Understanding Compassion in Family Medicine: A Qualitative Study

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Graduate Program in Family Medicine
A thesis submitted in partial fulfillment of the requirements for the degree in Master of Clinical Science
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Understanding Compassion in Family Medicine: A Qualitative Study

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by

Jane Melek Uygur

Graduate Program in Family Medicine

A thesis submitted in partial fulfillment of the requirements for the degree of Masters of Clinical Science in Family Medicine

The School of Graduate and Postdoctoral Studies
The University of Western Ontario
London, Ontario, Canada

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The thesis by

Jane Melek Uygur

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Understanding Compassion in Family Medicine: A Qualitative Study

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Date

Chair of the Thesis Examination Board
Abstract

**Aims:** This thesis aimed to explore the physician’s capacity for, and their experiences and notions of compassion throughout training and in family practice.

**Methods:** This qualitative study used a phenomenological approach. In-depth interviews with 22 family physicians were audio-taped and transcribed verbatim followed by independent and team coding. Then an iterative and interpretive analysis was conducted.

**Findings:** Participants expressed their understanding of the definition of compassion and described how it was an important quality in family physicians for both patient and physician satisfaction and effective quality of care. They explained the many factors that influenced physician motivation and capacity for compassion and the connection they developed with their patients as a result. Finally, participants described the challenges physicians face to keep compassion in balance throughout training and during their careers.

**Conclusions:** Three core concepts arose from this study: 1) a clear definition of compassion in the family physician; 2) The Compassion Barometer which describes the relationship between physician demonstrations of compassion and patient vulnerability; and 3) The Compassion Trichotomy which describes three interrelated developmental areas that determine the evolution or devolution of compassion in family physicians.

**Keywords**

Compassion, Family Medicine, Empathy.
Co-Authorship Statement

The research for this thesis was conceived, planned and conducted by the author.

The following contributions were made:

Dr. Judith Belle Brown provided advice and guidance regarding the research protocol and ethics submission. She also helped to develop the thematic analysis of the qualitative data from the in-depth interviews, and edit the thesis write up.

Dr. Carol Herbert provided advice and guidance regarding analysis of the qualitative data, editing and structure of the thesis write up.
Dedication

To my mother Dr. Helen Rosamond Lees Brown,

and my now deceased father, Dr. Ali Oktay Uygur,

my first role models of the “compassionate physician”.

v
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Working on this thesis has been a journey of tremendous personal and professional growth. I would like to thank all of my family, friends, mentors and colleagues who have given me their unwavering support during this long process:

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Chapter 1

1 Introduction

The definition of compassion, according to the Oxford dictionary is: sympathetic pity and concern for the sufferings or misfortunes of others.\(^1\) However, this definition does little to inform us about compassion, nor does it help us understand the role compassion plays between patient and doctor. Compassion has traditionally been viewed as an inherent part of the patient-doctor relationship. However, as Matarazzo\(^2\) states, “Good bedside medicine consisting of empathy, compassion, and a nurturant attitude was a major component of physicians' armamentarium until the recent explosion in biology, physiology, chemistry, and microbiology.”(p7) The scientific revolution has drastically changed the whole culture of medicine and with it the role of compassion has become less valued by physicians. Coulehan\(^3\) remarks upon the conflict that this creates in medical students: “… today's culture of medicine is hostile to altruism, compassion, integrity, fidelity, self-effacement, and other traditional qualities. Hospital culture and the narratives that support it often embody a set of professional qualities that are diametrically opposed to virtues that are explicitly taught as constituting the "good" doctor.”(p892)

Despite these realities in medicine today, studies continue to show that “A practice style emphasizing psychosocial aspects of care was predictive of improvements in patient health status.”\(^4\)(p879) In response to the current technological culture of medicine we have the birth of the patient-centered method.\(^5\) There is much evidence\(^5\) that: “Patients strongly desire patient-centered care. It has been associated with improved patient and doctor satisfaction, greater compliance, fewer investigations, referrals and malpractice complaints, and no change in consultation time. Patient-centered care exerts a positive influence on health outcomes and is especially applicable in general practice, providing an efficacious and compassionate response to suffering.”\(^6\) (p1103)

Trying to practice patient-centered medicine in our current medical culture is challenging. Medical students are at the center of this conflict. Coulehan and Williams\(^7\) “contend that
North American medical education favors an explicit commitment to traditional values of
doctoring--empathy, compassion, and altruism among them--and a tacit commitment to
behaviors grounded in an ethic of detachment, self-interest, and objectivity.”(p598) They
further note that “medical students and young physicians respond to this conflict in
various ways.”(p598)

The stress of residency training is well documented. 8 How does the stress of residency
impact the residents’ capacity for compassion? Studies9 show that “unprofessional
behavior [in residents] may significantly correlate with burnout”. (p825)

Once training is finished, what happens to the family physician’s capacity for
compassion? Studies have shown that experienced physicians actively elicit patient's
views of medical problems (i.e. a "patient-centered" approach).10 However family
physicians are often the first contact for patients with a range of mental health problems,
many of whom have a history of trauma or loss. Exposure to emotionally challenging
encounters puts them at risk of burnout and compassion fatigue.11

Each physician brings to their clinical relationships complex, very personal models of
medicine that put emphasis on meaning and human relationships and act as a source of
strength. 12 By interviewing family physicians from medical school to retirement, we may
understand where compassion fits in these models and what external factors diminish or
nurture it. With this knowledge we may be able to understand better how to bring
compassion back into the forefront of the patient-doctor relationship.
Chapter 2

2 Literature Review

2.1 Definition

The earliest records of philosophical discussions around the nature of compassion date back to Aristotle. Since that time many people have attempted to define compassion. Within medicine the definition of compassion has primarily been explored within the realm of ethics and professionalism. There have been no studies that clearly define what compassion is within the context of family medicine, although there have been some studies that have attempted to define empathy. This section will look into the different components of compassion based on current bioethical literature and research on empathy.

From the ethical point of view, compassion is considered a virtue or a “trait of character that is socially valuable.” Traditional virtues in medicine originate mainly from health care relationships, like the patient-doctor relationship. Virtues are related to emotional states but also have a moral aspect and an intellectual aspect. Within this context compassion has been defined as “a trait that combines an attitude of active regard for another’s welfare with an imaginative awareness and emotional response of deep sympathy, tenderness and discomfort at another’s misfortune or suffering.”

Based on the above definition, it is evident that compassion comes with a certain attitude. This attitude can be defined by exploring other concepts closely related to compassion. Ethicists see pity, mercy and sympathy as being associated with compassion but distinguishable in that they imply condescension. These components can be seen to be linked with judgment and inequality whereas compassion is seen to be lacking in these elements. The compassionate attitude is thus seen as a non-judgmental one with respect for the human dignity of others.

Against the backdrop of this attitude of respect, compassion appears to engage both emotional and mental processes in response to suffering. Within bioethics, there is
agreement that compassion has both a cognitive and an emotional aspect.\textsuperscript{13, 16, 17} Again, exploring closely related concepts can further elucidate this. The emotional component has some links with sympathy in that it is “concerned with a sharing of feelings”\textsuperscript{16} (p82) although sympathy lacks specificity and can be associated with condescension. It refers to the “feelings we have in harmony with another person”.\textsuperscript{18} (p640) Empathy, on the other hand, refers to the “understanding or reconstruction of another person’s emotions”.\textsuperscript{18} (p640) It appears to be closely related to both the emotional and the cognitive components of compassion.\textsuperscript{16, 17, 19, 20} Empathy is considered a required first step towards compassion but not equivalent to compassion. From a bioethical standpoint, empathy is different from compassion in that it may not be associated with “active regard for the other person’s good”\textsuperscript{19} (p175) or related to suffering at all.\textsuperscript{16}

Recent research defining empathy within the context of health care has been conducted as academics endeavor to understand how to teach empathy to trainees. Empathy has been described as having several components: 1) emotional or affective; 2) moral; 3) cognitive; and 4) behavioral.\textsuperscript{14, 22} Mercer and Reynolds\textsuperscript{15} defined empathy in the clinical context of primary care as “the ability to: a) understand the patient’s situation, perspective and feeling (and their attached meanings); b) to communicate that understanding and check its accuracy; and c) to act on that understanding with the patient in a helpful (therapeutic) way.” (p9) This definition of empathy links it closer to compassion than the bioethical definition, as within it there can be inferred an intention to help the patient.

Empathy and compassion both include a component of action. They both require acting on an “understanding” of the patient. Dietze and Orb\textsuperscript{23} point out that “compassion is inextricably linked with action: listening, feeding, clothing, visiting, sheltering, educating, comforting, forgiving…” (p171) The commonality for these actions is that they are supportive and helpful and have the goal of alleviating suffering. Authors have argued that compassion without action is, in fact, only pity.\textsuperscript{17}

These actions of support all come within the context of relationship. The definition of compassion also relates to the aspect of togetherness. Compassion comes from the Latin
com (together) and pati (to suffer) in other words suffering together. This suggests that compassion is entrenched in a relationship between individuals and is part of the interaction between them. Through this co-suffering there is, in essence, a sharing of humanity within compassion. Pellegrino suggests that there is a “special human relationship that binds one who is ill to one who offers help” (p13) and that the physician’s moral obligation to care for their patient stems from this. He sees compassion as one of four aspects of care and describes it as “being touched by the caring person”. (p13)

From this review we can conclude that compassion involves: 1) a non-judgmental and respectful attitude; 2) an emotional component where feelings are shared; 3) a cognitive component where the other person’s situation is understood; 4) supportive and helpful action to alleviate suffering; and 5) all within the context of a caring relationship. It is also evident that empathy and compassion share many facets although they cannot be considered synonymous. Indeed it could be surmised that empathy is an integral part of compassion.

2.2 Motivation

What is it that motivates us, as humans and as physicians, to be compassionate? Theories on the evolution of compassion suggest that compassion may have evolved because compassionate care provides mutual benefit for both patient and physician. In addition, we know that people are motivated by their value systems and that value systems reflect people’s motivations. Some authors have explored how compassion is valued in society, medicine and family medicine in particular. Other authors have considered how multiple motivations play into compassion.

Compassion and mutual benefit

There are many theories as to why humans, as a species, have developed compassion. Some would argue that the development of compassion is counterintuitive to
evolutionary theory based on natural selection and survival of the fittest. However, Darwin himself viewed sympathy as the strongest of humans’ evolved instincts. In 2010 Goetz et al. reviewed the literature and identified three evolutionary theories regarding compassion. According to these theories, compassion arose because: 1) it improves the wellbeing of vulnerable offspring; 2) it is a desirable quality in the process of mate selection; and 3) it facilitates cooperative associations with non-kin.

This third line of reasoning implies that individuals will favor lasting relationships with more compassionate individuals who are non-kin because this trait predicts cooperative and trustworthy behavior that will be mutually beneficial. When reflecting on this theory with respect to the practice of medicine, the questions that are raised are: Do patients favor compassionate family physicians? Does compassionate physician behavior result in benefit for both the patient and the physician in family medicine?

**Do patients favor compassionate physicians?**

There are many studies showing that patients appreciate and want empathetic and compassionate care from their physicians. Conversely, one of the most common causes for complaints about physicians is lack of compassion or empathy. There are several studies relating to what patients want specifically from their general practitioners. Wensing et al. did a systematic review of the literature on patient priorities for general practice care, involving analysis of nineteen studies. In more than 50% of the studies, “humaneness” was one of the factors considered most important by patients. It was also one of the most often included categories. The category of humaneness encompassed “compassion” and other words like “understanding,” “attentive,” “treats you like an individual,” “patient,” “honest,” “friendly and pleasant”. As described previously, many of these words as are associated with compassion.

We are only just starting to understand why patients want compassion and most of our information comes from pathographies or illness narratives. In a reaction to the biophysical approach of physicians to illness that ignores patient experiences, there has been an increase in pathographies since the 1950s. Through pathographies there is much more documentation of how illness is experienced.
In their qualitative analysis of health providers’ illness narratives, Kempainen et al. described challenges to patients and their families and listed health care provider qualities that were helpful or unhelpful. They described how compassionate health care providers improved patients’ and family members’ experiences of illness. Participants in this study described many psychosocial challenges faced by patients and their families. Fear, stress, helplessness, sadness, emotional pain, embarrassment and isolation were aspects of the illness experience they expressed. They also found the physician’s communication and interpersonal skills greatly impacted the experience of illness. In addition, participants described how their physicians’ ability to recognize their patient’s humanity enabled practitioners to be patient-centered and see beyond their technical needs.

Studies have shown that patients want compassion in challenging circumstances like those involving medical error, psychosocial issues, life support, palliative care and situations involving ambiguity. However, there is little evidence in the literature to indicate whether patients want compassion during all interactions or only during these more emotionally laden circumstances.

**Does compassionate physician behavior result in benefit for the patient and the physician?**

In the literature, compassion is often talked about with respect to palliative care and end of life. However, there is increasing research that looks at how empathy and compassion impact the quality of patient care and physician effectiveness in general. There is also evidence to support the positive impact of compassionate physician behavior on the physician but this will be addressed later in the “Capacity” section.

Redelmeier et al. conducted a randomized trial on compassionate care with homeless people within the emergency care setting. They found that during the course of one year, patients who had received compassionate care sought emergency care much less often than those in routine care, with the return rate to emergency decreased by one third or 2.5 visits per year. Rakel et al. did a randomized control trial (RCT) on the impact of physician empathy on the duration of the common cold. They found that “when patients with a common cold rated encounters with clinicians as “perfect” on a measure of
empathy, the patients had a significantly shorter duration of illness and trend toward lesser severity of illness and higher levels of immune response.”(p500) Empathy has also been studied looking at broader outcomes. For example, Mercer et al. 41 in their prospective study in a high-deprivation area in Scotland found a positive relationship between GP empathy and patient enablement and between patient enablement and changes in main-complaint and well being at one month.

Along with growing evidence in the literature that compassion and empathy have a positive impact on patient health, authors have reflected on the underlying mechanism. Neumann et al. 42, in their review of current and past literature on empathy, found that “clinical empathy seems to be a fundamental determinant of quality in medical care, because it enables the clinicians to fulfill key medical tasks more accurately, thereby achieving enhanced patient health outcomes”. (p339) Neumann et al. 42 described a model to demonstrate how empathy can improve patient outcomes. When the clinician is empathetic, patients will talk more about their symptoms and concerns. This in turn allows the physician to gather more thorough and holistic information about them and their illness experience. Clinicians develop a better perception of the situation which leads to a more accurate diagnosis. Empathy also helps the clinician understand the needs specific to that patient and respond to them accordingly. Empathetic communication also means that patients participate in decision making and clinicians can provide helpful educational information. There is also evidence to suggest that empathy and compassion are important in maintaining an effective therapeutic alliance.45 Furthermore, Straumanis’ 46 examination of the literature suggests that when physicians make mistakes; timely, well communicated, and compassionate disclosure will result in less frequent legal action.

With more research in neurobiology relating to empathy and compassion, we are also starting to understand more about how our relationships with each other impact our biology. Adler, 47 in his article, reviews recent research in neurobiology and socio-psychology and discusses them in terms of the patient-doctor relationship. He concludes that: “As psychosocial responses are necessarily bio-psychosocial responses, patients and physicians must likewise be influencing each other’s psychobiology. This
mutual influence may be subjectively experienced as empathy, and may be skillfully employed by the clinician to directly improve the patient’s psychobiology.” (p280) If physicians have the capacity to impact their patients’ psychobiology through their interactions, we can see through the mind-body interaction how this can have an impact on their physiology. There is some physiological evidence suggesting how empathy might be beneficial to the patient. Ono et al. 48 studied the physiological (heart rate variability on ECG and left temporal lobe activity on EEG) and psychological responses (visual analog scale for subjective stress) to the expression of emotion and empathy. They found that the comfort of having shared a message reduced physiological activity (indicating stress), especially when associated with empathy.

As physicians rarely work in complete isolation, one could postulate that compassionate interactions with other healthcare professionals might affect the quality of patient care. Although there are no studies looking at how compassionate interactions between physicians and other professionals impact patient care, Martin et al. 49 reviewed 14 RCTs looking at interventions to improve inter-professional collaboration. Although study results were mixed all but one of the studies reported at least one statistically significant improvement in patient outcomes.

These studies support the theory that compassion can be mutually beneficial for patient and physician and lead to improved physician effectiveness and better quality of care for the patient. This is all the more important when considering that studies show physicians are highly motivated by their desire to provide high quality care and by the desire to be perceived as good doctors by patients and colleagues. 50

**Valuing Compassion**

If compassion has evolved for the mutual benefit of human beings, including patients and physicians, it would seem logical that we should find it valued across cultures and various disciplines. Compassion has been a subject in philosophical literature since Aristotle 51 and Confucius. 52 Psychological research has been conducted on compassion and related states in many countries and across diverse societies. 53-59 In addition, we know that behaviors linked to compassion like helping, forgiveness and reciprocity are
valued in all cultures.\textsuperscript{60-62} However, we also know that compassion is likely to vary across societies.\textsuperscript{63} Compassion may differ in how focal compassion is in daily experience\textsuperscript{64} and in how much it is idealized.\textsuperscript{65}

Within the culture of medicine, it is important to examine the following: 1) students’ motivation for compassion when entering medicine; 2) the valuing of compassion in medical education; 3) the value family physicians place on compassion; and 4) factors that contribute to compassion being a core value for family physicians.

\textbf{Valuing compassion in medicine}

Compassion has traditionally been considered one of the core virtues of medical practice\textsuperscript{16} and beneficence the physician’s primary obligation.\textsuperscript{13} However, the course of recent medical history has shifted it from center stage. In his paper on Health and Behaviour, Matarazzo\textsuperscript{2} argues that, prior to the scientific revolution, physicians had little in the way of drugs or effective therapies and relied on good bedside medicine including empathy, compassion and a nurturing attitude toward the patient. However, the expansion in scientific knowledge at the beginning of the twentieth century resulted in a drastic change in the way medicine would be taught and practiced. In the United States and Canada, after the Flexner report in 1910\textsuperscript{66}, the standard medical school curriculum that still remains prevalent in various forms today, consisted of two years of lectures in the sciences with a progression to the clinical years of training. With more focus on learning the science and less time at the bedside the previously-valued caring behaviors were crowded out.

Criticism about the state of compassion in medicine has existed since the start of the scientific boom. In 1925, in his final lecture, “The Care of the Patient”, Francis Peabody’s oft quoted conclusion was: “One of the essential qualities of the physician is interest in humanity, for the secret of the care of the patient is in caring for the patient.” In the lecture he was addressing criticisms of young medical graduates as too scientific and not knowing how to care for patients.\textsuperscript{67}
Matarazzo\textsuperscript{2} argues that scientific progress has enabled us to master many infectious diseases, yet today in western societies we are now challenged by chronic illnesses linked to lifestyle, which require a better understanding of the human psyche and the role of the patient-doctor relationship in health behaviors. In response there is a growing interest in research on empathy and compassion, not only in the psychosocial sciences, but in the neurosciences and medical education.

Alongside these changes, there has also been a shift in emphasis within medical ethics. In the sixties and seventies in North America, along with civil and consumer rights movements and in response to physician paternalism, medical ethics and law emphasized informed consent and autonomy. Some argued that other principles like beneficence, non-maleficence and justice were superseded and the “good will” of the doctor was replaced by “the contract”. \textsuperscript{68} Physicians resented the distrust implied \textsuperscript{69} by this shift and were initially ambivalent about this new model. The benefit, of course, was that patients became more informed and involved in decision making and in many ways this is in alignment with the compassionate patient-doctor relationship. However, the downside was that “the contract” implied physicians could not be trusted and it has been argued that this has been damaging to the patient-doctor relationship. \textsuperscript{70} (See Connection – relationship for more on trust and compassion)

**What factors contribute to family physicians’ valuing compassion?**

McWhinney\textsuperscript{36} has described how family medicine emerged in response to the challenges of specialized medicine, as a discipline where the focus was on relationship with individuals and families. Indeed the College of Family Physicians of Canada lists relationship as one of four core principles of Family Medicine. \textsuperscript{71} Does a discipline that focuses on relationship value compassion more than those that specialize according to organ system? Although there is considerable literature about physician views and beliefs around specific disease management \textsuperscript{72-74} and ethical issues like abortion, \textsuperscript{75} end-of-life care, \textsuperscript{76} and patient autonomy, \textsuperscript{77} there has been less research exploring values of family physicians in the broader sense. However, one 1993 study explored how personal values influenced primary care specialty choice. \textsuperscript{78} First-year medical students, entering
residents, and graduating residents at a medical school completed a questionnaire on their specialty aspirations and a survey measuring 10 types of values: achievement, benevolence, conformity, hedonism, power, security, self-direction, stimulation, tradition, and universalism. Primary care aspirants rated power and self-direction values lower and benevolence values higher than did aspirants to other specialties. Benevolence, an inclination to help others, is closely linked to compassion so this may indicate that family physicians are seen as more likely to value compassion than physicians in other specialties. More recent studies, 79, 80 though not specifically addressing values, identified ‘societal orientation’ as one of many factors associated with career choice in family medicine.

