conference notes. They are detailed below. If adopted, we believe they would go a long way toward making compassionate healthcare a greater priority in the U.S. and in health systems around the globe. To draw attention to these commitments, we have established a website, http://www.committocompassion.org, where individuals interested in joining with us to advance compassionate healthcare can endorse them.

1. Commitment to compassionate healthcare leadership

Healthcare leaders who embrace and model compassion foster a culture of compassion within their institutions and organizations. They play a crucial role in communicating the

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value and benefits of compassionate care and marshaling the resources necessary to make compassionate care possible.

2. Commitment to teach compassion

Healthcare leaders, educators, and clinical caregivers who model, teach, and reinforce the core values and skills of compassionate care foster them in students and trainees. These skills include attentive listening, empathic concern, mindful self-awareness, effective communication, and the ability to elicit, understand and appropriately respond to the concerns, distress and suffering of patients and their families.

3. Commitment to value and reward compassion

Healthcare institutions that value, support, and reward the cognitive, emotional, and collaborative work and time required for clinicians and teams to provide compassionate care allow such care to thrive. These institutions are committed to the development of valid and reliable measures and methods to assess and reward compassionate care.

4. Commitment to support clinical caregivers

Healthcare institutions that demonstrate compassion for clinicians, teams, and staff equal to the compassion shown to patients and families help preserve resilience and sense of purpose. Excessive workloads, lack of control, lack of rewards, loss of a sense of community with colleagues and co-workers, perceived unfairness, lack of respect, and conflict between organizational and individual values contribute to burnout and erode engagement with one's work.

5. Commitment to engage, involve, and partner with patients and families

The needs and perspectives of patients and their families should be an organizing principle around which compassionate care is delivered. Patients and families should be involved in designing and evaluating care delivery and organizational policies at all levels. Healthcare, consumer, and advocacy organizations can play a key role in helping us all to learn about the elements and importance of compassionate care, so that patients and families can ask for it when it is absent, and take action when its absence impacts their health or well-being.

6. Commitment to build compassion into healthcare delivery

Those who design care processes should consider how changes in care delivery and associated tasks affect clinicians' and teams' capacity, ability, and time to interact directly with patients and families. Personal interactions are not wasteful processes that must be trimmed to avoid waste and maximize efficiency—they are care. The continuity of patient-clinician relationships should be a priority within and across all healthcare institutions as well as in the community to lessen patients' sense of being alone and unknown when they are most vulnerable.

7. Commitment to deepen our understanding of compassion

An integrated research agenda should be developed and funded to study the neuroscientific, psychological, and clinical aspects of compassionate care, its outcomes, and what compassionate care means to diverse patient populations. Most importantly, health professionals cannot compassionately care for others when they themselves are in pain. Physicians in particular often have difficulty acknowledging their own personal distress. We must practice self-compassion by prioritizing personal values, relationships, work-life balance, and self-care. Compassion and mindfulness training can also help by boosting positive emotions and increasing altruistic behavior (5). These programs enable clinicians to better manage their emotions and build resilience, which enhances their ability to provide compassionate care to others. Also beneficial are programs that allow clinicians and staff to meet on a regular basis to discuss the emotional and psychosocial challenges of patient care, to build mutual respect and trust, and to reduce feelings of isolation (6).

Compassion is an ethical obligation that reminds us of our responsibility to always act in the best interest of patients while caring for ourselves as well. Each of us should ask ourselves how today's healthcare culture and changes in healthcare delivery are affecting our individual and collective capacity for compassion and our ability to relieve the pain and distress of those who entrust us with their care. Clinical caregivers can deepen their individual capacity for compassion, but without systemic and organizational support, compassionate care will be impossible to sustain and patients will continue to suffer needlessly.

Ethical issues

Not applicable.

Competing interests

Author declares that she is employed by the Schwartz Center for Compassionate Healthcare which is a non-profit organization operating under the 501(c)(3) tax-exempt status of the Massachusetts General Hospital.

Author's contribution

BAL is the single author of the manuscript.

References

1. Tipping MD, Forth VE, O'Leary KJ, Malkenson DM, Magill DB, Englert K, *et al*. Where did the day go?--a time-motion study of hospitalists. *J Hosp Med* 2010; 5: 323–8. doi: 10.1002/jhm.790
2. Linzer M, Manwell LB, Williams ES. Bobula JA, Brown RL, Varkey AB, Man B, *et al*. Working conditions in primary care: physician reactions and care quality. *Ann Intern Med* 2009; 151: 28–36.
3. Wallace JE, Lemaire JB, Ghali WA. Physician Wellness: a missing quality indicator. Lancet 2009; 374: 1714–21. doi: 10.1016/s0140-6736(09)61424-0
4. Mannion R. Enabling compassionate healthcare: perils, prospects and perspectives. Int J Health Policy Manag 2014; 2: 115-7. doi: 10.15171/ijhpm.2014.34
5. Weng HY, Fox AS, Shackman AJ, Stodola DE, Caldwell JZK, Olson MC, *et al*. Compassion training alters altruism and neural responses to suffering. Psychol Sci 2013; 24: 1171–80. doi: 10.1177/0956797612469537
6. Lown BA, Manning CF. The Schwartz Center Rounds: evaluation of an interdisciplinary approach to enhance patient-centered communication, teamwork and provider support. Acad Med 2010; 85: 1073–81. doi: 10.1097/acm.0b013e3181dbf741