Saba 12 has also studied the beliefs and values that family medicine residents bring to their clinical practice. His analysis of reflection exercises that were part of their third year behavioral sciences curriculum found that family medicine residents have very personal models of medicine that put emphasis on meaning and human relationship. Eighty five percent of the 143 residents explained that their desire to become a physician was rooted in a sense of mission or calling while 63% described their beliefs and values as reflecting formal philosophic or religious traditions. It is possible then, that philosophic, spiritual and/or religious beliefs contribute to family physicians valuing compassion.

Although there is much debate in the literature regarding where spirituality and medicine should intersect 81 there is little to be found regarding whether physician values develop through their own spiritual or religious beliefs. We do know that many religions extol compassion. Armstrong points out in her book “Twelve Steps to a Compassionate Life” 82, that many religions including Buddhism, Christianity, Islam and Judaism have compassion as a core concept. The essence of compassionate teaching across these traditions rests on what she terms the “Golden Rule” or: “Always treat others as you would wish to be treated yourself”. If compassion is indeed a core value of family physicians, it may be this message in religious and spiritual teachings that they bring to their medical practice.
Are there aspects of personal development in family physicians that might account for how they began to value compassion? Although there is little in the literature that directly explores how compassion develops as a value in the human life cycle, the literature on pro-social behavior may give us some insight into this. There has been significant research into the factors that lead to pro-social behavior during childhood development.\textsuperscript{83} It has also been suggested that compassion is a motivator for pro-social behavior.\textsuperscript{84} The literature on pro-social behavior tells us that parents who espouse and teach pro-social values in the family tend to have children who are comparatively kind and helpful.\textsuperscript{85, 86} We also know that children model pro-social behavior they observe in parents and other adult role models.\textsuperscript{85} So it is possible that those family physicians who value compassion have had this kind of exposure prior to entering medicine.

**Does the motivation for compassion change over career?**

Is compassion a factor that motivates individuals to choose medicine as a career? A study by McManus et al.\textsuperscript{88} looked at the motivations of medical school applicants using a Medical Situations Questionnaire at a two day conference for medical school applicants. They discovered four main motivating factors:

1) Indispensability – focused on control, power and technical expertise
2) Helping people – focused on caring, compassion, support and service
3) Respect – focused on being respected by patients, families and society for skills
4) Science – focusing on interest in applied science and research

Those who were motivated by helping people scored higher on their ability to “walk in another’s shoes” (perspective taking) on the empathy scale. This may indicate that some of those who are motivated to enter medicine are motivated by and value compassion. However, the findings also demonstrated that motivation varied from individual to individual. Correlation with career preferences demonstrated the four motivating factors over most career choices in medicine. Interestingly, however, indispensability was not correlated with family medicine.
Once students have entered the medical education system, do they continue to value compassion? Rabow et al.\textsuperscript{89} conducted a qualitative study on personal mission statements of first and second year medical students who participated in an elective professionalism course called, “The Healer’s Art”. These statements frequently included phrases about listening, presence, empathy and relationship. All these concepts are associated with compassion and may indicate compassion was valued within this cohort of medical students.

However, also in this study, participant statements indicated the negative emotional and physical effects of medical training and expressed concern that training might diminish their passion. Their concern is underscored by the growing medical literature concerning the decline of empathy during medical education.\textsuperscript{90-93} This has been met by an increasing emphasis on professionalism\textsuperscript{94-99} and yet many in the field of medical education are concerned that courses in professionalism alone are not the answer.\textsuperscript{3,100}

Coulehan\textsuperscript{3,7} distinguished two types of learning around professionalism in the culture of medical education: that which is explicitly taught in a didactic format, focusing on empathy, communication, trust, fidelity and other traditional values in medicine related to compassion; and that which is tacitly taught in clinical settings, focusing on objectivity, detachment, self-interest and distrust (of emotions and patients) based on the scientific values described previously. In his view, medical trainees adopt one of three professional identities to overcome the conflict between the two: 1) the technical professional who adheres to the tacit values and narrows their responsibility to technical areas; 2) the non-reflective professional who consciously embraces the explicit values but unconsciously bases their behavior on the tacit values; and 3) the compassionate and responsive professional who overcomes this conflict and adheres to the explicitly taught values.\textsuperscript{3}

Coulehan goes on to say that this latter group somehow appears to be “immunized” against the tacit values presented to them in clinical training.\textsuperscript{7} In his view, immunization depends on personal characteristics (i.e. gender, belief system and non-medical commitments) and on medical school features (i.e. family medicine, communication skills courses, medical ethics, humanities and social issues in medicine).
Once in practice do family physicians continue to be motivated by and value compassion? There is some evidence to indicate that family physicians continue to value compassion over their careers. Eliason et al.\textsuperscript{101} studied the role that personal values had on practice satisfaction in family physicians by surveying 1224 family physicians. Respondents rated the benevolence value highest and those who viewed benevolence as a guiding principle in their lives reported a higher level of professional satisfaction. There was no significant difference in valuing of benevolence between younger and older physicians.

Saba’s\textsuperscript{12} research with third year family medicine residents provided evidence that their understanding of their role as a physician started to change. Thirty one percent of participants identified that although curing disease was still a goal, they realized that opportunities to cure were more limited than they had been taught. Cocksedge et al.\textsuperscript{102} did a qualitative study looking at what they described as “holding relationships”; a doctor-patient relationship that is trusting, constant, reliable and is concerned with ongoing support without expectation of cure. They found that these relationships were valued by both patients and physicians particularly for patients with chronic conditions or complex health problems. As these relationships require trust and support it is quite possible that compassion plays a significant role.

**Motivation compassion and burn-out**

We know that family physicians are under stress and suffer from burnout. Lee et al.\textsuperscript{103} surveyed family physicians across Canada and found that 42% are under stress and approximately half report emotional exhaustion and depersonalization (two of the three components of burn-out\textsuperscript{104}). One of the strategies for decreasing stress at work described by participants was valuing relationships with patients. This and Eliason’s\textsuperscript{101} study points to the role compassionate motivation may play in helping physicians combat stress and find satisfaction in their work.

However, concern has been raised about the impact of compassion-related motivation on physicians over-extending themselves. Bishop and Rees\textsuperscript{105} explored this in their reflection paper articulating the differences between altruism and pro-social behavior in
medicine. Their stance is that the promotion of altruism in the medical literature can be harmful to physicians as it means total self-sacrifice. They argue for promotion of pro-social behavior within medicine which is focused on caring for others while balancing interests of the self.

Psychoanalysts like Halpert and Marcus have pointed out that physicians can develop a “hero-healer” complex, believing they can defeat disease and death. This can lead to high expectations and, when the reality of medical practice becomes evident, to chronic dissatisfaction. Remen, author of “Kitchen Table Wisdom” has suggested that physicians who are motivated by their ego to “help” and “fix” their patients view them as weak and broken. On the other hand, physicians who are motivated spiritually to “serve” their patients, view their patients as whole. In her experience the latter group is less likely to suffer burnout and continue to be renewed in their practice.

2.3 Capacity

This section will focus on the factors that determine capacity for compassion. There is substantial literature that addresses the issue of whether compassion is indeed innate or learned. In addition, there is much written on the role of emotion regulation and how this relates to compassion. Within the caring professions, there is also research into compassion fatigue and compassion satisfaction that provides insight into how self-care plays a role in the capacity for compassion. Finally, the struggle between empathy and detachment is explored in relation to training and clinical practice.

Innate versus learned

Compassion has been described as a vicarious emotion, a blend of sadness and love, and a variant of love but Goetz et al. in their empirical review of the literature provide convincing evidence that compassion is indeed a distinct emotion. Studies in neuroscience suggest there is a biological correlate for the emotion of compassion and that the anterior cingulate is the primary anatomical site where
However, the anterior cingulate borders several areas and several others are involved in the process of compassion. In summarizing recent neuroscience studies, Goetz et al.\textsuperscript{25} suggest that compassion activates the following areas:

1) Temporal parietal cortex – detecting another person’s suffering expressions
2) Inferior frontal cortex, insula and temporal pole – mirroring the person’s emotional experience (this is where mirror neurons are located)
3) Mid-ventral medial prefrontal cortex – assessing relevance and deservedness of the sufferer
4) Dorsal medial prefrontal cortex and interior frontal cortex – coping with empathetic distress
5) Periaqueductal gray, substantia nigra and ventral tegmental area (midbrain) – feeling warmth or tenderness towards others
6) Heightened left hemisphere – motivation to approach

Studies of the subjective experience of compassion also support the theory that compassion is a distinct emotion. These studies show that the transitory experience of compassion motivates altruistic and caring behavior in a distinct way.\textsuperscript{118-120} Goetz et al.\textsuperscript{25} also review studies associating compassion with physiology, specifically the autonomic nervous system. These studies\textsuperscript{121-123} showed that compassion is associated with decelerated heart rate due to activation of the parasympathetic autonomic nervous system, whereas distress and sadness activated the sympathetic nervous system. Again this points to compassion being a distinct emotion with clear biological correlates.

These studies, and those discussed previously that point to the evolutionary and cross-cultural phenomena of compassion, would lead us to believe that compassion is a distinct emotion innate in human beings. However, compassion is also experienced as an enduring affective trait.\textsuperscript{124-127} What is it that makes one person more compassionate than another? Is compassion something that can be learned?

Twin studies indicate that the predisposition to experience empathy is partly inherited.\textsuperscript{128-130} However, neuroscience studies suggest that positive emotions are less determined by our DNA than negative emotions.\textsuperscript{131} Other studies indicate that the brain structures
involved in positive emotions like compassion are more “plastic” and can change with environmental input.  With this in mind it is possible to envision that the environment that individuals grow up in can impact their predisposition to compassion.

Studies looking at sympathy, empathy and the parent-child relationship have demonstrated some such correlations. Eisenburg reviewed the literature in an article in “Visions of Compassion”. Studies have shown that parental responses of sympathy and empathy are linked with empathy responses of children (primarily if the parent and child are the same gender) demonstrating that role-modeling develops empathy. In addition, studies looking into the security of attachment to parents predicted empathetic responding in children. Similarly, studies demonstrated greater empathy in children who were more involved with their grandparents. Parenting style is also related to empathetic responding in children. Authoritarian (low warmth and very directive) parenting was correlated with low pro-social behavior in children, authoritative (warm, democratic and directive) parenting correlated with pro-social behavior in children and permissive (warm and nondirective) parenting correlated with lower levels of sympathy and empathy. Finally, how parents deal with emotions impacts their children’s empathy, i.e. whether children are encouraged to look at others’ emotions, how parents react to the child’s negative emotions, parental willingness to discuss emotions in a constructive manner and parental expression of their own emotions.

Outside of parenting, there are numerous other studies that have looked at various interventions to develop empathy and compassion. These attest to the neuroplasticity of compassion and the type of interventions that nurture its development. For example, Mary Gordon developed a program in Canada called “Roots of Empathy” to develop empathy and diminish violence and bullying in primary school children. Roots of Empathy teachers encourage children in school to discuss parenting, and reflect on emotions of self and others during and after visits with a volunteer parent and their infant. This program has been shown to increase social and emotional knowledge, decrease aggression and increase pro-social behavior for up to three years.
There is other research to suggest that compassion can be cultivated using meditation techniques. Some meditation practices cultivate compassion through loving kindness exercises where the individual contemplates feelings of compassion towards themselves, then others close to them, then to more distant others and finally to all fellow humans. Research has shown that these meditations shift lateralization patterns in the brain to the left frontal lobes which is associated with greater approach tendencies, and this improves well being and social connection.

Newberg and Waldman, a neuroscientist and therapist respectively, in their book “How God Changes Your Brain,” discuss how the different practices of many religions impact our brains. From their research and review of the literature they have found that religious practices that involve contemplation or meditation on any kind of love can strengthen the neural circuits that permit us to feel compassion. On the other hand they also describe fear-based religious practices that can diminish compassion and increase the activity of the amygdala, the more primitive area of the brain.

From the above studies, it is evident that although compassion may be innate with a biological basis, there are several factors related to personal experience and development that may impact the cultivation of compassion. This raises an interesting question with respect to gender. Women are often perceived as being more compassionate or empathetic than men. Indeed, women physicians score higher on empathy scales and are more likely to view their empathy as a strength compared to male physicians.

There is some evidence to suggest that gender differences in perceived empathy may be due to differences in communication skills between genders. From an anatomical standpoint, women’s anterior cingulated gyrus’ is larger than men’s; however, recent studies like the one by Mercadillo et al. show that the neural mechanisms related to empathy may be more developed in women because of social learning, for example, nurturing skills.

**Emotion Regulation**

From the above studies it is apparent that compassion is indeed innate and people may be more genetically predisposed to it, but clearly it is also learned through role modeling,
discussion around emotions and contemplative practices. So what are the competing responses to compassion? When exposed to suffering, people may have an empathetic response which initiates action to relieve suffering of the other. Alternatively, people may experience personal distress which leads to actions that will relieve suffering of self. Studies show that the differences in these responses come down to a combination of emotional intensity and the ability to regulate emotions.

In “The Compassionate Mind,” psychologist Paul Gilbert describes three types of affect regulation predominant in humans. He proposes that these systems need to be in balance with each other for us to be emotionally healthy:

1) The threat and self-protection system - operates through the amygdala and cortisol levels and involves emotions like anxiety, anger and disgust
2) The incentive and resource-seeking system - driven by the dopaminergic system and motivates us to pursue, consume, achieve and want things
3) The soothing and contentment system - driven by endorphins and oxytocin and associated with feelings of calmness, kindness and safeness

Gilbert argues that the structure of modern Western societies leads us to spend too much time in the first two systems and less time in the latter, leading to hostility, fearfulness, self-criticism and endless striving to get ahead. To combat this tendency, Gilbert outlines a set of skills that build compassion including mindfulness, imagery, cognitive therapy, self compassion, working with negative emotions and cultivating compassionate behavior and lifestyles. So, in essence, to up-regulate compassion and empathy individuals must be able to down-regulate the threat and incentive systems.

The concept of emotion regulation also ties in with what is now widely known as “Emotional Intelligence”, a concept popularized in the mid nineties by the work of Daniel Goleman. He outlines four factors that determine emotional intelligence:

1) Self-awareness – the ability to read one's emotions and recognize their impact while using feelings to make decisions
2) Self-management – involves controlling one's emotions and impulses and adapting to different circumstances
3) Social awareness – the ability to sense, understand, and react to another’s emotions while understanding social networks
4) Relationship management – the ability to inspire, influence, and develop others while managing conflict

These four components categorize emotional capabilities into awareness and regulation of both emotions of oneself and of others. Emotional intelligence is of increasing interest in medical education; a review of this literature by Arora et al. found that the available research indicates that emotional intelligence does indeed correlate with compassion in physicians.

As mentioned earlier, Gilbert identified self-compassion as a key strategy in affect regulation and cultivating compassion. Research by Heffernan et al. has also recently demonstrated a link between emotional intelligence and self-compassion in the nursing profession. Self-compassion is an evolving concept in compassion research developed by educational psychologist Kirsten Neff, which entails three aspects: 1) self-kindness rather than harsh self-judgment; 2) a sense of common humanity rather than feelings of isolation; and 3) mindfulness rather than over-identification with painful thoughts and emotions. Her research has shown that higher levels of self-compassion were significantly linked to more perspective taking, less personal distress, and greater forgiveness, while self-compassion was linked to compassion for humanity, empathetic concern, and altruism in some groups. The concept of self-compassion in relation to physician compassion becomes all the more relevant considering that self-criticism has been shown to be associated with physician depression in several studies.

**Emotional Awareness**

Many researchers have described mindfulness as integral to self-compassion, emotional intelligence and emotion regulation. The goal of mindfulness is to maintain awareness moment to moment, separating oneself from strong attachment to beliefs, thoughts, or emotions, resulting in a greater sense of emotional balance and well-being.
Mindfulness has been found to be effective in reducing depression, anxiety and chronic pain but more recently, researchers have been looking into its applications to medical education. Epstein has advocated that mindfulness can be modeled by mentors and cultivated in learners. Shapiro et al. found that premedical and medical students who were randomly assigned to mindfulness training, demonstrated less psychological distress and increased empathy compared with the control group. More recently, Krasner et al. studied the impact of a program of mindfulness education in primary care physicians and found that it reduced burnout and improved empathy. Finally, it has been suggested that mindfulness meditation can enhance present-moment awareness that might reduce medical errors and improve patient care. Jha et al. found some improvement in attention and memory related to mindfulness training.

Meier et al. developed a medical model to improve emotional self-awareness of physicians in the realm of clinical care. They outlined the risk factors that might lead to under- or over-engagement of physician emotions:

1) Physician factors - for example, over-identifying with a patient, poor psychological health, fears of ill health or failure

2) Situational factors - for example, close relationship with patient, discord with patient or colleagues over care, time and professional conflicts, uncertainty in prognosis or goals

3) Patient factors - for example, difficult or angry patients and families where relationships are dysfunctional, caring for a health professional

Then they identified: 1) the signs (physician behaviors) - avoidance, disparaging patients, failing to follow through, physical signs of stress and over-communication and 2) the symptoms (emotions) - anger, contempt, guilt, feeling harassed, manipulated, or victimized and rumination about patients and obligation. Finally, they summarized the approach to emotion management as: 1) naming the feeling; 2) accepting the normalcy of that feeling; 3) reflecting on the emotion and its possible consequences; and 4) consulting a trusted colleague.
Compassion Fatigue, Compassion Satisfaction and Emotion Regulation

As described above, practices that improve empathy and compassion, such as mindfulness, have been shown to decrease symptoms of burnout. Symptoms of burnout are quite prevalent amongst family physicians\textsuperscript{103} and “compassionate empathic” physicians may be more likely to suffer from emotional exhaustion.\textsuperscript{172} However, in the literature there is also mention of a phenomenon called “compassion fatigue.” Compassion fatigue is a result of working with and feeling compassion for people who have experienced stressful events.\textsuperscript{11} It can be sudden in onset and include symptoms of helplessness, confusion, isolation, exhaustion and dysfunction. Those affected can feel overwhelmed by work and become ineffective. It can be a precursor to burnout but, if identified and treated quickly, recovery is rapid.

Figley\textsuperscript{173} has written and researched extensively on compassion fatigue in relation to those in the helping professions who care for victims of trauma. In his view, empathy and compassion are necessary for the therapeutic alliances that these professionals must establish with their clients in order to be effective. With any empathetic response, however, there is “compassion stress” which is the residual emotional energy from the encounter accompanied by the ongoing demand to relieve their client’s suffering. There are some factors he suggests that can lead to compassion fatigue and burnout which include: 1) prolonged exposure to the traumatized; 2) traumatic recollections from interactions; and 3) disruptions in the professional’s own life. Figley describes other factors that can prevent this compassion stress from developing into compassion fatigue: 1) sense of achievement from helping the traumatized; 2) disengagement between sessions; and 3) social support.

Stamm\textsuperscript{174} has coined the phrase “compassion satisfaction” to describe the sense of achievement and pleasure that people derive from helping others. Her viewpoint, which is in alignment with Figley’s, is that compassion satisfaction may actually prevent people from developing compassion fatigue. Several studies have found a correlation between
compassion satisfaction and lower risk for compassion fatigue and burnout looking at child protection workers, \textsuperscript{175} palliative care workers\textsuperscript{176, 177} and trauma therapists.\textsuperscript{178}

The importance of disengaging from work to prevent compassion fatigue has been recommended by other authors. Benson and Magraith\textsuperscript{11} suggest family physicians keep professional boundaries around time at work, self disclosure and expectations. In the personal arena they recommend things like humor, relaxation, exercise, good nutrition, sharing of emotions and hobbies to maintain self-care and spiritual connections. These suggestions mirror research findings prevalent in the literature related to compassion fatigue in other disciplines,\textsuperscript{180} burnout in family physicians,\textsuperscript{103} and self-reported coping strategies in high compassion fields, such as hospice care\textsuperscript{181} and working with the elderly.\textsuperscript{182}

Benson and Magraith\textsuperscript{11} have also suggested that Balint groups provide social support and may be effective in preventing and managing burnout and compassion fatigue. Balint groups\textsuperscript{179} are groups of doctors, led by a facilitator, that meet to discuss those patients that cause a reaction in their own lives. Their argument is that, in this kind of setting, family physicians can debrief, normalize emotions, decrease stress by sharing experiences and, strengthen the value of their work and reformulate boundaries. One preliminary qualitative study, done by Nielsen and Tulinius\textsuperscript{183} with a small group of family physicians, reported benefits in well-being and work-life related to group supervision sessions with a psychoanalyst, focusing on reflective practices, awareness of occupation conditions and strategies for prevention of compassion fatigue.

**Empathy and Capacity for Compassion during Medical Training**

The conflict between empathy and detachment in medicine is very evident in the medical education literature. There have been many studies looking into empathy decline during medical training. Although critics might argue that these studies use self-reporting measures and show small differences in empathy,\textsuperscript{184} there is mounting evidence that medical education does diminish empathy. Neumann et al.\textsuperscript{185} conducted a systematic review of these studies and attempted to elucidate the reasons behind this decline with the available data. The studies they reviewed demonstrated a self-reported decline of
empathy in the later clinical years of medical school and in residency. Decline in empathy seems to start when clinical experience and patient exposure begins. During residency training, empathy decline was associated with less patient-oriented residency programs (i.e. surgery, radiology). In this review, they identified several components in the curriculum that may contribute to empathy decline, for example, the learning environment (i.e. unstructured study, little bedside teaching etc), inappropriate role models and poor continuity with patients. Hidden curriculum variables identified included: trainee mistreatment and vulnerability (caused by trainee idealism and humanism being faced with the reality of suffering and limitations of medicine), loss of peer support and high work load. Trainee personality and biography seemed to have some impact on moderating the decline of empathy.

Shapiro, in her review article addressing empathy and medical education, suggests that the ideals in Western medicine contribute to the decline in empathy. These ideals (dualism, positivism, objectivism, reductionism, control, mastery) lead to fear of vulnerability and contamination by imperfection, pain and death. This fear, in turn, leads trainees to withdraw from and to scapegoat patients. She proposes a philosophical shift towards Eastern ideals (post-modernism, acceptance of uncertainty, limited control, shared vulnerability) that would lead to more empathy, mutual recognition and a more altruistic approach.

There is some neurophysiological evidence that may also explain why empathy declines during training. Studies have shown that anxiety, tension, and stress can reduce the signal rates of mirror neurons that are linked with empathetic ability. One neuroimaging study by Decety et al. compared differences in empathetic neural pathways in a group of physicians versus a control group. They found that physicians down-regulate their response to visual stimuli of painful events, like a needle prick, compared to controls. This, in turn, dampens their negative arousal to the pain of others which the authors postulated may free up cognitive resources necessary to assist in clinical reasoning.

Much has been written about how to alter the effect that training has on empathy. As mentioned above, some programs are implementing mindfulness training to develop
emotional regulation and empathy. Some educators have focused on identifying and diminishing the stressors of medical training. Others have prescribed opportunities for reflection to develop awareness of self and others. The patient and physician narratives are one such tool that has been used successfully. Finally, some educators feel that introducing a broader education in the arts may promote empathy by broadening trainees’ understanding of people and the world around them.

### Empathy and Compassion Over Career

Although some research has shown that empathy does not decline with age, other research indicates that the neural processes involved in empathy change. In these studies, cognitive empathy (where you recognize what another person is feeling) is relatively more prominent than affective empathy (where you feel what the other person is feeling) in adults as compared to children and adolescents.

There is some evidence that “compassionate empathic physicians” tend to be younger. However, quantitative and qualitative studies seem to indicate that physician personal experience of illness highlights for them the importance of compassion and empathy in the patient-doctor relationship. The current evidence in this area is conflicting and does not illuminate possible contributing factors like compassion fatigue and burn out. However, a trend these studies may be capturing is that younger physicians have more affective empathy, while older physicians with more experience may have more cognitive empathy. As a result, compassion may be experienced more cognitively than emotionally by older physicians.

### 2.4 Connection

#### Showing Compassion

Physicians use many communication skills, both verbal and non-verbal, to express compassion to their patients. A study by Marcinowicz et al. defined 48 non-verbal cues that patients perceived from general practitioners. Some of these communicate
multiple messages. Neuroscience is providing us with additional information about what these gestures do. For example, MacDonald\textsuperscript{202} reviewed some of the studies relating to eye-contact and found the importance that it has in establishing “meaningful rapport, supplying implicit information about a patient’s emotional state, providing diagnostic clues to common psychiatric disorders and delivering impactful clinical messages and provisioning hope and embodied empathy.” (p136)

Studies of nonverbal compassion cues have identified several ways that people show compassion. They can be summarized as follows:

1) Orientation – eye gaze toward person,\textsuperscript{203} head and body turned toward person\textsuperscript{120,122,123,203} and forward lean\textsuperscript{123}
2) Touch – hand contacting forearm of person\textsuperscript{204}
3) Facial expressions – oblique eyebrows,\textsuperscript{205} furrowed eyebrows,\textsuperscript{120,122,123,203} lower eyelid raised\textsuperscript{120,122,123,203} and slight mouth press\textsuperscript{120,123,203}

In addition, a recent study has shown that people can identify compassion in even short vocal bursts.\textsuperscript{206}

The following section examines studies that describe how compassion can be shown by demonstrating openness, being available, endeavoring to understand, being supportive and connecting on a human level. Next, challenges identified in the literature to showing compassion will be examined.

**Demonstrating openness**

There are many ways that physicians and other healthcare providers show compassion to their patients. Several articles in the literature point to an open attitude towards the patient from the stance of the healthcare provider. The compassionate person demonstrates this openness by being respectful,\textsuperscript{207,208} non-judgmental,\textsuperscript{209,210} considerate,\textsuperscript{211} forbearing,\textsuperscript{211} and one who honors the other person.\textsuperscript{210,211} Apker et al.,\textsuperscript{212} in their study of how nurses communicate compassion in health care teams, described many verbal and non-verbal ways that nurses demonstrate this quality, for example: “facial expressions and body language that invite others to communicate (e.g., facing others, smiling,
nodding head, open stance) and responding with positive feedback and support when others share feelings and uncertainties.” (p187) Wynn\textsuperscript{213} also identified an affective expression of empathy where the physician demonstrates that they share the same feeling the patient is experiencing at the moment.

Kalish et al.\textsuperscript{208} developed a tool for teaching compassion in clinical encounters. One of the key themes they identified in compassionate communication was validation. Validation of the patient’s emotions and perspectives is another way of expressing compassion through openness. Lack of condescension is also part of the open attitude thought to express compassion\textsuperscript{16} and this has implications on the hierarchy within the patient-doctor relationship. There is some suggestion in the literature that compassionate physicians demonstrate compassion by adapting their styles to suit the patient. For example the “Adaptive Practice” model described by Feldman et al. demonstrates that compassionate care practices encompass the full range of relating to patients from traditional hierarchical relationships to full patient or family control.\textsuperscript{214}

**Being present**

Compassion also involves the physician’s own mental processes and is reflected in the ability to be present in the moment with a patient. Epstein\textsuperscript{166} describes how practicing mindfulness facilitates this, thereby helping practitioners clarify their values so they can act with compassion. “Mindful practitioners use a variety of means to enhance their ability to engage in moment-to-moment self-monitoring, bring to consciousness their tacit personal knowledge and deeply held values, use peripheral vision and subsidiary awareness to become aware of new information and perspectives, and adopt curiosity in both ordinary and novel situations.” (p833) Mindfulness also allows physicians to listen attentively to their patients.\textsuperscript{166} Skaff et al.\textsuperscript{211} also identified attentive listening as a method of demonstrating compassion in their studies examining compassionate qualities of physician assistants.

Another way of being present and compassionate described in the literature is the use of silence. Back et al.\textsuperscript{215} in their literature review of silences used by clinicians identified a compassionate silence. These silences occur spontaneously from clinicians who have
developed mental capacities of “stable attention, emotional balance, along with pro-social mental qualities such as empathy and compassion.” (p1114) Through this technique, they claim that compassionate silences will “affirm mutual respect and understanding”. (p1116)

**Endeavoring to understand**

Empathy is described in the literature as being associated with good communication skills that facilitate an understanding of the other person. 207,209 Norfolk et al. 207 developed a model to explain the role of empathy in establishing rapport, then validated it with general practitioners and psychologists using qualitative analysis. Their model demonstrates how the physician tries to understand the patient through empathy using various techniques. They include verbal/non-verbal behavior to elicit the patient’s story and test perceptions regarding patient’s thoughts, feelings and expectations (e.g. silence, smiling, reflecting, asking open questions, checking, acknowledging, mirroring).

Once an understanding is achieved, empathy also requires an expression of the understanding achieved. 15,207 One aspect of this is the explicit recognition of suffering. For example, Selph et al. 31 investigated empathy in interviews about life support. They described several empathetic statements that recognized families’ difficulties with having a critically ill loved one, making decisions around their care and facing death.

Another aspect of expressing understanding of another’s suffering involves showing an understanding about what the patient might want to know or talk about. 210,211 In Sanghavi’s study, physicians at rounds were questioned about what they thought was compassionate care. One of their key findings was that physicians believed “imparting medical facts in a clear and useful manner to patients,” (p287) especially with respect to complex medical issues, was a central way that physicians showed compassion to their patients.

Wynn 213 summarizes how understanding is transmitted when describing what he called “cognitive expressions of empathy”, where the physician recognizes and expresses the patient’s innermost experiences, state or motivations. These themes parallel the
exploration of the illness experience (patient feelings, ideas, function and expectations) that are described in the “Patient Centered Clinical Method” (p41).

**Being supportive**

Aside from communicating understanding and facts, literature on demonstrating compassion also describes a further set of actions around support to the patient. For example, Apker et al. identified advocacy for the other person as a way of demonstrating compassion. Wynn also identified a “nurturant empathy” where the physician demonstrates that they are supportive, attentive and providing a sense of security. Kalish et al. emphasized the importance of acceptance of the patient’s views and the importance of conveying a desire to alleviate the patients suffering by comforting and offering help.

**Connecting as one human to another**

Wynn also described a “sharing empathy” when the physician expresses that they have something in common with the patient. There are many ways that this can be communicated. Verbal ways of connecting on an empathetic and compassionate level cited in the literature include the use of humor. Dean and Major found through their clinical ethnographic research in health care settings that: “Humor served to enable co-operation, relieve tensions, develop emotional flexibility and to 'humanize' the healthcare experience for both caregivers and recipients of care”. (p1088)

Studies have also shown that physicians who have experienced illness develop empathy for their patients and are compelled to share their stories with patients to develop a connection. Other research has shown that physicians sharing their own stories can be disruptive and may cross boundaries.

Goetz et al. reviewed the studies on touch and compassion and found that two social processes were involved: soothing and the formation of cooperative bonds. Apker et al. also described how nurses show compassion by connecting through touch to “provide reassurance, esteem and belonging” (p187). Although touch is a routine part of physical examination touch outside of this realm is more controversial amongst physicians.
Factors Influencing the Showing of Compassion

There is evidence to suggest however, that patients and physicians sometimes have differing views about what constitutes compassionate or empathetic behavior. For example, Skaff et al.\textsuperscript{211} found that patients validated only three out of the ten elements of compassion identified by physician assistants; those validated were centered on the concept of communication. Another study by Lin et al.\textsuperscript{225} used in-depth interviews with emergency patients and their doctors to qualitatively analyze perceptions of empathy. They found emergency physicians and patients perceived physician empathy differently on numerous levels. For example, emergency physicians thought they were showing empathy by trying to relieve physical discomfort, while patients were looking for psychological comfort. However, scales are being developed to measure physician empathy and are being validated by studies regarding patient perception. For example, Glaser et al.\textsuperscript{226} used the Jefferson Scale of Patients Perceptions of Physicians Empathy to validate the Jefferson Scale of Physician Empathy and found that the two were correlated. In addition other studies have examined what it is patients expect from communication with their physicians. For example, Hammond and McLean\textsuperscript{227} asked parents and caregivers what medical students should be learning about communication with children and families. Many of their recommendations included the kind of compassionate communication discussed above, i.e. being non-judgmental, listening and trying to understand the whole picture.

Foundations of the Doctor Patient Relationship

The foundational elements of the patient-doctor relationship are important in showing compassion. Phillips-Salimi et al.\textsuperscript{228} reviewed the literature to better understand the concept of connectedness in patient-provider relationship. Seven attributes of connectedness were identified in this review: intimacy, sense of belonging, caring, empathy, respect, trust and reciprocity. There are several models in the medical literature that describe the elements in a compassionate patient-doctor relationship. For example, in the Patient-Centered Clinical Method,\textsuperscript{5} compassion, empathy, caring and trust are considered fundamental to the patient-doctor relationship. Ridd et al.\textsuperscript{229} in their review
and thematic analysis of qualitative studies characterized the four main elements of the patient-doctor relationship as knowledge, trust, loyalty and regard.

Trust is central in all of these models. According to Fugelli, trust implies a transfer of power to another whose sincerity, benevolence and truthfulness they believe will ensure they will act in their best interest. With this in mind, it would appear that trust would be enhanced with a compassionate approach and would aid in building patient-doctor relationships.

A qualitative study conducted by Scott et al. endeavored to define the “Healing Relationship” between patients and physicians. In their analysis hope, trust and being known were the desired relational outcomes and many of the processes that develop healing relationships were related to compassion (non-judgmental stance, connecting, presence, accessibility and caring actions). Another interesting component to their model was the different processes that occur in these relationships over time. “Valuing” through non-judgmental stance, connecting and presence happens in single encounters. “Appreciating power” through partnering, educating and pushing (encouraging the patient to do something they are initially reluctant to do, for their benefit) occur in single encounters and over time. Finally, “Abiding” by being present for major health events, being available, committed and caring occur over time. Ridd et al.’s review of the qualitative literature suggested that although quality of the patient-doctor relationship might improve over time it also depended on the quality of the interactions. They found that patients viewed empathetic physicians as having a better understanding of them and the knowledge developed over time was an important factor in the perceived quality of the relationship.

**Difficult patients**

The ability to show compassion may be impeded when physicians are caring for patients they find “difficult”. Some examples are patients who have symptoms that don’t improve, who are demanding, have multiple morbidities or psychiatric problems, or are drug seekers. Elder et al. conducted a qualitative study exploring techniques that respected family physicians used when working with these “difficult” patients. Several of the
strategies revolved around using empathy and power. Clashes between patient behaviors and physician traits were identified as being at the crux of difficult encounters with these patients.

These findings resonate with research that has examined the role of appraisal in compassion. Goetz et al. argue from an evolutionary perspective that if compassion exists for mutual benefit, a process of appraisal must occur to determine likelihood of benefit. Through their review of the literature, they identified several appraisal steps that occur during compassion. First, individuals consider whether the outcome of the other person’s suffering is relevant to their wellbeing (alternatively, does the person’s suffering satisfy a goal for them which might lead to happiness or schadenfreude - pleasure from another’s misfortune). Secondly, they contemplate whether the person is deserving of help (if not they revert to anger) and finally, they assess whether they have the resources to cope and help in the situation (if not then they revert to anxiety, distress or fear).

Certain patient traits and behaviors may instinctively cause physicians to react with anger rather than compassion because of this aspect of “not deserving” compassion or relief from suffering. This concept is related to the role of mindfulness and emotion regulation in developing compassion. Halpern, in her article looking at patient-doctor conflicts, also promotes the notion that emotion regulation and empathy can be used to resolve issues. Olsen examines empathetic maturity in the nurse-patient relationship which ties into this notion of deservedness. He proposes that empathetic maturity develops over three levels. As one progresses through the levels there is a shift from self-centeredness to appraisal of the patient in relation to how the nurse understands the world and finally, to a non-judgmental approach where the nurse is able to find meaning in the situation regardless of the patient’s behavior.

External Factors Impacting Connection

Difficult patients may challenge physician compassion but there are other factors outside the patient-doctor relationship that can make it difficult for doctors to connect with their patients. As previously discussed, the biomedical emphasis in medicine has had a negative impact on the role of compassion in the patient-doctor relationship. Some of this
is thought to be due to the scientific culture of objectivity and repression of emotions.\textsuperscript{235} However, it can be argued that scientific progress has also created a technological barrier. Some would dispute that our over-reliance on technology inhibits us from developing connections.\textsuperscript{236} Advances like the electronic medical record have raised concerns about how the physician connects with patients,\textsuperscript{237-239} although a recent review article\textsuperscript{240} points out that the research to date has not confirmed these concerns.

Physicians have also raised concerns about how evidence based medicine may usurp the patient-doctor relationship in the form of clinical practice guidelines. Family physicians are concerned that guidelines don’t apply to many patients and do not promote patient-centered care.\textsuperscript{241, 242}

**Time and Connection**

The challenges of family practice are well known: paperwork; feeling undervalued; long waits for accessing specialists, diagnostic tests, and community resources; difficult patients; and medico-legal issues.\textsuperscript{103} Many issues that frustrate physicians are ones that impact time. These can be environmental factors\textsuperscript{225} and organizational factors\textsuperscript{172} that result in issues such as patient overload and bureaucratic red tape.\textsuperscript{243} A shortage of time may also impact the ability to connect and be compassionate. Exploring psychosocial issues\textsuperscript{10} or providing counseling\textsuperscript{244} takes time and there is some evidence to indicate that family physicians who subjectively experience lack of time are less patient-centered.\textsuperscript{245} Yet there is evidence that compassion can occur in a small amount of time. Fogarty et al.\textsuperscript{246} looked at the impact of viewing forty seconds of standard versus compassionate physician videotapes on anxiety levels in breast cancer survivors and found a significant reduction in anxiety in the latter group. Some authors suggest that compassion and attentive listening are skills that when they are fully developed, actually save time.\textsuperscript{247}

One qualitative study has looked at the issue of time and exploration of psychosocial issues. Marvel et al.\textsuperscript{248} compared transcripts of clinic visits with patients who saw either family physicians trained in counseling or community family physicians. They found
that, although the former group demonstrated more psychosocial involvement and offered more support, their office visits did not differ in length.

2.5 Summary

The definition of compassion in medicine has been examined from the viewpoint of ethics and professionalism. Empathy has been studied in family medicine and is closely linked with compassion. However, there is no clear definition of compassion in the context of family medicine to date.

Current theories attribute the evolution of compassion in humans to the promotion of mutual benefit and there is significant evidence to indicate that physician compassion may benefit patients and physicians alike. Although compassion has been traditionally valued in the medical profession, there is considerable literature concerning the decline of compassion associated with the increased emphasis of science and technology in medicine. Despite this finding, some research indicates that family physicians value compassion though we know very little about how they come to value compassion and what motivates them to be compassionate.

There is good evidence to indicate that compassion is a distinct emotion that is partly inherited and partly nurtured. Although there is significant research to indicate that compassion can be cultivated through multiple methods, there is no research that explores family physicians’ understanding of, or beliefs about, developing compassion. Evidence indicates that compassionate interactions could lead to physician satisfaction but that compassion fatigue can be a significant issue for those caring for the traumatized. However, it is unclear how family physicians experience compassion satisfaction and compassion fatigue.

Research shows that compassion can be demonstrated in distinct modes of verbal and nonverbal communication. In addition, studies seem to indicate that this kind of compassionate communication is important to the development of the patient-doctor
relationship. However, there is little research that explores what family physicians regard as the role of compassion in developing these relationships. Preliminary research indicates that compassionate communication may not take more time; however it is unclear what the family physician perspective is on this.

Medical educators are concerned about the decline in empathy that is evident in medical training. It is proposed that medical trainees are given mixed messages about valuing compassion and that the stresses of training and lack of continuity damage development of empathy. However, it is not clear whether family physicians experience a decline in compassion over their training or how compassion changes over their career.

2.6 Study Purpose

The purpose of this phenomenological study was to address some of the identified gaps in the extant literature by exploring family physicians’ experiences of compassion in the care of patients. This study examined their perceptions, experiences and ideas about the factors which influenced their capacity for compassion at various phases of their training and practice.
Chapter 3

3 Methods

Qualitative methodology, using a phenomenological approach, was employed to examine family physicians’ capacity for, and their experiences of compassion throughout training and in family practice. Phenomenology penetrates meanings and perceptual experiences of phenomena, capturing their interconnectedness and resulting in an in-depth understanding. As a means of qualitative research, in-depth interviews have been used extensively in primary health care to explore a variety of issues and have proven to be an effective means of data collection. In particular, in-depth interviews have been used to examine family physicians’ perceptions and experiences of obstetrical practice, palliative care and burnout and stress. The physician’s understanding of compassion is not only experiential, but unique and personal. For this reason, qualitative methodology, through the use of in-depth interviews is ideal for exploring this topic to elucidate the rich diversified perceptions and experiences of the participants.

3.1 Participant Recruitment

Three groups of participants were recruited: family medicine residents, family physicians practicing less than five years and family physicians practicing more than ten years. These three groups were chosen to reflect three key areas: training, transition from training to practice and extensive practice experience. A purposive sample of participants was recruited by personal and professional contacts. Participants in family medicine residency programs were identified through the Directors of the Family Medicine Residency Program and the Masters of Clinical Science in Family Medicine Program (M.Cl.Sc.) at The University of Western Ontario. Two rounds of emails were sent to residents in the Family Medicine Program inviting them to participate in the study. Residents in the M.Cl.Sc. Program were recruited by the Program Chair by email. Family physicians were identified by the researchers based on prior knowledge and using snowball sampling. This technique for participant recruitment has been found to been
effective means of participant sampling\textsuperscript{255, 256} and provides a useful method of sampling to the point of saturation.\textsuperscript{257} The researchers sought participants who were articulate, reflective, English speaking and interested in sharing their personal experiences and perceptions about compassion in family practice. All family physicians were practicing in Ontario. Potential participants who were interested were provided with a letter of information about the study. (Appendix A, p180)

### 3.2 Data Collection

Twenty two in-depth interviews were conducted at convenient locations within participants’ communities during the time period of April 2007 - February 2008. Thirteen participants preferred to be interviewed in their own homes, six in their offices, two in a mutual friend’s home and one in a library. All locations had good lighting, comfortable seating and a quiet environment. Participants signed study consent forms prior to interviewing (Appendix B, p183). In-depth interviews were conducted using a semi-structured framework of open-ended questions to explore the participant’s ideas and experiences of compassion when practicing family medicine (Appendix C, p184). The duration of the interviews ranged from 55 minutes to 75 minutes. Two audiotapes recorded the entire interview while the investigator took detailed field notes. The confidentiality of participants was assured, questions were answered and informed consent was obtained from all participants prior to commencing the interviews.

### 3.3 Data Analysis

Following each in-depth interview, the audiotapes were transcribed verbatim. The transcriptions and notes were independently reviewed by two of the investigators to identify themes. After independently reviewing the transcripts, the investigators met to compare and corroborate emerging themes. Thereafter, they communicated frequently to organize and re-organize emerging themes and establish connections. The iterative
process was conducted three times for each transcript. Emerging themes were presented to participants in later interviews for further clarification and confirmation. In-depth interviews were conducted until all probable themes were uncovered. For this study, twenty two in-depth interviews were required to reach saturation of themes.

The five phases of the interpretive process comprising of describing, organizing, connecting, corroborating/legitimating and representing the account were employed in an iterative method for thematic analysis.\textsuperscript{250} Immersion and crystallization techniques were also utilized to identify themes and interpret the data. This is an effective technique in qualitative research for analyzing data where the search is one of discovery and the research participatory.\textsuperscript{258} Thus it is an ideal qualitative technique for exploring a topic like compassion which involves personal perceptions and may best be discovered or understood through experiential means. This technique involves “immersion into” the text and an experiential understanding of the text followed by continued reflection and “intuitive crystallization” \textsuperscript{258}(p23). Hence, data analysis occurred before, during and after data collection as requisite of this technique.\textsuperscript{259} Specifically, this included analysis during: the initial study design and preparation the study period when in-depth interviews were conducted, the concluding analysis, the study completion and the write-up. Furthermore, the use of immersion and crystallization technique call for investigators to be cognitively and emotionally engaged in the experience, to be open to uncertainty and to permit time for reflection without preconceptions.\textsuperscript{259} In addition, this technique requires a rigorous data recording the ability to listen deeply to participants and the data itself, time and patience, and guidance from an experienced qualitative researcher.\textsuperscript{259} This study met the above requirements.

3.4 Trustworthiness and Credibility

Trustworthiness and credibility of the data analysis were assessed by several means. Reflexivity, the ability of researchers to reflect back on their own role and participation in the study and to understand and appraise these influences on the study findings and
interpretations, was essential. In this instance, one investigator’s clinical experiences in family medicine and care of the elderly had influenced her perception of the importance of compassion in patient-doctor interactions. As a result, her bias regarding compassion needed to be taken into consideration during both the study design and analysis. The investigator’s cognizance of this positive bias as well as the counterbalance of the co-investigator, who worked with family physicians, but not as a physician, was felt to neutralize any investigator bias towards positive study findings. In addition, a conscious effort was made to find participants with varying clinical experiences that might result in many different conclusions about compassion.

Other means for assessing trustworthiness and credibility included: “depth of description accuracy, rigor, intellectual honesty and a search for alternate hypotheses and interpretations”\(^\text{259}\) (p193). These requirements were ensured through the processes of: verbatim transcription of the in-depth interviews, rigorous field note use and independent review of the data by the researchers as well as team analysis and member checking during later in-depth interviews with the participants. A third researcher provided a peer audit of the study findings, thus advancing the conceptual understanding of the emergent themes.

### 3.5 Final Sample and Demographics

The final sample consisted of 22 family physicians. Participants ranged in age from 26 to 64 years of age, with an average age of 37 years. Nine men and thirteen women participants were interviewed. Nineteen participants were married and 14 had children. Participants were from many religious backgrounds. Nineteen were brought up as Christians, however only five considered themselves currently practicing and others described themselves in a variety of ways (agnostic, non-practicing, spiritual, humanist, atheist and Muslim). Aside from the one participant who converted to Islam, one other participant was Muslim from childhood and still practiced. One participant was brought
up Sikh but no longer practiced and one participant was brought up in and continued to practice Judaism.

Six participants were family medicine residents at The University of Western Ontario Family Medicine Program (n=3 post graduate year one, n=3 post graduate year three who were candidates in the M.Cl.Sc. program). Seven were family physicians who had been practicing for less than five years (ranging from 6 months to 4.5 years). Nine were family physicians who had been practicing for more than ten years (ranging from 10 years to 40 years). Regarding practice characteristics of participants in the latter two groups, thirteen worked in a family practice clinic part-time or full time. Three participants no longer worked in a family practice clinic but now worked in institutional settings. Many participants worked in specialized areas of family medicine including twelve in geriatrics (including longterm care), nine in acute hospital medicine, five in emergency medicine, two in palliative care, two in inner city medicine and one in obstetrics. Three participants were academic physicians and nine other participants taught medical students or residents occasionally or regularly. Participants practiced in both rural (n=6) and urban (n=16) parts of Ontario. Most participants received their residency training in Canada, except two who did their residencies in the United States of America.

3.6 Ethics Approval

This study received ethics approval from The University of Western Ontario’s Health Services Research and Ethics Board (see Appendix D – Approval # 13171E, p185).
Chapter 4

4 Findings

4.1 Overview

During the interpretative analysis of the participant interviews, several themes emerged from the data. The definition of compassion was the starting point of the interviews and is the first theme in our findings. The subsequent data fell into three categories: the motivation for compassion, the capacity for compassion and the connection in the patient-doctor relationship associated with compassion. Within each of these categories, participants articulated key themes and described boundaries and changes over career. It also became apparent that these three categories were interrelated through feedback loops which give rise to a model entitled “The Compassion Trichotomy”. Another key theme that arose was “The Compassion Barometer” which described how physicians think patients expected their family physicians to have the capacity for compassion always, but to titrate their demonstrations of compassion to their suffering.

4.2 Definition

Creating a definition of compassion in the patient-doctor relationship

During each interview, the participants were offered a definition of compassion in order to elucidate their understanding of the meaning and process of compassion in the context of the patient-doctor relationship. The definition given from the Oxford Dictionary\(^1\) was, “Sympathetic pity and concern for the sufferings or misfortunes of others”. The inadequacy of this definition provoked much discussion about the nature of compassion. Participants described: 1) the underlying attitudes present in compassion; 2) how both emotional and cognitive reflection developed understanding in compassion; 3) a three part process to compassion that consisted of information gathering, empathy and action; and 4) the link between relationship, concern, caring and compassion. The majority of
participants mentioned feelings, empathy, and understanding in relation to compassion. Participants differed in how they described the role of feelings in compassion; however, few expressed different views about the connections between compassion and action and compassion and suffering.

**Attitude**

The word *pity* was universally decried as unsuitable for the definition of compassion. It was seen to be negative, judgmental, distant and hierarchical. One participant described why *pity* does not fit with compassion in the patient-doctor relationship.

> I think pity implies a power differential. I think pity implies that you’re looking down on somebody else. My view of compassion is that you’re actually standing on level ground and that it’s a shared feeling as opposed to “I’m standing here and I’m going to judge you”

The attitude of the compassionate person was seen to be less judgmental than pity implies.

> I guess part of it for me is trying to be an advocate for my patient and not being necessarily judgmental of the things that they do. Compassion to me, in one way, is trying to help them regardless of what issue that they’re bringing to me.

Another participant used the word *respect* in this context. The compassionate physician’s attitude was described as *non-judgmental* and *respectful* and this was seen to be within the context of a *non-hierarchical* patient-doctor relationship.

**Emotion, Cognition and Understanding**

Most participants felt that both feelings and emotions (feelings associated with a mental concept) were part of being compassionate.

> Compassion is something different than being emotional and sensitive. I think they are separate things but to show compassion you have to have some kind of emotion, whether it’s caring or feeling or sensitivity towards someone. I think there’s an emotional component definitely.

*Sympathy* was a word that participants thought went well with compassion, as it was related to feelings. One participant described it as, “*Sympathy is what you feel about*
what their suffering is all about.” Thus the sympathetic physician feels the patient’s suffering.

One participant felt that one could be compassionate without having feelings for the patient: “compassion doesn’t necessarily mean that you have to feel anything for that patient, it just means you understand what they are going through.”

Understanding was a key word used by participants in relation to compassion. Participants associated understanding more with empathy rather than sympathy. Empathy was a word that many participants used to encompass the process of feeling, reflecting and understanding that occurs as part of compassion. For example: “When I feel compassion for someone I feel that I can place myself in their situation and understand and empathize with the feelings that they’re feeling and where they’re coming from.”

Many participants described this process as “walking in someone’s shoes”.

In order to develop an empathetic understanding of the patient’s situation, participants felt that the physician must be aware of both their own feelings and the patient’s feelings. The following participant described the process.

When I go into a room with another person there are feelings in the air. I have to know what mine are so that I can subtract those from the feelings in the air. Then I know what that person feels. Then because I’m a human and they’re a human I can imagine where they might be and then I can take that feeling that I am imagining into my thinking area and try to develop an idea.

When participants described this empathetic process of feeling, reflection and understanding, it was often followed by an expression of empathy. For example: “If you are trying to make them feel better too and you’re kind of reflecting and saying ‘yes I can see what you’re going through and it’s really hard for you’. That’s the empathy part.”

Information Gathering, Empathy and Action

Many felt that some action as described above was part of being compassionate. For example one participant described the process of compassion as being three-fold. “I think
there is an element of understanding in it. So... seeing and understanding and responding.”

Thus, prior to the process of analyzing feelings, reflecting and understanding, there was an information-gathering process. While seeing was the word the above participant chose to describe the information-gathering component, most participants used the word listening. “I think one thing about compassion words like empathy and understanding and even just patience – those I think are the big ones – and just taking the time to just listen.”

The final piece of the process was described by many as action or support. For example: “And I think compassion also implies a little bit more of action, rather than a passive emotion. It’s something that implies you want to do something or you want to act upon it.”

Another participant described the process of compassion, the interaction of the emotional and cognitive processes and how they lead to an action.

I can understand their situation by a resonance in my humanity. I don’t fall apart or anything with those feelings, but I transfer it into knowledge and think about it. From the thinking then I can imagine ideas about what might be useful for me to do; whether I should touch the person, whether I should develop some sort of plan, whether I should give them something for whatever their symptom is. I think that compassion allows you to develop ideas around what is useful and what your plan might be to help the person.

Other action-related words described by participants included help and support. For example: “...then if you have more compassion you have more desire to help.” Or as another participant stated, “There is some combination that’s necessary where you can understand and appreciate the patient’s world view and then be compassionate and supportive – there’s another word, supportive”.

From this it might be gleaned that compassion is something we can feel and/or show. Feeling compassion can compel us to action, however it is when we are showing compassion that we take action.
Caring, Concern and Relationship

Caring was another word that many participants linked to compassion. It was also described as having a feeling and a showing component. Again, the showing component was more action-oriented. For example, “taking care of” or “caring for”. The word care was also used as a feeling associated with compassion. For example, “I care”. The following participant attempted to articulate the depth of caring that is associated with compassion.

When I think of the word compassion it evokes an image of someone not just being concerned but wanting to understand the other person and what that person is going through and trying to offer support and care for them or even a type of love for that other individual.

Concern was also a word that participants associated with compassion and caring. The above statement, however, alluded to the fact that concern was not action-oriented. “I am concerned” was used in a similar way to “I care” but did not have a component of action or perhaps the same depth of feeling. The following participant associated it with the word interest, which was more intellectual.

I guess I would think of compassion as just a general concern for others well-being, not only when they are in a very difficult situation, but also when you’re seeing someone for a routine type of thing. You have some interest in who they are and what they are all about.

Both concern and caring were described by the participants as elements that grow as the relationship with the patient grows.

Over the course of several meetings I think it may become evident that you’re concerned about the person that you’re treating despite the fact that you’re not discussing issues of a necessarily extremely personal nature.

This links the quality and length of the patient-doctor relationship to the degree of concern, caring and compassion. Underlying this relationship, participants described a common human bond and several felt that compassion was either a product of or an adhesive for this connection.

Maybe compassion is the part of what we do that allows us to connect as human beings together as opposed to physician-patient. So it’s that part of the physician-
patient relationship which is not teacher-learner, it’s not diagnostician, it is validation of the human experience with another human being.

**Suffering**

In the definition that was given to the participants, compassion was described in relation to the “misfortunes and sufferings of others”. One participant raised the possibility that it might be possible to have compassion in less negative instances also.

*I hesitate because I think there are times when people don’t necessarily feel negatively about their experience but they need somebody who understands and that might possibly qualify as a function of compassion not necessarily related to sufferings.*

By and large, however, compassion was seen to be in relation to suffering and misfortune. One participant summarized the process of compassion in relation to suffering.

*Compassion to me is somehow “with suffering”, so you are not engaging in the suffering process yourself. The resonance of that ‘walking along with’ in some ways is a compassionate response. I think empathy has both an emotional and a cognitive component to it but it’s an attempt to achieve an understanding. Compassion seems to be more on the support end. Empathy doesn’t necessarily have to be a supportive process. It’s more a reflective and understanding process and through that some support is achieved but the idea of compassion to me has more to do with the holding up of somebody who has the experience of the suffering.*

**Summary**

Participants described compassion as a complex process within the patient-doctor relationship. They believed it occurs when a patient is suffering or presents to the physician because of some misfortune. For compassion to be present, they believed the patient-doctor relationship must not be hierarchical and the underlying attitude of the physician must be respectful and non-judgmental. Participants illustrated how the process of compassion within the physician involves both an emotional and a cognitive component; hence, the optimal distance between physician and patient is the one that allows for both objectivity and emotional engagement. The process of compassion within the physician can be described in several steps.
1) Information gathering, seeing and listening to the patient.

2) Identifying feelings of both the physician and the patient. Sympathy may occur in this step if the physician feels the same feelings as the patient.

3) Reflecting on the patient’s feelings and situation to gain a better understanding. This is done by imagining themselves in the patient’s current situation. This results in the expressive component of empathy which is a conveyance of understanding to the patient.

4) Combining this understanding and the physician’s medical knowledge, problem solving then occurs and an approach or plan formulates in the physician’s mind.

5) Having developed understanding and empathy, the physician feels a desire to take action. These actions essentially take the form of approaching and proposing a plan of action to the patient. The underlying purpose of these actions is to help and support.

Participants believed the compassionate physician is concerned for the well-being of their patient. They care about their patient and they care for their patient. Their care and concern evolves as the relationship between patient and doctor evolves. Underlying this relationship is a human bond. This human bond is both the foundation for compassion and the product of it.

Based on the interviews with these participants, a new definition of compassion might be: “Compassion is the development of emotional resonance and cognitive understanding regarding the suffering of a fellow human being that evolves into a desire to alleviate said suffering.”

4.3 Motivation

4.3.1 Motivation Introduction

Participants identified three major areas that impacted their motivation for compassion. First, participants believed patients wanted compassionate physicians which they felt
motivated family physicians to be compassionate. Secondly, participants described the many ways that compassion helped them be more effective in their work. Subsequently, they became motivated to use compassion to achieve satisfactory interactions with their patients. In addition, participants divulged how family physicians’ core values were important motivators for compassion. Participants also expounded on how other motivations could lead to imbalances in compassion. Lastly, they described how motivation for compassion evolved over the course of their medical career.

4.3.2 Patients Want Compassion

Participants unanimously agreed that patients wanted compassion from their physicians. They cited this as one of the main reasons compassion was important in the patient-doctor relationship. In this section, the analysis is related to how physicians know their patients want compassion, why they think patients want compassion and whether they think patients want compassion all the time. Based on feedback and personal experience, participants understood their patients’ desires for compassion to be of varying levels, depending upon the visit and the patient’s experience of illness.

**How do physicians know their patients want compassion?**

Participants knew patients wanted compassion because they received direct or indirect feedback from patients when they used a compassionate approach. They also described how the patient-doctor relationship and decision making with patients were positively influenced by the use of compassion. Furthermore, participants noted how a lack of compassion was often present in negative interactions described by patients with other physicians. Finally, having their own personal experiences as patients and caregivers, the participants expressed their own desire for compassion.

Participants knew patients wanted compassion by the personal feedback they received. In their experience, when they listened and empathised their patients were very
appreciative and told them so. For example, this participant said, “*I have gotten personal feedback from patients, ‘Oh you’re such a good listener’ or ‘Thank you for listening,’ and ‘You helped me work this out.’*”

Feedback to the physician also happened outside the encounter with the patient. They described instances where the patient made a comment to another staff person or another patient. Comments were conveyed in person, by letter or even on the internet.

Some participants described how staff members were conduits of patient feedback.

> I have managed to have a lot of good relationships with my patients and I think it has to do with how I show compassion and my nurses have told me that “the patients thought that you listened and they really like that”.

A few participants mentioned websites which evaluate doctors and how through this form of feedback, they knew patients want compassion.

> I think that’s the whole reason that you’ve had these websites spawn like ratemds.com where people just want to get on there and bash or applaud the physicians that have been good to them. It is the way that patients feel that they’re treated, from not a medical perspective but just from - “Were they nice to me?” “Did they take time with me?”

Participants commented that the remarks on these websites focused largely on the components in the patient–doctor interaction associated with compassion. According to the participants these websites made it clear that patients wanted compassion from physicians. However, participants stated that they also know this because of what patients say about encounters with other physicians. “*When people talk about other doctors it kind of gives you some sense of what they expect from you as a physician.*”

Participants also stated that when they were compassionate visits with their patients were enhanced. They described how the decision making process during the visit was better for both parties when they were compassionate.

> I always find that I get more from my patients if I’m more compassionate. I’ll get more of the story. I’ll get a more complete picture. I’ll get more buy-in from them in terms of what we’re trying to achieve. It’s easier to come to decisions with them if they feel that you really are compassionate. I think a lot of it is by experience. If I take that extra step to demonstrate or make them feel like there is
compassion for the situation, the whole process moves along better. Overall it’s more satisfying for all involved.

Participants felt that their patients were aware that the compassionate approach resulted in a more satisfying visit. They felt cared for and heard, and the outcome of the visit was more satisfying with regards to the treatment plan and agreed-upon decisions.

Negative feedback about other physicians often pointed to a lack of compassion.

You hear about doctors who don’t listen. For instance yesterday I had a patient who said “This doctor came in and showed me this and said oh you’re pregnant” and left the room. There are always so many people talking about their interactions with doctors that they didn’t really find compassionate.

Participants also received feedback about the lack or abundance of compassion in other physicians when working with students or residents. They received feedback from patients about their trainees which often highlighted the patients’ desire for compassion.

Working with residents you would hear either complaints or accolades in how they deal with patients. You get the negative comments usually when people have felt that they weren’t listened to. Feeling “listened to” has a lot to do with compassion because it is self expression of feelings and emotions tied to the medical problems. If they felt somebody wasn’t understanding or listening or seeing eye to eye with them, appreciating their experience, then they are not satisfied. I also found that all the good residents are those who are able to show compassion.

Finally, participants who had experiences within the medical system as a patient or caregiver stated that being “on the other side of the equation” also demonstrated to them the value of compassion from the physician.

I guess we’re all patients at some point in our life and as a family unit we’re patients as well. From those experiences, I know I would want, and I’ve had, compassionate physicians. I don’t think it would be a good experience to have an uncompassionate individual caring for me because then I don’t know if they would truly be caring for me.

One participant provided an example of a personal experience with a relative in the emergency room.
I was going to the Emergency Room with my Grandmother and my folks were so relieved when she saw such a nice doctor. She was very worried about her condition and he recognized that and said some things to put her at ease. Just from being on that side you really recognize how he could have easily come in, did the same physical exam, derive essentially the same results but because of just taking that extra time, being a bit gentle, saying a few things - that really made the difference in how she felt.

As patients and caregivers, participants experienced first-hand the benefits of dealing with a compassionate physician, and extrapolated that other patients would desire the same treatment.

**Why do patients want their physician to be compassionate?**

Based on these experiences, participants articulated why patients wanted compassion from their physicians. They felt that patients wanted their physicians to listen and be supportive. Participants also commented on the state of the patient at presentation and how it related to their desire for compassion. Patients often presented in a state of suffering, either sick, worried or both. They felt vulnerable as their issues were often of an intimate nature. Participants remarked that the type of problems that patients presented with were often complex, with emotional and social issues. Patients wanted to feel connected to their physicians and be treated as a human beings rather than diseases. As a result, they believed patients wanted a compassionate approach.

Several participants stated that their patients wanted to be *listened* to because they were worried and sick. They argued that patients often presented to their physician because they were suffering either physically or mentally. As compassion involved listening and implied a desire to alleviate suffering, participants felt their patients sought this in their physicians “… because somebody is coming, generally, when they are at their worst. Either they are worried about something or really sick. So they need to feel like they are being listened to - so compassion helps.”

While this participant articulated the desire of those who were *experiencing illness* to be heard, another participant pointed out how problems patients shared with their physicians were often very *intimate*. Because of the intimate nature of their problems
patients often felt vulnerable. In order to lessen this sense of vulnerability, patients wanted a non-judgmental, respectful and understanding physician.

Especially in difficult situations, but really in any situation, you’re sharing something very intimate - your body, your symptoms... It can range from a cough or cold or maybe sexuality, fertility, mortality, fears. When you are sharing something that intimate you want that person to have some compassion for you and treat you like a human, treat you kindly, have the signs of compassion (sympathy, empathy for whatever you’re feeling), honoring your values and choices.

Participants also remarked on the complexity of the issues presented by patients. There could be many intersecting components, including physical, mental or social. The following participant’s comments expanded on this idea, noting how the illnesses patients presented with often had an emotional component and were multi-factorial.

Illness is so multi-factorial and there are so many different things that come into it. Patients experience, not only the physical, but an emotional component as well. There are so many questions that patients have about well-being and death. You have to be compassionate. You have to understand that they are not taking their car in to get fixed. You can be very good at reading an x-ray or reading a lab value but if you can’t put that in the perspective of the patient and how it impacts on all the different facets of their life, I don’t think you are really doing anybody any favors.

Participants viewed the compassionate physician as able to grapple with the emotional aspects of illness and grasp the impact illness had on their patients’ lives. They felt this was one reason why patients wanted compassionate physicians.

Participants remarked on how patients often present with social issues and, in these instances, patients might not have adequate support networks. As one participant articulated, patients who lacked other social supports looked for support from their physician and consequently wanted a compassionate physician.

Sometimes that’s all they need - just to have someone outside of their home environment or their friends to listen to them and to offer support. Perhaps they don’t have that kind of support. You always have more needy patients than others but I think any patient would expect their physician to be compassionate.
Compassionate physicians were viewed as more supportive and more likely to rally social supports when required.

Participants articulated that patients wanted support from their physicians but they also wanted to feel connected with them.

*It can’t just be simply task oriented or question/answer - “off you go”. I think people want to make a connection, need to make a connection, and often I find that the connection is more important than what you do for them at the end of the day.*

Participants felt that because patients wanted this connection, they sought a compassionate approach from their physicians. Many participants described this as a human connection or connecting on a personal level. Several commented on the desire of the patient to be seen as human or as a person and not a disease. Connecting as a human being was a function of compassion.

*I think the patient wants the physician to see them as a person and I think that it's easier for us sometimes to fall back on disease, especially when things get a little bit tougher for the physician or the patient to handle.*

Participants stated that patients wanted understanding of and caring about their unique situation and when this was demonstrated by the physician, their patients felt like a person with an illness rather than just a disease. Understanding and caring are two integral parts of compassion and participants observed how patients in the care of a compassionate physician were treated more as unique individuals.

*When you’re in the midst of illness you can feel like you’re the only person experiencing that, or that no-one else really gets what’s going on. So if your physician makes an effort to be compassionate and to gain a greater understanding of what’s going on with you, that helps you get through the whole process - to know that there’s somebody else who cares. It’s in context - a personal thing instead of just the disease.*

**Do patients want compassion all the time?**

Without hesitation, participants articulated that patients wanted their physicians to be compassionate. However, they did not believe patients wanted to be shown overt
compassion all the time. They viewed patients as expecting a gradation of explicit compassion based on their presenting needs.

I don’t think that patients necessarily have an expectation for a lot of compassion when they come in for their sore throat or medication. But larger issues, or even just issues that we might not consider disease-related issues, like when the patient comes in and they’re having difficulties in a relationship… I think they look to their physician for some compassion.

Participants explained that when patients expected a quick visit or had a very specific and uncomplicated goal for the encounter, they were less likely to seek compassion. In instances where their main complaint centred on more emotional or complex issues, patients were more likely to seek compassion from their physician. Some participants described compassion as something that the physician “turns up or down” based on the circumstances. This was labelled as the “compassion barometer”.

So on that compassion barometer for that person who just comes in with their script it’s turned down, but the patient knows that they have this physician that is compassionate and so if something arose they could turn that barometer up and could be potentially more caring, more compassionate – even though it’s not necessary for that visit.

Participants noted that even if patients wanted “you to be different things at different times, they expect you to have that capacity [for compassion] if necessary.” Participants also distinguished between being compassionate and showing compassion. “I think it’s different to be compassionate, have the person’s best interest in mind and be trying to help them, versus being overtly compassionate.”

After distinguishing these two types of compassion, most participants felt patients wanted their physicians to be compassionate in a latent manner or have the capacity for compassion at all times. However, overt or more demonstrative compassion was the kind of compassion which physicians needed to adjust “up” or “down”, based on the requirements of the patient. The following participant pointed out that in acute situations, patients wanted the physician to take action first and foremost.

I think there’s always a place for a little compassion. I don’t think you ever want to take it out of the equation but if someone’s in the middle of Acute MI and in emerg for Acute Coronary Syndrome you absolutely want compassion but would
rather they be injecting the thrombolysis medication immediately and leaving the hand holding for a little bit later. “I would be happy if you could relieve my small bowel obstruction and then be supportive”. There are clearly times when - “Intubate me first.”

Participants made it clear that patients did not want compassion to come at the expense of other medical skills, especially in more critical situations. Another participant pointed out that patients also wanted their physician to “do a good job” in aspects other than compassion.

Patients want compassion, in the majority, but they want you to perform at your best as well, and under some circumstances if you are to perform the best that you can you might not be at the most compassionate level.

Summary

Participants were adamant in the belief that patients want their physician to be compassionate. This was based on feedback they had received directly or indirectly from their patients, because of what patients had told them about other physicians, and based on their own experiences as patients and caregivers.

Participants elucidated the reasons they thought patients wanted compassion from their physician which included physicians who listen, communicate well, show understanding and are caring and supportive. Participants believed patients wanted these qualities because of the nature of the illness experience. They described the illness experience as having the potential to be intimate, emotional and multi-factorial. The patient may not only feel sick, but they may also be worried about their illness and feel vulnerable. Participants thought patients wanted to connect with their physician and be seen as a human being with an illness rather than simply a disease.

Participants perceived patients as wanting compassionate physicians but not needing demonstrations of compassion all the time. Most participants believed compassion should underlie all patient interactions but how much to demonstrate varied. Some described this as “turning up and down the compassion barometer”. This was the key finding in this section. In the acute situation, participants felt that sorting out the problems should take precedence over compassion. Participants made it clear that
patients also want their physician to be good at their craft outside of the skills of showing compassion.

4.3.3 The Impact of Compassion on Physician Effectiveness and Patient Care

Participants felt compassion was not only important because patients wanted it, but because compassion facilitated many aspects of patient care. They described how compassion played an important role in their interactions with patients and made them more effective in their role as physicians.

Participants explained how compassion aided them in history-taking, diagnosis and treatment. They indicated that the non-judgmental approach associated with compassion facilitated open communication and full disclosure in a caring context. This aided physicians in getting a better history and allowed them to learn more about their patients’ lives. With a comprehensive history, participants noted that they were able to make accurate diagnoses. Compassion also contributed to better diagnoses by enabling the physician to get a better understanding of the whole person, their feelings about their illness, emotional issues and hidden agendas.

Participants viewed compassion as enabling them to meet the needs of their patients better when planning treatment. They explained how compassion facilitated finding common ground regarding treatment plans and seeking solutions that met emotional and physical needs of the patient while taking their context into consideration. Participants indicated that patients were more likely to adhere with these treatment plans and resolve differences directly with their physician when a compassionate approach was used.

Participants described how compassion impacted patient care outside of their direct interactions with patients. Role modeling compassionate approaches for family and staff members was thought to impact patient care. Similarly compassionate dealings with staff
members were viewed as facilitating communication and positively impacting patient management.

**Compassion and History-taking**

History-taking was a central function in understanding patients’ presenting problems. Participants believed compassion could be key to obtaining a full history.

*I think its [history-taking] really basic to medicine and I think the problem is that we’re getting so evidence-based oriented and people are on the internet coming in with what they want. We just have to be careful because history is still a big part of it. I think that’s where compassion comes in.*

Most participants thought compassion facilitated more open communication, which aided history-taking. Several participants felt it was the trust, fostered by compassion, which enabled more open disclosure from patients and thus enhanced the history-taking process.

*I would say patients are going to have more trust in you. They are going to open up to you more. They are going to be just more upfront with you and it’s also going to allow you to understand what it is that they need and allow you to provide better care.*

When compassionate physicians let their patients know that they cared this enabled disclosure. The following participant gave an example of how the caring, compassionate physician might encourage a patient to open up about their history of drinking.

*We know, for the most part, that people don’t tell us the truth about how much they drink or just how out of control it really is. When we acknowledge to someone that it’s ok to talk about that and you care about them and wouldn’t want them to hurt themselves, patients are more open and honest with us.*

Participants also considered the non-judgmental attitude of compassionate physicians central to gaining patients’ trust, and thus facilitating the disclosure of shameful or difficult information during the history-taking process.

*They can open up to me. It’s easier to talk to me because I’m a bit more compassionate or more understanding, more open. People have also told me secrets in their lives or important things that they’ve done that they may have been ashamed of. People have said that they feel they can open up to me and say things and they won’t be judged.*
In addition to disclosing sensitive topics, participants observed that patients shared details about other aspects of their lives. Participants described how a compassionate patient-doctor relationship allowed patients to communicate about their life at home and work. This broadened the physician’s understanding of their patients’ symptoms within their personal context.

*I think for me it makes the relationship a lot richer when I do have compassion. Sometimes you have a really good relationship with a patient, so you are able to communicate fairly well and you have an idea of their life outside of what you see in the office. Having compassion gives you insight into what’s going on that you might not get otherwise.*

**Compassion and Making a Diagnosis**

Compassion facilitated history-taking by allowing the patient to open up thus facilitating the physician’s understanding of the patient. They emphasized that treating *people with illnesses* rather than isolated *diseases* required a deeper understanding of the person and their situation. For example, the following participant described how compassion aided physicians in recognizing contributing factors and making a diagnosis by looking at the whole person.

*More and more now we’re starting to recognize that it is the whole person that we’re treating and not just the symptoms. Even if we looked at it from a purely biomedical point of view and said “our role as a physician is just their medical health – their physiological well-being,” so much of it is influenced by other factors and unless we’re compassionate we won’t be able to recognize those other factors. So, two people coming in with stomach complaints; one can be because they have a ruptured appendix and one can be stomach problems because of unresolved issues at home and if we’re not compassionate we’re not going be able to recognize and treat that.*

Participants recognized that to make an accurate diagnosis, the physician must have some understanding of the patient’s emotional state. They described how compassion enabled physicians in their understanding of patients’ *feelings*. This facilitated their ability to better understand the patient’s perspective and analyze the problem at hand.

*I think that it is almost impossible to be a family doctor and care for people without being able to understand their situation and the feelings that evolve from whatever they’re going through. It is hard to get there without coming up quite*
close to the person. Unless you have the ability to be compassionate and the person feels that back from you, then I don’t think you can get close enough to feel what they feel, and therefore know how to transfer that feeling into knowledge, and know then what might be your response.

Participants pointed out that gaining access to feelings was most helpful when dealing with emotional and social issues and instances where illness had significantly altered the lives of the patients. In all of these examples, participants felt that compassion assisted their understanding of the issues distressing their patients. “It helps more with those more emotionally charged issues, the psycho-social stuff, the chronic illness and the impact it has on peoples’ lives. Those are the people that I tend to be more compassionate with.”

Patients were naturally reticent to share issues of an emotional, psychological or intimate nature with their physicians. Participants believed this led to “hidden agendas” whereby patients would present with one issue when really they wanted to discuss another more difficult issue. However, they found that when compassion was part of the interaction, it was easier to access these underlying issues. In this way, they avoided making the mistake of a more superficial or one-dimensional diagnosis.

Some people have much bigger problems. If you don’t have compassion then it would be easy to get through the mechanics of that visit and address all the medical stuff without really addressing their true need. They obviously have a need for coming for that visit because this one issue is bothering them and if you don’t have true compassion I don’t think you can address that. I don’t think you can actually understand that person or give that person a sense that you truly care for them and want to help them.

While compassion assisted in identifying issues and making the diagnosis, participants also emphasized that an increased understanding of the patient sometimes had minimal impact on the diagnosis or treatment. Nonetheless, a deeper understanding of the patient as a person was regarded as valuable.

Even within the patient-centered model you’re doing it so that you can understand their disease a little bit better, or that’s kind of the slant that you’re given throughout your training. It’s important to know the context and you get this context because it’s going to help you with the disease bit or you get it just to gain greater understanding of the person and sometimes that has nothing to do with the disease and it’s not going to actually help change your management at all. It just gives you a greater understanding of the patient.
Compassion and Treatment Plans

While participants described how compassion assisted in establishing a diagnosis, they also reported how compassion assisted in achieving a treatment plan.

*It helps you in terms of your plans - what you’re going to be doing for your person, your recommendations. You can use that to modify what you suggest. It’s the basic back bone of the relationship but also within the context of a day to day visit it can help you in terms of finding out what’s really going on, diagnosing. It also helps you in terms of what your plan is and what your course of action is going to be.*

When compassion was present, participants observed how treatment plans were more caring in that they met the emotional needs of the patient as well as their physical needs. As a result, patients felt better cared for.

*I think it facilitates the end goal of being able to care for your patient and by care I obviously mean much more than just looking after the medical needs of the patient - also the emotional and mental needs of the patient. It would be a key function for me to be able to care for my patients.*

According to participants, the compassionate physician was more likely to look at the whole person and develop a management plan specific to that patient. “*Compassion and caring is looking more at the whole person - as opposed to a disease. If you have more compassion and you have more care, maybe you are able to tailor the treatment towards that patient.*”

Similarly, a compassionate approach aided physicians in helping their patients explore different treatment options and choosing the most appropriate one. Compassion helped the physician with their approach to and understanding of their patients during this process.

*If you are compassionate towards your patients you have a much broader, more in-depth understanding of your patients which will help you deal with their issues medically, help you know how to approach them in their choices, to deal with illnesses. I’m looking at it for chronic illnesses to help them put in perspective what their choices are and how it applies to them. So I think it helps you actually do the patient management part more.*
Participants related that part of treatment planning involved understanding the patient’s context. Compassionate physicians who explored their patients’ illness experiences gained a better understanding of how it impacted their patients’ lives. This could lead to a better understanding of which treatment options would most benefit the patient.

Compassion deals with their perception of their illness, the impact of the illness on their day to day, the impact on their other illnesses or on their own philosophy or well-being, how they perceive life and how it’s going to interact with other aspects of their lives be it family interactions, be it their job, be it their outlook, be it their religious background. It has to do with the experience of the illness.

Participants also perceived the compassionate physician as being aware of patients’ expectations of the visit and how this understanding of patients’ expectations helped formulate a better plan of treatment.

I think it allows you to understand what they need when they are coming to see you with a particular problem. Maybe they just need a little reassurance or they just want information, just want you to do something for them. I think that will lead you to better satisfy what they need and you’re going to help yourself in trying to understand.

Participants believed that with a compassionate approach to treatment planning, patients were satisfied with the outcome of their visit and more likely to be in concordance with the agreed management plan. The following participant remarked how compassion and caring played a role in patient concordance.

I think we underestimate the compliance of our patients with our treatment regimens. A large part of that really depends on if the patient feels that the physician genuinely cared about them. Sometimes it’s just taking that extra moment to explain the right way to take it, to explain side effects to a patient, to say “This is something you might encounter”. To take that extra step I think the patient feels like “OK this doctor actually cared about me”.

From a compassionate stance, the physician was able to perceive what would be helpful to the patient including what they might expect during their treatment. In addition, participants believed that patients were more likely to value the advice of a compassionate physician, thus strengthening their adherence to treatment plans.

If you are a compassionate person in general, part of that being a good listener, a good communicator, trying to understand where the patient is coming from, they
are going to value your advice. You can arrive at similar conclusions to agree on a plan, a therapeutic alliance with them, if you have a solid relationship.

As a consequence of developing a strong therapeutic alliance, participants thought that patients received better care from compassionate physicians. Some participants suggested that patients were more likely to address problems or concerns they had around their care directly to a more compassionate physician. Subsequently, if the physician made errors, patients chose to deal with the mistake within the patient-physician relationship. Participants believed this came about because compassionate physicians communicated their intent to help and support their patients.

We know that doctors tend to get sued because they don’t communicate well but if the patients know they care about them then they’re less likely to complain about us to someone else. They may complain to us but that’s different than complaining about us to the College. So I think people are more likely to be able to sort differences out with their individual family physician when they know that their intention is to help and I would expect that compassion would be an element of that.

Compassion and patient care outside of the patient-doctor relationship

Participants described ways that compassion had a constructive effect on others outside of the patient-doctor relationship. Several participants thought that compassionate interactions with families, staff and other patients had a positive impact on their patients as well. This participant relayed how a compassionate interaction with one patient may benefit an interaction with another patient.

Sometimes you don’t get the opportunity to have compassion for all of your patients, all of the time, because the things that you see or do for them are not necessarily compassion inducing. But when you have that opportunity I think it really makes that relationship richer and gives you greater insight into some of those other patients that you have that you haven’t maybe had that kind of relationship with.

Not only did a compassionate relationship with one patient impact other patients but participants believed it also impacted the way others interacted with the patient. For example, this participant described how a compassionate interaction with a patient modeled behavior for family and staff.
Around other people you have some modeling way of behaving around someone who is in distress. You do that with family members, with anybody who is around. Certainly in institutions you do it with staff and maybe when you do it with a little more thoughtfulness, talk a little louder so people hear what you say, that is a demonstration of a way of approaching people.

Others pointed out that a compassionate approach with staff also improved patient care by improving staff-doctor communication. One participant described how compassion improved communication with staff.

... how important compassion is in our relationships with colleagues, residents, allied health people, nurses that we work with. It’s so easy to get frustrated at 3 in the morning when somebody calls with a lousy story. All you want to do is get back to bed. Just stall for a minute and understand and appreciate the world that they’re in. Maybe they are actually doing their best. So compassion is probably the pause button that allows you to not go down the wrong path.

By showing compassion to staff, participants observed how communication and understanding improved, resulting in better care for their patient.

**Summary**

Participants described how physicians achieved a better understanding of their patients’ issues when communication was open and there was trust between patient and physician. They believed that compassion aided in addressing hidden agendas, psychosocial issues or multi-factorial problems. Participants remarked upon how compassion not only aided in understanding a patient’s situation and making an accurate diagnosis, but facilitated a successful treatment plan. They believed that treatment plans were experienced as having supportive and caring elements to them and subsequently patients adhered to them. When patients viewed the physician as caring, they had confidence in the physician and trusted and valued their opinion. Another sequela of compassionate care that participants noted was that patients felt more comfortable addressing errors with their own physician. Participants believed that compassion also trickled down to other patients, family and medical staff resulting in better overall care for the patient.

They key finding in this section was the generative nature of compassion in patient-physician interactions. The initiation of a compassionate approach was seen to
generate a virtuous circle where compassion, trust, care and understanding grew for
and between patient and physician resulting in patient satisfaction and physician
effectiveness.

4.3.4 Motivation, Core Values and Compassion

Participants were motivated to be compassionate family physicians because it was
important to their patients and it helped them do their job well but also because it was one
of their core values. They described how their families, religions and experiences
developed their motivation to be compassionate. They also disclosed thoughts about
compassion as a core value in the role of physician.

Developing Compassionate Values

Participants described how compassion as a core value developed throughout their life-
time. They believed compassion was developed through many different vehicles. The
following participant elaborated: “It makes a lot of impact on how compassion might be –
the way we were brought up, family, religion maybe, moral values.”

Participants viewed an individual’s upbringing as crucial to the development of a system
of values. Several participants mentioned the role their parents and other family
members played in this process. This participant described the characteristics of her
parents that made them good role models for compassion: “I think my parents have been
fantastic role models like they are really loving, warm, generous people.” Participants
perceived role modeling as the principal way in which these values were handed down.

Participants also believed being brought up in a religion helped them develop their
compassion as individuals. This participant stated: “Some could argue - by going to Bible
School or Sunday school when you were brought up as a child made you a more
compassionate person today.” Some participants went further and commented on the
impact a religious upbringing had on their use of compassion with patients. The
following participant described it in this manner:
Those global concepts from the Bible that you learn at Sunday school stay in you as you grow and that infuses my demonstration of compassion because it’s part of my upbringing. It’s all part of my makeup and so I don’t consciously think of it. It would definitely be influencing the degree of compassion and how easy it is for me to be compassionate when somebody needs me to, because those fundamental beliefs make up my philosophy of living.

Other participants felt that their upbringing in religion had little impact on their development of compassion. They felt that other life experiences were more important.

I’m not necessarily sure how much it is because of my religious upbringing versus other aspects of my life. For example, the Karate teaching experience and maybe even the way I was brought up as a child. Going to church and thinking about some of the things the priest and the homilies have said would give me the periodic checks to say “Are you doing this and are you doing the right things?”. I derived more of my understanding from my surroundings and my more immediate experience.

However, most participants who were brought up in some religious tradition believed that religion developed their concepts of compassion and provided some guidelines for them.

Having an organized religion helps to develop compassion in that it’s almost like goal setting or objective setting for a student...When you haven’t developed a good idea of compassion or if you haven’t developed your own personalized conception of what compassion is, [it] can be helpful. It’s like guidelines - you should follow them to a certain degree but then you should use your own individual judgment.

As well as providing guidelines for compassion, some participants also observed that religious teachers in their faiths provided great role models for compassion. This participant described the compassionate qualities that they modeled:

I often try and think of different clerical people that I’ve encountered over the years too. I think of that really non-judgmental approach that I find a lot of them really do have - very open and compassionate. I try and be like that.

**Doing unto others – motivation for being compassionate**

Participants noted that their personal philosophies related to compassion, provided them with motivation within their work. Despite coming from several different perspectives many participants emphasized the importance in their faiths of “doing unto others”. They
felt that this was closely linked to their motivation to be compassionate at work. A participant described this concept in the Jewish tradition:

> In the Jewish tradition it’s actually connected to the idea of justice and that there is an obligation to achieve justice for all. That would include things relating to suffering so one has an obligation to support...and then the idea of reciprocity. Looking at it from the Jewish themes, the very traditional idea of doing for others as you would wish they would also do for you. There’s something about that in terms of compassion for me too.

The following participant described this concept from a Catholic perspective.

> I’ll be honest; I was probably brought up a very traditional Catholic boy. I’m not doing that now as a family but I think it’s important when you hear “Do onto others as you would have done to you”.

Finally, this participant described the importance of helping others from the viewpoint of Islam:

> In terms of Islam, it does strongly say that you need to be kind to your parents, your siblings – pretty much the same ideology as other religions - as well so be kind to your neighbor and really go out of the way for people that are sick and ailing.

Participants, who considered themselves more spiritual than religious, also commented that “helping those in need” was part of their spirituality and was connected to their motivations around compassion.

> I had very loving parents, a very good upbringing...the general rules but other than that, just being kind, polite and respectful... I think my spirituality brings to it a duty, especially [to] those who are vulnerable, because of their situation, or [to] different groups who are not fully understood by other people, [those] who are stereotyped.

Participants believed their philosophy of “helping others” was an important motivator for compassion in their work, especially when they found themselves drained or overwhelmed by their work. This participant shared a saying that she found motivating.

> I worry about keeping balance. In terms of getting emotionally drained that’s something that really helps – [like] just remembering this beautiful saying “When I die, I hope that the poor, the weak and the oppressed will miss me.”
Participants did note, however, that religion could lead to unhealthy motivations for compassion. The following participant described how pressure and guilt could play a role.

*My Mum’s Methodist which is a lot about self sacrifice, serving the greater good and giving up everything to do that. A number of people on her family’s side are Ministers so they lived in poverty and they did a lot of missions and they went out and lived in Timbuktu. So I grew up with that on one side of my family and then my Dad’s side of the family is very, very strongly Catholic and is along the same lines. I find that influences how you feel - sometimes you feel almost guilty for not being as good as other people. I think that that can affect your compassion. You almost feel like you need to be extra compassionate to make up for maybe not being as intrinsically compassionate as you think other people might be.*

**Valuing Compassion and Physician Motivation**

Participants believed that most people who enter medical training have some of the core values related to compassion. Indeed, for many this was one of the driving factors that led them to become doctors. However, several participants described how in the role of physician, it could be a struggle to keep this value central to their practice. The following participant described the importance of maintaining the motivation to be compassionate over the years:

You are motivated to truly try to understand another person’s suffering and what they are experiencing or another person’s experience of their illness and not just going through the number of patients that you can in a day...If you’re truly trying to understand - your motivation is why you went into medicine way back when - then you’ve kept that belief.

Participants commented on how as physicians they often have to play multiple roles. They believed this sometimes hampered their motivation for compassion. For example, participants described the challenge of having to “break bad news” to their patients, with full and ethical disclosure. In some instances participants thought this impeded compassion. This participant commented: “If you’re not giving them that reassurance people will say you’re not compassionate. It’s kind of a bit of a struggle - me wanting to be truthful about possible outcomes.” Participants believed the challenges involved in trying to be supportive and truthful led to a conflict in values. The many competing
values that accompany the many roles of the physician were seen by participants as detractors from their motivation for compassion.

Another obstacle that participants identified was the motivation of their co-workers. When their co-workers or supervisors were not motivated by compassion, it could potentially impact their value system and their motivation for compassion. However, when they had co-workers with similar values, they felt supported and were more conscious about compassion. They described these positive relationships as ones where “social interactions were psychologically or emotionally refreshing”, people shared the same “value system and work ethic” and where they were able to “vent” and “share stories”. In these situations, the physician’s motivation for compassion was amplified by their co-workers’ motivation for compassion.

**Summary**

Participants believed when compassion was a core value held by the physician, they were more motivated to be compassionate. They described how these values developed through family upbringing, role models, life experiences and religion. The central value that they identified was that of “doing unto others as you would have done to you”. This value was common amongst participants from many different religions and spiritual inclinations. Participants also described how these values often lead physicians into medicine as well as the challenges that physicians faced to stay motivated. They described the impact of other physicians and the challenge of conflicting roles that could bolster or suppress their own values and their subsequent motivation for compassion.

The key finding in this section was that “doing unto others as you would have done to you” was a central value.

**4.3.5 Motivations, Boundaries and Balancing Compassion**

Participants described how some physicians, while appearing “too compassionate”, were driven by self-serving motivations rather than compassion. They observed that these
physicians became so invested and controlling that their patients became dependent on them. To prevent over-involvement and burn-out, participants believed physicians needed to understand what patient factors and internal motivations prompted too much compassion. Finally, they described boundaries around availability to promote a healthier balance of compassionate and supportive care.

Some participants stated that, for each physician, specific types of patient predisposed them to crossing boundaries around support. Commonly, they were patients who had little support from friends or family. This participant gave an example:

There are certain populations of patients that I find a little more difficult to stay more objective with. So elderly dying – I have a very hard time being more objective especially when they don’t have family members and they do expect you to be more than just their doctor. They do expect you to be their support and sometimes the boundaries can get a little bit pushed because you know how lonely they are and how much they need you. I think a lot of people in medicine want to be needed and they allow that boundary to get pushed a little bit.

However, participants mostly focused on physician-centered motivations that prevented physicians from encouraging patient independence. The most mentioned of these relayed by participants was a physician’s “need to be needed”. Some alleged this was a need to be the “rescuer” or the “savior”. The following participant illustrated how she reflected on her own motivations when supporting patients.

I always ask myself, “Should I really be doing this for this patient?”, “Is it actually meeting the need of the patient or is it meeting my need to go be the savior and the rescuer?” It’s very easy in our job to make ourselves feel good by going and helping others and we don’t always help others by doing things for them especially at the expense of everyone else left at home.

When physicians did not reflect on their motivations, participants believed patient care became less patient-centered. This participant described this as “the dark side of compassion”:

So the dark side of compassion to me can lead down a pathway towards a physician-centered view of the world and a relationship that is based on the physician’s need to feel good and to feel like they are acting positively with patients.
Without any check on motivations, physicians’ desires to fulfill their own needs superseded needs of their patients and jeopardized provision of appropriate care and support. The following participant gave an example of residents who were motivated to show compassion to meet expectations of supervisors and patients.

*I have seen residents think they are doing a tremendous job because they are holding somebody’s hand and their arm is on their shoulder and they are giving them their cell phone number to call whenever they want. Yet there is no attempt to help the patient really understand and reflect on their experience and help to lead to empowerment.*

In this example, physicians were playing a role they thought was expected of them rather than trying to gain a compassionate understanding of their patients. Participants explained that when the physician didn’t truly have the patient’s interest at heart, compassion became pity. The following participant described it like this: “Compassion in its worst form leads to pity - ‘Oh the poor patient; let me help them.’ You have a narcissistic physician with a distorted sense of compassion.” In such situations, the power differential between patient and physician was evident. Participants believed that although the physician might appear compassionate, they were taking more control and making the patient more dependent. This participant demonstrated how pity reinforced the power differential.

*When people say someone is too compassionate, I almost think that it’s no longer compassion. It’s actually pity that they are expressing and that can be detrimental because that whole power differential can play out in a negative way...Compassion can sometimes lead to that direction because you want to act on and fix things but you really shouldn’t take over control of the situation...and it also takes away the patient’s ability to develop their own independence and self reliance and empowerment.*

In addition to monitoring their own motivations, participants suggested physicians need to constantly monitor the impact their support and compassion was having on their patients. As this participant noted:

*If the degree of compassion that you are demonstrating is not helpful to the patient or is crossing boundary issues or in any way is going to harm the patient – either psychologically, mentally, physically, then obviously you need to turn the compassion barometer down.*
Participants also considered boundaries important for balancing compassion to prevent unreasonable expectations developing in their patients and themselves. This tipped the balance toward supporting the patient effectively rather than creating dependence. The following participant demonstrated how boundaries, patient expectations and physician burn-out were linked:

To be compassionate is one thing but you have to make sure that when you’re compassionate that you don’t: a) overstep boundaries on a personal level, b) don’t create expectations. Make sure they have other resources so that you don’t burn yourself out. You can be compassionate but you can’t be over involved. It’s their issue to deal with and you will be there to support them but you can’t look after them if you don’t look after yourself.

Participants believed burn-out was also related to other motivations. For example they considered some physicians driven by a need to “fix” all their patients’ problems. This participant explained how this was different from showing balanced compassion:

I think you can be unattached and be compassionate. Meaning it is one thing, but getting intricately involved, saying “Oh you can call me anytime” that’s a little bit different. As long as you mean what you say and you’re giving people a genuinely open and honest picture of what you understand the situation to be, I think you can do that and not be too attached. Compassionate to me is understanding and showing empathy but not necessarily having the thought process that you have to fix everything every time, because you can’t.

Participants explained how compassionate physicians driven by their own motivations were more likely to overextend themselves to meet their patients’ needs. Participants believed this led to neglect in physicians’ personal lives and burn-out. This participant illustrated how this happened to a physician acquaintance.

His level of compassion ultimately ended up by being a major problem...In his case, he ended up having to leave his practice and divorcing his wife. He was completely over extending himself and taking personal calls with patients and constantly being late at work or doing more house calls and attending to people beyond regular office hours. So he had difficulty putting down a boundary around what he was doing for his patients.

Participants endorsed physician boundaries to put limits around availability and prevent burn-out. For example, they explained how physicians set boundaries around giving out phone numbers. Many participants chose not to give patients their phone numbers and
therefore not be accessible outside of clinic hours. Some participants felt there was some flexibility around this boundary. This participant discussed how she set limits around this issue.

*I give my phone number to patients and everyone thinks I’m crazy. “Are you crazy? They’re going to come over and they’re going to stalk you.” It’s not like I give it to everybody but I have a few patients that have problems and maybe I set myself up to be able to handle it at home but they don’t abuse it or anything. I can think of maybe two other times when I’ve been called here.*

Participants also considered setting boundaries around time spent at work and time spent at home crucial for physician overall health. Without this, participants felt that compassionate physicians could easily become over-extended. This participant described the boundaries he set for himself around time management:

*If being compassionate means you end up spending all your time doing medicine, then that’s got to be detrimental to your personal life or to your family life. As long as you keep some barrier towards that eating into your family life you’ll do well. I live by a rule of thirds: a third work, a third family, a third sleep.*

Although participants did not always concur on where boundaries should be they all believed that boundaries helped physicians balance their compassion. Boundaries prevented physicians from becoming too available, involved and burned-out.

**Summary**

Participants considered self-serving motivations an area where physician compassion could become imbalanced. Although they viewed compassionate physicians as supportive, they believed when physicians became too involved, due to these motivations, they diminished patient independence. They described these motivations as a “need to be needed”, a need to “fix” things or “control” situations, or simply a desire to appear compassionate. Participants believed that this led to pity and a physician-centered approach to problems. Patients lost autonomy and physicians became prone to burn-out. Participants articulated how crucial self-reflection and boundary setting was to prevent these negative consequences. They were very clear that boundaries around availability, such as work hours and phone access, resulted in more effective physicians and supported, yet independent patients.
The key finding in this section was that when physicians were motivated to be compassionate for egocentric reasons, they ran the risk of being too controlling, increasing patient dependence and becoming “burned out”.

4.3.6 Motivation for Compassion over Career

Participants described how family physicians’ motivation to be compassionate changed over the course of their careers. They discussed how medical training with its large workload and biomedical focus deterred their motivation for compassion. However, participants also illustrated how motivation for compassion increased with clinical experience and the emergence of a better understanding of their role as family physicians.

Participants believed that at the outset of medical school “medicine is about saving people, saving the world and being altruistic and all that points towards compassion.” They believed they were idealistic, enthusiastic and eager to please. However, this was dampened by their lack of knowledge and experience. This participant put it this way: “When you’re in medical school you’re very compassionate because you come in very idealistic and you don’t really [have] the knowledge and the experience.”

But once training commenced medical school was focussed on the bio-medical aspect of medicine. Participants described being overwhelmed by the amount they had to learn and how their main motivation was to learn what was required for their exams.

In medicine when you come in, do anatomy, the whole language is foreign. It’s a new culture to learn basically and I just wasn’t mature as some individuals might have been to be reflecting on the other aspects that were not tested such as compassion and caring and relationships. I was focused on what do I need to pass this next exam.

As training progressed, participants had more patient contact and learned how to interview patients. However, participants believed there was little emphasis on compassion during these sessions. As they came to their final years in medical school and their time in residency, participants considered what time for compassion there had been,
became less as time pressures and stressors compounded. They viewed this as another shift away from their motivation for compassion.

You’re too busy doing the minutia to really employ or have time to think about compassion so I think you lose it for awhile. You’re focusing on “OK how does this engine work? How do I function as a doctor...or as a student...as a resident? What does it mean to be working in a hospital environment? What does it mean to be working in an office?” You go into a survival mode of just trying to fit in, to be part of the team. If you have a moment when it’s ten o’clock and you’re on call and nothing’s going on, you can go over and talk to a patient and be compassionate.

Participants perceived residency as a time where it was often difficult to satisfy even the most basic needs of sleeping and eating. They believed this also impacted their motivation to be compassionate.

The learning curve is very rapid during those years, especially late medical school, residency, early practice years. Compassion isn’t, for most of us, number one or number two on our priority list at that time. We’re trying to survive. We’re trying to sleep. We’re trying to eat. We’re trying to learn the actual medicine.

However, some participants sensed a shift in teaching focus when entering family medicine residency. The following participant described how, for him residency was geared to a more holistic approach:

The years in my residency were a big turning point for me. Medical school, I found to be geared towards medical learning, physical exams, diagnosis and treatment. [In] residency the focus shifted to rounding it out to be more able to care for the whole person not just the particular medical issue or the bigger medical problem.

Participants believed holistic or more compassionate approaches to patients varied from rotation to rotation and supervisor to supervisor. Participants perceived family medicine, palliative care and psychiatry rotations and supervisors, as more focussed on compassion.

My first day of my palliative care rotation I went on a home visit with one of the docs and was there when the patient died...He was so incredible with the family and [they] were so grateful that he was there. It was just this wonderful experience to see what it can be like. That was really good. On the flip side, I would say a lot of the in-hospital rotations time is a stressor and it’s really just about getting the next task done.
Participants found after completing training and spending more time in practice their focus continued to change from bio-medical to holistic, from cure to care and from control to support. Along with these changes they believed their motivations for compassion increased. Participants perceived a “recognition that you actually can’t do all the things you thought you could do when you graduated.” This participant described how his focus had changed:

After ten years of practice I’m realizing that what we’re doing is supporting people in their life journey. This whole idea of curing people - it’s idealistic. We think “I’m going into medicine to cure people” - the cliché of stamping out disease. It’s really not what it’s about. We all live. We all die. We’re all on a journey....We’re supporting them. We’re guiding them.

Participants described a shift from the biomedical to the more holistic when they realized that only a small portion of their work involved “curing” people. They attributed some of this change in attitude to dealing with chronic issues over long periods of time. The following participant explained how this changed his philosophy to “help-centered care”:

I was talking to this student I have today about... person-centered care. We do that a little bit but what I do is “help-centered care.” When I go to see somebody I try to help so I am almost never disappointed. I can almost always do something. I can fluff the pillow up or I can give them a glass of water or I can just sit and talk and hold their hand. I almost never feel that I’m not a help. I don’t think I do anything different than almost every other doctor around but when your expectation is that you are going to cure people – in nursing homes there’s not that many people you can cure and there are not that many people in complex care that you can cure - so I don’t try to do that. You change your focus.

As participants experienced appreciation from their patients and were rewarded with good outcomes when using compassion, they felt motivated to keep using it. The following participant described how compassion became positively reinforced:

There’s the positive reinforcement for me in seeing good come out of someone’s dying and feeling that you’ll be able to take what you can out of every situation. Those situations help you to become more compassionate in the future - you deal with other people in a better way too.

Participants believed physicians who could not change their focus from cure to care became perpetually frustrated in their work. Part of this, they felt, was that they were
unable to relinquish control. This participant described how relinquishing the illusion of control changed how he saw his role as a physician:

What have I learned in practice? I’ve learned that we have far less control over the world than we might hope. I don’t think I knew that when I was young. I think there was a sense then that I had great mastery over the world and if I was vigilant enough bad things wouldn’t happen to my patients. The corollary of course was, when bad things happened I was directly responsible for not having done something about it earlier or found it earlier...I have learned that compassion is even more important than I may have once thought because of that inability to act.

Participants believed focusing on compassion helped physicians change from trying to control their patients’ outcome to supporting them.

Summary

Participants believed their motivation for compassion changed significantly over their careers. They found medical school very bio-medical and crammed with much to learn. As a result they found themselves focusing on the material on which they would be examined, namely the biomedical topics. Participants recalled that although they had more patient contact, they also had increasing responsibilities and had to struggle to adapt to their new roles, learn the medicine and meet their basic needs like eating and sleeping. These factors all detracted from their motivation to be compassionate. However, participants remarked that, in family medicine, the teaching was more holistic. They considered rotations such as family medicine, psychiatry and palliative care to be more focused on compassion than some other rotations. After entering practice and spending more time dealing with chronic illness, they noticed another shift in their perception of what was important to their patients and helpful in their roles as family physicians. Their focus changed from the biomedical to the holistic, from curing to caring and from controlling to supporting. Participants believed physicians who did not change their focus in family practice became frustrated as they were limited in their ability to control and cure.

The key learning in this chapter was that medical training focused little on compassion, diminished capacity for compassion through workload and subsequently weakened
motivation for compassion. Clinical experience in practice, on the other hand, underlined the importance of a holistic, caring and supportive approach which increased physician motivation to be compassionate.

4.4 Capacity

4.4.1 Capacity Introduction

Participants identified several areas that affected their capacity for compassion. They first described how the development of emotions and empathy during their early years contributed to their capacity for compassion. They then discussed the factors that impacted their emotional and mental energy and thus their capacity for compassion, including how they cultivated compassion by learning to care for themselves. Participants went on to describe the delicate balance involved in the emotional engagement and how setting boundaries helped maintain capacity for compassion. Finally, they described how their capacity for compassion changed as medical training and life experiences influenced their ability to empathize.

4.4.2 Emotions, Empathy and Developing the Capacity for Compassion

Participants described many factors that affected an individual’s capacity to be compassionate. They believed the capacity for compassion to be attributable to both nature and nurture. Participants emphasized how emotional development and empathy developed based on gender, family upbringing, religion and experiences of caring. Finally, they expressed how all these factors developed the capacity for compassion in physicians.

Participants believed compassion was an innate human quality. Some portrayed it as “something inherently in your system” or “people’s nature”. However, participants also
pointed out that compassion “comes natural[ly] to some people and some people are more compassionate than others”. This participant described what he believed an individual’s capacity for compassion consisted of: “50 per cent is probably innate, 25 per cent learned and then 25 per cent conscious.” A few participants described a compassionate personality as an innate temperament but most also believed personality depended on both the traits they were born with and what they had learned. The following participant described the internal capacity for compassion using the “compassion barometer”: “Maybe it would be easier for people to turn on that compassion barometer if they have it within them - their personal traits and their upbringing - all that stuff supports the compassion barometer.”

Participants believed there were many factors in an individual’s upbringing that developed their capacity for compassion. Some of these were similar to those influencing their motivation for compassion. They mentioned parental role models, religion, cultural factors and starting early in the role of caring. Others emphasized how these factors all contributed to emotional development and the capacity to empathize.

A few participants commented on how a family’s handling of emotions impacted on a person’s comfort level in expressing and dealing with emotions. They felt this had a significant impact on an individual’s capacity for compassion. “When they show their emotions or try to understand another individual’s emotions - whether those things have been encouraged and supported and fostered when they were growing up and positively reinforced rather than the opposite.”

Other participants described how their religious or spiritual practices also made them more open to emotions and compassion. The following participant believed being more spiritual enabled him to experience compassion and put it into action. “Maybe spirituality leads to the ability to experience the feeling [of compassion] and then translating that into action which is important.” Another participant described how growing up in his religion encouraged him to act on his feelings of compassion.

*Judaism is a religion of intent. The old adage is: “It doesn’t matter what you think. It matters how you act”. That would be where it connects to compassion.*
Compassion in its action is the important part not the feeling. It doesn’t matter how much I feel compassion for somebody - if I’m not acting on that, then that’s a useless feeling.

Participants also explained how they learned to act on compassionate feelings by being in caring roles within the family from a young age. Participants described caring for both the young and the old as critical in developing their ability to empathize with the infirm and the caregiver. The following participant noted how the culture she came from provided more opportunity for this kind of role within the family.

Because we have combined family systems in Pakistan, which is more a cultural aspect, you tend to see that you’re used to taking care of your grandparents because they are living with you. So even as a young granddaughter you’re used to caring for them... People tend to have more children – I’m the eldest of five children, so my youngest sibling, my sister, is eleven years younger than I am.... I would be with my sister taking care of her, doing her diapers or whatever after school.... So you’re more hands on.

Participants described other experiences outside of the family unit that shaped their capacity for compassion. These experiences often involved caring for others, volunteering or teaching. Through these activities participants felt they learned to empathize and became more adept and comfortable in caring roles. The following participant described how teaching karate provided this kind of experience:

I was involved in Martial Arts since I was about 12, shortly after I came to Canada. And I was very lucky to meet a very good teacher who showed that he cared for us.... At about 13 years old I was starting to teach younger kids, like 5 year olds, 6 year olds and then as time went on I did more and more teaching in that capacity... needing to be there, both physically and emotionally for the children and your learners - showing that you understand what they are going through... You are dealing with technical aspects but you’re also dealing with how they perceive their failure. So I think that has been a major formation period for me as a person. That is what I mean when I refer to my past experiences making me somebody who recognizes that listening and being there is important.

Some participants commented on the role of gender in determining an individual’s capacity for compassion. A participant stated: “Female doctors tend to spend to more time with their patients and tend to be seen as being the more compassionate ones.”

Most participants emphasized, however, that societal expectations of men and women were the central factor rather than differing biological capacities for compassion. Social
expectations not only affected different upbringing between the sexes but also impacted what was considered appropriate expressions of emotion. A participant described how a compassionate male physician might be perceived: "I think men are compassionate on a different level but I think when they are too compassionate they are seen as soft or they are seen as soppy." A female participant described how this differed for female physicians:

*I think gender does play a role in it. I think women are almost expected to be more compassionate than men are, not just society but patients expect it – especially when you get women who come in and talk about very intimate things like sexual abuse or violence or things like that. They almost expect a woman to be more understanding about it and there is that pressure there of feeling that you should be more sympathetic or that you should be more compassionate.*

Participants believed that the expectations of others, based on a person’s gender, impacted the degree to which they were expected to engage compassionately over time. The more they were expected to engage, the more practice they had dealing with emotional issues and this subsequently affected their comfort level and their capacity for compassion.

**Summary**

Participants believed that a physician’s capacity for compassion was both innate and learned. They described how comfort with expressing feelings and dealing with emotions was related to family upbringing as well as spiritual factors. They went on to divulge how experiences of caring inside or outside of the home further developed their comfort in dealing with emotions and also their ability to empathize. Finally participants discussed how social expectations around how men and women express emotions resulted in women experiencing compassion more.

The key finding in this section was that although the capacity for compassion is partly innate, physicians learn to be comfortable with emotions and develop empathy through their early life experiences.
4.4.3 Energy and the Capacity for Compassion

Participants believed a physician’s energy level at any given time impacted their capacity for compassion. Although they experienced compassionate exchanges as energizing, they also found that compassion required energy. Participants described how and why compassion consumed energy. They articulated how different mental, emotional and physical stressors diminished their energy and hence their capacity for compassion.

Participants described compassion as something that fuelled and motivated them at work, energized them and provided them with job satisfaction. However, they also believed that compassion required energy. The following participant described the flux of energy and compassion this way:

*It’s a balance between getting energy from the work, getting energy from the patients that I see - because it’s extraordinarily rewarding but it’s extraordinarily demanding mentally. So that can feel like energy is being sort of sucked away from you.*

Although participants considered compassion inherent in people, they felt it required effort to express it. *“It is peoples’ nature. And sometimes when it takes that extra effort to make sure you make that call and to make sure you’ve satisfied a question, I think that may take a little bit of energy.”*

One reason participants believed compassion took energy was because it required emotional engagement. *“It’s emotionally draining. It’s making an emotional connection and that’s tiring. It’s a stress even in itself sometimes. It’s a very good stress but it’s still tiring.”* Other participants articulated how the act of distancing oneself emotionally to keep compassion in balance was draining.

*It’s not the compassion that takes the energy, it’s the distancing yourself. Because the compassion is easy...all you have to do is ask them a few questions about their background and learn a little bit about their life and you get sucked in. What’s difficult is realizing who they are and what they are going through and their suffering and being able to step back and say “but it’s not my fault, it’s not my responsibility and it’s not my burden”. I think that’s what takes the most energy...and the going home and not thinking about it.*
Participants believed emotional energy had limits and the capacity for compassion at any given time was related to what else was using up emotional energy in the physician. The following participant described the relationship between emotional energy and compassion using a car battery metaphor:

*It’s like driving your car - most of the time you stay within the speed limit because it’s the law. It’s probably better for your car and less chance of running over people and getting in trouble. If you have to though, you can always put your foot on the pedal. When I see people I try to have the ability to accelerate and to get into it but you can’t just throw it away. It’s a very high draining activity if you’re doing it hard, so you can’t do it all the time and waste it. On days when I don’t have it, it’s usually because I’m using up ...that same battery power seems to run my emotional stuff as well. If I’m having a lot of emotional things going on, or I’m worried about things... something stressing me would certainly influence my decision making on whether to embark on something. I don’t think it would stop me but the near empty light would start flashing. You would hope that you could go in and do what you had to do and get back out before the battery went dead.*

Participants also described how compassion required mental energy as well as emotional energy. This took the form of focus and attention. They explained that to be compassionate with a patient, the physician had to mentally block off the other issues on their mind and focus solely on the patient. Some participants described this as “stepping away from yourself”. This participant described how focus impacted her capacity for compassion.

*I find that it’s quite easy to be compassionate as long as I can be in tune with the patient and not thinking of something else - “Did I leave the grocery list on the island?” As long as I’m focused I can easily turn on the compassion barometer if I know that’s it needed.*

Participants described how focused attention helped the physician gather information from the patient and process it efficiently, therefore increasing their capacity to be compassionate. The following participant illustrated how focus, mental energy and compassion were related:

*If I get too little sleep I actually have trouble focusing on what is the actual issue or if they come in with multiple issues I lose track of the details of each one and I might not pick up or be as sensitive to something. On another day when I’ve been well rested and I haven’t been frazzled leaving the house, I might just be really attuned to that other individual’s experience simply because of the frame of mind*
and the state of physical and mental health that I am in when I get to the office. It allows me to really be there and be a presence for my patients.

The mental and emotional energy required to engage in compassion was influenced by the physical, mental and emotional well-being of the physician. All participants described having challenges meeting some basic physical needs at times. These included adequate sleep, a regular diet and general health. This participant described how not meeting these physical needs impacted his ability to focus and be compassionate:

You’re not feeling well or you’re really tired or you’re post-call. The worst day is in the morning when you’ve been on overnight and you come back and work. You’re sitting there and all you’re thinking about is sleeping and eating.

Fatigue was the physical impediment to compassion most mentioned by participants. Participants believed that fatigue not only affected the physician’s ability to focus but their ability to engage emotionally. “One of the big ones for me is fatigue. It’s really tiring to be compassionate sometimes and if you’re too tired you just put up the wall. You just can’t go there.” Participants also related fatigue to mood and articulated how it impacted the capacity for compassion.

If I get more sleep I’m more happy and if I’m more happy then it seems like everything is flowing so much better. I found that if I wake up earlier in the morning, I have a nice breakfast, I relax, I read some news and then I go to work, it seems like maybe I’m nicer to people. If I sleep in and I’m rushing in the morning, I didn’t get a good night’s sleep, I was on call and I’m tired and I get to work and maybe I’m not as nice a guy.

Participants explained that the mental health of physicians had a major effect on their capacity for compassion. They described many mental stressors that had a negative impact on their ability to be compassionate. Some of these stressors related to what the physician was experiencing at home. “Too busy; too stressed; whether you have your own health or marital or financial concerns going on. Those things will all definitely affect your ability to be compassionate.” Participants commented that when these areas were a source of worry, the emotional energy and focus that physicians could take to work was hampered.

Whatever is going on at home clearly has impact on me and I’m not always able to wall it off completely. I’m worried about the kids or if K and I had a fight about
something or whatever it might be ... it absolutely impacts my ability to be compassionate.

Work-life balance was touted by all participants as critical in maintaining physician mental health and their capacity to be compassionate. Participants pointed out that when physicians were out of balance, they resented their work and this impacted their ability to be compassionate with their patients.

Well I think if you are burnt-out and you’re stressed and you’re tired it makes it more difficult to be compassionate. If you’re well rested and well rounded and have time to spend with your family and do the things you enjoy doing, then your work isn’t a burden to you and your work is something you enjoy doing and you’re able to be more compassionate with your patients. You’re not constantly thinking “Oh my God, I can’t stand being here. I’m just tired. I need a break.”

Summary

Participants observed how the capacity for compassion was related to physician energy. They described how compassion motivated them in their work but also required energy to engage in. They believed that compassion necessitated energy because it took effort to engage emotionally, and to distance oneself enough to balance compassion. Participants also articulated how compassion called for focus and attention, which required energy. They then elaborated on the physical, mental and emotional factors that impacted the energy for compassion. Physical factors like sleep, diet and general health were important in this regard. Participants described how work-life balance was important in maintaining physicians’ physical and mental health and their compassion. Stressors at home, marital and financial issues all impacted on physicians’ ability to focus and engage emotionally with their patients.

The key finding in this section was the reciprocal relationship between compassion and energy. While compassion required an initial output of energy from the physician to engage with and focus on the patient, compassion energized and fueled physicians in their work.
4.4.4 Self-Care and Cultivating the Capacity for Compassion

Participants described many activities and life choices that they felt boosted their capacity for compassion. These varied from person to person but revolved around caring for themselves physically, emotionally and spiritually, spending time with friends and family and broadening their horizons. A participant summarized: “I think it’s important to understand your own physical and mental health and well being. Take time for yourself. Try [to] take enough holiday time to recuperate, regenerate.”

Participants emphasized the importance of keeping physically healthy to maintain their capacity for compassion. They highlighted the importance of rest, healthy diet and physical activity. The following participant described how exercise not only kept him healthy but relieved stress, making more room for compassion: “Exercise is another stress reliever I think I use. To go out running or something where there’s intensity to work off some of that stress, I find [it] works.”

To promote mental health, participants advised spending time with family or friends and nurturing the other roles and relationships they had in their lives. This participant described this way of bolstering his capacity for compassion: “Just having a nice healthy interaction, personal interaction with and knowing my kids and their friends or just absorbing other people’s experience at home or somewhere else; it always helps.”

Participants pointed out how critical their close adult relationships were in maintaining their capacity for compassion. “I have a great relationship with my husband and I think being really grounded and in a strong relationship has made it much easier for me to go into the world and help other people.”

Participants also mentioned the importance of self awareness in knowing what “recharges the batteries”. While some participants described spending time with others to unwind, others preferred to be alone. “I’m an introvert in the true sense of someone who recharges alone. I enjoy being with people but it takes energy from me, I’m not somebody who gets energy from being with people so I need my alone space.”
Participants commented on how their religious and spiritual practices allowed them to reflect. They believed this impacted the compassion they were able to bring to their patients. This participant described how religious holidays are a time for reflection about compassion: “Within the Jewish calendar...[there are] time[s] of year when I’m thinking more about things like compassion and that idea of justice and reciprocity.” Participants described how having a time and format to reflect on compassion brought it into their awareness resulting in an effort to be more compassionate. “The more spiritual I happen to be feeling, the more compassion is there.”

Participants remarked that many religions had official times and places for reflection but those without religious affiliations found other ways to reflect on compassion in a spiritual way. A participant explained:

That’s the way I think of churches - an hour of time out of your busy week life, to have time to reflect on how to be a better person. That’s all it is – whether you’re Protestant or Catholic, Buddhist, whatever – as long as you take time out of your busy life to think about what else is out there in life and how to be a better person and how to interact with people....I now use running to think about all that stuff...to reflect and think about life.

Several participants commented that they found this time for reflection an important source of strength, a way to recharge their compassion. A participant explained how important it was for her to find the right context in which to do this:

Making it clear to myself that I don’t believe in God has been very grounding for me. I get my strength from people around me, the world around me – very much the natural world. It’s always been that way and now I make sure I seek out those things.

Many participants believed that in addition to time for reflection physicians needed time away from work with friends or family to reset their balance. For example, a participant said: “Some people don’t like to travel but I think by travelling you get away from all the distractions and from your pager...and you have good quality time with your kids or family.” Other participants pointed out that holiday travel opened their minds to new things and altered their perspectives. “Travelling is always good - going somewhere or other cultures or those experiences.” Participants believed that broadening their horizons
increased their capacity for compassion by deepening their understanding of humanity and the world in which we live.

> Observing things in the world, the news, the ability of other people to be compassionate, people that have been horribly treated but [are] still able to forgive and be understanding... the circular nature of the world and the universe and people, families. There seems to be something about that that influences me. I think observing other people who are creating some other artistic things influence me, things that I see, music, observing nature.

Music and art were mentioned by several participants as inspirational and compassion building. Many participants mentioned reading as another way of opening their minds and increasing compassion. “I read a lot - that helps to build compassion just because it puts you into all these different life circumstances and makes you see the world through other people’s eyes.”

Participants emphasized repeatedly, the importance of establishing work-life balance to be able to take time to regenerate and build their capacity for compassion.

> knowing your own limits and what makes you happy. And we’re all different. Some people are happy or comfortable doing call once or twice a week. Some people are not and could only do it once a month. So, ultimately each of us needs to know what makes us happy and where we fit in. To be, maybe, compassionate to yourself first.

Summary

Participants revealed activities and life choices that they believed bolstered their capacity for compassion. These included spending time with friends and family, time alone, taking holidays, travelling and exercise. They emphasized that having the self awareness to understand what energized them was critical. Participants also described how spiritual time for reflection through religious practices or other means was important for building their compassion. They described how exposure to art, music, nature, literature and other cultures broadened their horizons and deepened their understanding of and connection with people and the world around them. Making the time for these activities was considered crucial in increasing physician capacity for compassion.
They key finding in this section was that to cultivate compassion for their patients, physicians first had to care for themselves.

4.4.5 Emotional Engagement, Boundaries and Balancing Compassion

Participants described physicians who lacked emotional engagement as lacking in capacity for compassion. They believed that compassionate physicians were emotionally engaged enough to empathize but still able to be impartial and logical. However, physicians whose emotions overrode their judgment were described by participants as too compassionate. Participants illustrated the challenges physicians had in maintaining this balance, the methods they used to equilibrate their capacity for compassion and the impact that being too compassionate had on physicians and patients alike.

Participants believed balanced, compassionate physicians learned to manage their own emotions while still empathizing with their patients. They considered this balance challenging for physicians as the issues presented by patients were often emotionally intense. This participant described how patient experiences could be emotionally overwhelming.

The feelings that are welling up...you couldn’t function if they were there all the time. We have to manage compassion and help it to not feel overwhelming. It’s tremendously scary because somewhere along compassion must be “This could happen to me, this could happen to my wife, this could happen to my mother. I will die.”

Some participants described different triggers that might increase their risk of being too compassionate. They were often situations where they empathized strongly with the patient and more often instances where the “extent of prior involvement with the patient” was significant. For example, “somebody you’ve cared for [for] a long time or are close to, or a family member of a friend, or a colleague”. In this type of scenario participants believed physicians needed to have the self-awareness to “pull back professionally”.
Participants believed compassion was a delicate balance between being in touch with their patients and their own feelings while controlling and protecting themselves emotionally. “Often it’s to protect me. It’s not to protect them, because you can get totally sucked in and then you go home and all you do is cry. You’ve got to maintain a certain veneer.” However, the challenge was that physicians who became too protective of themselves could be seen to be lacking in compassion.

I think it’s person-dependent and situation-dependent. Sometimes it’s used to extremes where physicians just cut themselves off because either they just don’t want to deal with the sad situation or they don’t know how to deal with it. It can be negative to shut yourself down too much.

Nevertheless, participants noted that when physicians didn’t protect themselves emotionally their lives outside of work became affected. “I can see somebody who might be so compassionate that it is affecting their own personal lives, if they carry too much of that emotional baggage home with them”. Participants believed impact on their personal lives was a sign that they were getting too emotionally involved and needed to be firmer about boundaries.

Participants advocated for physician self-monitoring for signs of exhaustion so that they could take steps to restore equilibrium. “If you’re really just feeling exhausted at the end of the day and really just feeling upset then maybe you just need to do something for yourself to reset your own balance.” Participants believed that if physicians were unable to self-monitor, a vicious cycle developed where emotions at work impacted circumstances at home which led to emotional fragility at work. “I don’t know if you can be too compassionate but I think you can certainly have a problem with bringing those emotions into your work place and having that interfere with your relationship with your patients.”

Participants also believed that, beyond emotional control or self-preservation, physicians need to have limits on how much emotion to display with their patients. It was useful to have a clear set of rules about the appropriate level of emotion for physicians to display to their patients. “The boundary issues that I mentioned...yes it’s good to be feeling certain things but how much do you actually show?”
Participants purported that patients did not want their physicians to be too emotional. They believed patients would feel they couldn’t rely on a physician who needed comforting. This belief helped participants establish boundaries around how much emotion to show patients. The following participant described how “bursting into tears” exemplified this kind of boundary.

If the patient is going through a really tough time and you’re finding that it’s so emotionally draining for you that you’re bursting into tears with them...There are times when that might work but you don’t want that to be the norm. I think it’s ok to show some emotion in those situations but I think that there needs to be some feeling that you’re [the doctor] a safe haven - that you’re not going to collapse at the slightest news.

Participants expressed concerns that patients would feel overly-emotional physicians were unreliable for other reasons as well. They believed emotionally involved physicians lost perspective and gave inappropriate advice.

There doesn’t seem to be very much of a downside unless you go overboard; being so emotionally affected by whatever it is you’re hearing that you become unable to back up enough to have a perspective that allows you to act and give advice that is impartial. You have to bring to it your expertise and you have to have enough separation but not too much.

Participants highlighted that over-involved physicians were unable to keep the right distance to make appropriate decisions. One participant described how too much emotional involvement influenced the physician’s cognitive processes in this manner: “It [too much compassion] can lead to misunderstandings and assumptions from the physician.” With excessive emotional attachment participants believed physicians over-identified, blurring the line between their patient’s emotions, experiences and desires and their own. They explained that this affected physician judgment around appropriate treatment. Participants considered this loss of objectivity significant when physicians were unable to be firm with patients when required.

I’ve had a few situations in which you get too involved with the whole compassion thing and don’t see the situation clearly anymore. You lose your perspective on it, your objectivity. Sometimes the situation warrants that you give them a swift kick in the pants.
Participants also believed this left the physician more open to manipulation from the patient. The following participant gave an example of how an overly-compassionate physician might be manipulated by a patient.

An example would be someone that comes in with chronic pain and they are going through a really bad patch in their life and being a good compassionate doctor [you] are aware of it. They need those pain medications but they might up the ante and say, “It’s getting worse.” They think that you’re really soft and you’re feeling sorry for them. They might use that to actually increase their pain meds.

Summary

Participants claimed that emotional engagement was an area of compassion that required balance. They described how compassion required enough emotional engagement to empathize but enough distance to remain objective. When physicians became too emotionally engaged, there were negative consequences for both patients and physicians. Participants believed physicians became emotionally drained, resulting in difficulties at home and work. They considered physician objectivity at risk in these situations, which could affect patient care. Participants also believed patients regarded very emotional physicians as unreliable. Finally, they described an ongoing process of physician self-monitoring as necessary to prevent overstepping emotional boundaries.

The key finding in this section was that, without boundaries, compassionate physicians could become too engaged emotionally, thereby negatively impacting the patient and themselves and draining their capacity for compassion.

4.4.6 Empathy and Capacity for Compassion over Career

Participants described how their capacity for compassion evolved over their careers. They believed the change in their capacity for compassion was related to alterations in their ability to empathize with their patients. Participants illustrated how medical school, residency and life experiences influenced their empathy for their patients and subsequently their capacity for compassion.
Participants noted that many of them had been quite young when they started medical school. For this reason, participants believed they were in a less empathetic stage of their lives.

*At the time I didn’t actually reflect on compassion or caring or any of these things. In medical school, for me it was a very self-centered time as a young adult, just experiencing living on your own in a new city with no family around.*

Although participants described their time as medical students as one of being idealistic in their desire to help people, they believed lack of life experience at this early stage in their careers made it difficult for them to empathize with their patients. They described their feelings for their patients at this time as closer to “pity” than compassion. The following participant related his experience:

*I think I was compassionate in some ways but I think I didn’t really understand the impact of illness on people’s lives. I hadn’t really been around people who’d been sick and so that certainly was a learning experience for me.*

Having entered medical culture, participants also perceived an expectation to avoid intermixing of the objective with the subjective, the cognitive with the emotional, and the science with the art of medicine. Because of this perception, participants felt discouraged from connecting emotionally with their patients. This participant described how her perception that emotional involvement was taboo impeded compassion:

*There’s always been a certain, not taboo, but “You’re the doctor. Keep the stiff upper lip. Don’t emote.” I think being compassionate requires emotion and it requires for you to emote and to share some of yourself with your patients and again it’s finding the appropriate balance of that.*

In addition, participants perceived medical school training as a process of progressive depersonalization of the patient. They were confronted with dead bodies, dying patients and suffering and they had to learn to deal with shock, thoughts of mortality and feelings for the dead, the dying and the bereaved. They had to suppress their emotions and thoughts to be able to learn and perform their duties. To do so, they found themselves more removed from their patients and their patients’ experiences.

*In fourth year you’ve seen so many of these autopsies. You’ve had patients who died but still there are encounters. I was doing trauma so I’d see several people*
coming in. They are healthy; they are dying... Once again you change. After a month of being there, doing that rotation, I became totally different. I’m not saying I got less compassionate but somehow my threshold for something to be really sad or [to be] really depressed by what I’ve seen or really horrified had changed.

Although participants viewed the ability to suppress emotions as necessary, they pointed out that suppression could become extreme. They believed that as students they lost empathy for their patients. They described how teaching supervisors who did not demonstrate compassion or objectified their patients, calling them, “bed blockers” or “GOMERS”, could amplify this process.

Several participants believed empathy for their patients grew in family medicine residency. Many attributed increased empathy to the continuity they had with their patients in their family medicine clinics. As they had more opportunity to develop relationships with their patients, they viewed them as people and developed attachments. Participants perceived this as evolving to a greater extent when out in practice.

You deal with more chronic illnesses and working in the community you see more than you do in your training [or] acute care where you see a person for a very episodic thing and then they’re gone. When you are in practice and you follow them over 20 years go with them through life events, you have a very different perspective on things than when you do your training.

Participants spoke extensively on how experiences of birth, parenthood, illness and death in their own lives augmented their empathy and compassion for their patients. By reflecting on their own experiences, they were better able to understand the crucial issues for their patients and felt more motivated to act on their behalf. The following participant described how his experience with his grandmother helped him understand the issues for patients in similar situations:

My grandmother passed away...Mum looked after her until she needed more care. The struggle of putting her into a long term care facility, the difficulty my Mum had with that, the guilt and sadness – experiencing that with my parents has helped me understand other people going through similar situations, dealing with aging parents, dealing with dying parents.

Participants also encountered physicians and medical staff who may or may not have been compassionate during these personal experiences. As a result, they understood
more about the feelings and needs of their patients but also how much compassion was valued in those situations.

To have somebody during those times to encourage me and support – they mean the world. It wasn’t money, it was the caring - “You’ll be fine” or “You can make it” or just “What can we do?” The fact that these people behaved that way gave me strength to keep going. That somebody showed me they care and they believe in me and they wanted the best for me, so why can I not do the same thing for somebody else?

Participants believed as their empathy developed over time they became more compassionate. However, they described their empathy and compassion as being more conscious and less impulsive. This participant described it this way: “I would probably make more of a conscious effort now. I’m better able to organize my own feelings and be more in control of them. It’s probably polished more.” Some participants wondered whether their compassion was less genuine as it was more crafted.

However, participants pointed out that some physicians did not become more empathetic over time. Participants considered physicians who continually blocked empathy and compassion to be lacking in understanding, unaware of the pleasure of knowing their patients as people and submerged in the monotony and routine of their work. “As a doctor you may have seen this a thousand times and it's easy to dismiss - ‘Oh well, it's nothing’. You have to remember that individual patient, their situation is unique and you haven’t seen that a thousand times.”

Summary

Participants found their capacity for empathy evolved as they experienced life and subsequently affected their compassion. As medical students they described themselves as idealistic about helping people but with little understanding of the impact of illness, their compassion was more akin to pity. They also pointed out that the medical culture they were training in discouraged emotionality. To cope with their exposure to suffering, death and dead bodies, participants found themselves depersonalizing their patients. Although some detachment was necessary to learn and perform their duties, participants believed for some students, detachment became extreme. However, once in family
medicine residency participants experienced more continuity with their patients which they believed developed their empathy. Most noteworthy to participants was the impact of birth, parenthood, illness and death in their own lives as an expander of empathy and consequently, capacity for compassion. Although compassion and empathy grew participants also remarked that their emotions were more controlled and their compassion was more conscious. Participants commented that physicians who were unable to develop empathy for their patients, lost opportunities to explore and enjoy their patients and often got bogged down in the routine of practice.

The key finding in this section was that physician empathy and capacity for compassion diminished during medical training, was augmented by life experiences and became more conscious over time.

4.5 Connection

4.5.1 Connection Introduction

Participants illustrated the central role that connecting with patients played in compassion. They described the skills required by physicians to demonstrate compassion and make a connection with their patients. They also explained how this connection impacted the patient-doctor relationship and helped physicians work with “difficult” patients. In addition, participants described many aspects of the medical system that hampered their ability to connect and form relationships with their patients. Participants also revealed how time restraints impeded connection with their patients, discussing system related issues that affected time spent with patients and the relationship between time, connection and compassion. They also emphasized the need for boundaries when connecting with patients to keep compassion in balance. Finally, participants described how their ability to connect with patients evolved over their careers.
4.5.2 The Skill to Connect – Showing Compassion

Participants described how they demonstrated compassion to patients with many examples. These examples can be grouped into five major categories: 1) demonstrating openness; 2) being present; 3) endeavouring to understand; 4) being supportive; and 5) relating as one human being to another. Woven throughout these aspects of demonstrating compassion participants identified essential communication skills (see Table 1, p107). Participants believed compassion could be conveyed “in words, in tone and conversation” and also through actions. Participants also described how they decided how to show compassion and to what degree.

Being open and giving permission to be open

Several participants viewed giving patients the permission to show emotion as a way of showing compassion. For example, “letting them know that it’s OK to cry.” Permission giving could be a combination of verbal and non-verbal communication.

I found her a box of Kleenex, first of all. And told her that it wasn’t the first time – that she will notice that the box was half empty which means that it wasn’t the first time that it had been used that day. So permission I guess to feel those feelings.

Participants described being open to patients in many other ways including being honest, respectful and non-judgmental, all of which were components of showing compassion.

...trying to not say things that are completely fake - be honest - “I don’t know what you’re going through but if there’s anything I can do to help please let me know”. I think it’s a physician’s role too to say when they don’t know or they don’t understand, to say “I don’t know” and “I can’t explain” and “I’m not going to bullshit you”.

Showing respect and openness to patients’ beliefs and values were other ways participants demonstrated compassion. One participant described how she would verbalize this to a patient who might have differing ideas: “even though it’s not what I would ideally like and what is going to help you... still, it’s your way, I respect that and I still would be here to help you.” Assuming a non-judgmental position could also facilitate permission giving and hence express compassion.
...acknowledging what people say, validating it no matter what it is, whether it’s about me...whatever it is. It’s OK, no matter how horrible it is, no matter how stigmatized it is. And sometimes you need to actually give that permission upfront.

Furthermore participants felt physician body language could convey compassion by being open.

Body language is important. Particularly with the folks that I work with, you need to give people space, to sit back and not to encroach on peoples’ safe zone...where I am in the room, not crossing my arms, not even crossing my legs sometimes, just sitting very non-threateningly.

**Being present**

Participants described showing compassion to their patients by being present. For example taking time with patients was described by many as a way of showing compassion.

*I think that the things you do for your patient also can demonstrate compassion. So you take a bit of extra time on the day that you know a patient’s family is coming in and wants to talk to you.*

Participants felt that by taking time physicians indicated that they are available to *talk.* Many participants emphasized the importance of the *listening* aspect of “talking” with patients. “*I think the main thing that patients want is for their physicians to listen to them. And by listening you’re showing empathy and compassion. That’s probably our biggest drawback as physicians - we don’t take enough time to listen.*”

The *listening* described by the participants had two facets. The first facet was that by listening, the physician gave the patient time to talk and tell their story. For example a participant explained “*just being present and sometimes that’s using silence and just being there and letting people tell their story without interrupting.*” Participants felt this demonstrated compassion. The second facet of listening they viewed as expressing compassion was *active listening* which was described as “*listening to the person and then making sure that the patient knows that you are actively listening so you can respond to what they’re saying as well.*” Participants emphasized the importance of the physician demonstrating that they had been listening and had grasped the patient’s story.
Reiterating was described by some participants as a way they demonstrated active listening.

*It's always good to reiterate their problem and when you summarize at the end, it shows that you’ve listened. So if you can tell the same story and get it right – say “Yes, I understand your sister in law is bothering you” - then they know you’ve got it. I think that empowers you to get further with the patient to help develop the plan on how to get them through these issues."

Again, the physician’s body language was noted as important and in this instance could demonstrate active listening. “I think through a lot of non-verbal things like your body position, eye contact - a listening pose. You are giving them your full attention.”

When they actively listened the message received by the patient was that the physician was interested in their story and trying to understand their predicament. Some participants described their mental availability when actively listening as being present or being there.

*... just being present and sometimes that’s using silence and just being there and letting people tell their story without interrupting. Not very many people get to do that because we usually want to get our visit done in 8 minutes and move on but sometimes you need to shut everyone else out. I try very hard to do that at least a few times a week. I say “I’m really just with you” and “I’m closing the door and this is time with you”.*

Other participants used being there and being present to demonstrate a more emotional availability with the message of being there for patients during difficult times. This was another way participants reported demonstrating compassion. This participant recounts how she related this to a patient:

*I know you are going through a rough time and I'll be there for you. I acknowledge that you’ve been given crappy news and you are not feeling very well and I wouldn’t know how I would react in that situation but I will do whatever I can to help you.*

Some participants made it clear that it is availability, not just when it is difficult for the patient, but when it is difficult for the doctor also. “It is sort of parallel to caring and I think of Mayeroff’s stuff about being with people and not necessarily doing anything but a willingness to be there when it’s not very comfortable.”
The importance of talking to family members was noted by participants and they emphasized how compassionate physicians listen to them talk about their concerns. The physician also communicates vital information by talking to the family, not just medical information but also offering reassurance around the care and attention given to their loved one.

Calling people back...Make sure you talk to them. They want reassurance that people are taking care of their family members. They want respect for their family member and want to know that someone is listening and that someone is actually doing their best to try to take care of them.

Endeavouring to understand

Participants explained the many ways in which they tried to understand their patients’ situations. In their endeavours to do so, they felt they also conveyed compassion to their patients. Participants highlighted certain questions they asked with a view to showing patients their desire to understand their issues. Many of these questions were related to the four dimensions of the illness experience described in the Patient-Centered Clinical Method (feelings, ideas, function and expectations - FIFE)\(^5\). Asking questions to explore and understand the patient’s feelings were mentioned most often by participants.

I consciously try to ask how they feel about it because most people don’t talk about their feelings. They describe the situation. Often I find it’s the feelings that are more important for them...to understand themselves as well as me understanding what they are going through. I would always follow up, asking “So how do you feel about it?”

Some participants explained how exploring patients’ ideas about their illness experience conveyed compassion.

I think by “fifing” someone...You can show that you’re compassionate by trying to explore how they are feeling and how things are affecting them and what their outlook is. I think that’s part of being compassionate. It’s not just saying “OK you have hypertension, you need blood pressure pills – goodbye”. You need to at least see how it’s affecting them and be compassionate enough to have the time to sit there and explore those ideas with them.

Other participants emphasized the importance of asking questions to gain an understanding of how the problem is affecting the patient’s ability to function. They
alleged that by asking these questions, the physician acknowledges the patient as a human being with a life that is affected by his/her illness. The following participant described this dimension of exploring the illness experience.

*Compassion is something that has to be more involved. Say for example I saw the patient and he had an accident. We did MRIs and he had multiple disk bulges. This man is in pain. He can’t work. But if he can’t work, he doesn’t have an income, can’t afford physio….You understand this person’s pain but at the same time you see that he has to work and you say “OK I can give you pills which will be a short fix but in the long term I would like you to do this, this and this”. It cannot be blunt. I have to understand where he’s coming from. I have to look hard at his life. His social situations influence him, his decisions, his way to deal with this problem. All I can do is support him and help him the best I can to live with the pain.*

Therefore asking questions about these aspects of the patients’ illness experience demonstrated the physician’s desire to understand the overall impact of the illness on the patient and thus conveyed compassion.

Asking about patients’ expectations also communicated compassion. The following are some examples of how participants recounted their exploration of patient expectations. “Sometimes you’ve got to put everything else aside and say ‘What do you need from me?’” Another participant stated: “I usually say ‘What can I do? Is there anything I can do?’ I think that would be a nice summary of how I show compassion.” Participants felt that by asking about expectations they were letting the patient know they were there to mobilize a plan which would satisfy their specific needs. This was seen to convey compassion.

Hence asking these questions was a way to understand the patient’s illness experience and a means to demonstrate compassion. Participants provided several other methods they used to demonstrate how they understood their patients’ needs, for example, taking time to explain things to patients reflected understanding and compassion. By taking time, physicians showed they appreciated their patients’ desires to have things explained. 

*S sometimes people just think “Oh I’m sure they know what this is about” but I think we underestimate the desire to know exactly what’s going on and what’s causing it. And it doesn’t have to be a really long explanation just a description of what the condition is. So I think that’s compassion - showing that you*
understand their desire for that knowledge and that you value them as an individual.

In addition, participants conveyed the importance of letting their patients know they understood “where they were coming from”. For example, “doing little things at the end that just say ‘Hey, you know, I know you are a little kid and you’d like a sticker. So I know where you’re coming from.’”

Speaking on the same “level” could demonstrate the physician’s understanding of how their patients wanted and needed to hear information. “I think I try to speak, if I can, on a patient’s level whether it be a child or an elderly person.” Once again, non-verbal communication played an important role through facial expressions or gestures which conveyed compassion and understanding.

I’m making eye contact with the patient. I may smile, acknowledge the situation or I may just nod – depending on what’s being talked about. Sometimes I may touch the patient on the hand or knee (and that obviously depends on how well I know the patient) or a pat on the arm.

Compassion was also expressed through using small gestures to promote the physical comfort of their patients.

Just little things like just making sure somebody who is disoriented has their glasses and has things they need nearby - their medications, their breakfast tray is not across the room and things like that. Just little things that you can do that lets them know you are thinking about the little comforts that count because it’s a daily thing for them.

Through these gestures physicians could demonstrate their understanding of what makes the patient uncomfortable and how they were there to relieve and support them.

**Being supportive**

Participants expressed various ways in which they showed compassion through being supportive of their patients. Sometimes it was by words of encouragement; sometimes it was in plans of action.

One participant stated that in showing support you need to “allow the patient to feel that you are taking their problem seriously”. By taking action physicians demonstrated to
their patients that they do take their problem seriously. Support could also be demonstrated by being a patient advocate. As one participant said, “I guess part of it for me is trying to be an advocate for my patient”

Other supportive and compassionate actions highlighted by participants included getting people involved and obtaining services for the patient. For example a participant explained: “Things like getting family involved and having family meetings or getting nurses and social workers and other team members involved.” Other participants suggested that supportive demonstrations of compassion could be more subtle. They conveyed this through words that motivate. For example, this participant described the kind of encouragement she might give a patient: “Sometimes it’s just encouragement – to say ‘I think you’re doing an awesome job. You’re taking your medications on time and I know with your busy schedule that must be hard, so great job and keep it up’.”

Participants pointed out that part of this motivation involved recognition of the struggles patients may be encountering. Again, participants felt this demonstrated how physicians understand each patient’s unique life context.

Another participant viewed showing support as “giving hope – if that was appropriate for that particular patient”. By providing hope the physicians showed support, not just for the mechanical and physical process of the treatment plan but the psychological and spiritual aspect of the healing process as well. Participants indicated that support in this area was another way of showing compassion to their patients.

**Relating as one human being to another**

Participants believed too much distance between patient and doctor impeded compassion. They alleged that to show compassion the physician needed to relate to their patient as one human being to another.

*I think that it’s very important that they realize that you’re human too and that you do have feelings and there’s not this big divide between you like “I’m your doctor and you’re my patient and therefore I don’t have any feelings and what I say goes”*
Participants utilized combinations of verbal and non-verbal communication to relate in a more personal way with their patients. Many participants preferred sitting rather than standing over the patient to establish a “level playing field”. “It’s little things like sitting on the bed with the patient and not walking in there with a white coat and standing at the bedside and dictating - being human and maybe relating a story of your own life”.

Participants also commented on the importance of finding the right distance to position oneself within the room in order to convey compassion. The following participant explained the process of feedback in cues between patient and doctor which results in both feeling they have found the comfortable distance.

*I don’t think you can be compassionate from across the room and I think people probably have different ways [of being there] or different comfort zones. There is a distance that you sit from a patient that feels right. If you’re further away you feel disconnected. If you’re up close, either you or they, feel like you’re in their face. There’s a zone where whatever is going on between you is maximized.*

Another non-verbal way participants related to their patients in a human manner was by using touch.

*... making sure you actually examine or touch them in some way even as a gentle gesture to make that human connection. I think that’s one advantage other modalities have over us. Our college sometimes says don’t touch the patient. That’s why chiropractors do better for back pain. They actually touch the patients.*

The types of touch that participants described, included basic touch required during physical examination and touch during verbal exchange when providing reassurance, like touching the hand, shoulder or knee of the patient, holding the patient’s hand or giving them a hug. However, participants pointed out that their style of communication must be adaptable depending upon their patient’s comfort.

*So if you realize that a patient is really withdrawn and not the sort of person to be chatty, you may be doing things in a different way. If you’re the touchy, ‘lovey’ kind of person, you’re just going to be more reserved. You would probably change your tactics but I think that caring feeling does come out in some way - body language, eye gestures, hand gestures...*
Participants also found many verbal ways to relate to their patients and lessen the divide between them. Some participants used humor to do this. “I think I use humor a lot to break down that initial sort of doctor-patient relationship.” The object of using humor was to relax patients and to make them feel their issues were more universal than they might have realized.

Another way participants related to their patients was “talking about things that are maybe a little less clinical and more social.” By so doing, participants believed the physician sent a message to the patient that they recognize they are a human being, not just a “disease” in the context of the clinic. A number of participants told personal stories to connect on a human level with their patients. The following participant described an interaction where he shared personal experiences to let his patient know that he could understand where she was coming from.

She was a 35 year old woman who came in with her 4 year old boy, trying to deal with his anger. He left the room and it turned out that one of the things going on in their home is that the couple’s marital relationship is really devoid of a lot of feeling. I think she was feeling very angry about the road that her marriage was going down and I think the 4 year old was probably acting out a lot of her anger. I said that in my own marriage we’ve had times where we are just both so focused on the task that things…So some dropping of boundaries which was I guess one way to show compassion. Although my experience is different, I could at least have some sense of walking with her along that road.

Deciding how to show compassion

Participants agreed that how they demonstrated compassion was dependent on the patient’s characteristics, the reason for their visit and patient expectations. They perceived age, gender, culture, religion, social environment, personality and type of illness as patient factors that might determine how they expressed compassion.

I think the way we show compassion would have to be different depending on the patient’s personality and what stage of their experience they are in. I can imagine inappropriate ways of showing compassion - when somebody is not ready for that kind of communication.

As discussed in the sections on Motivation for compassion and Showing compassion, participants perceived that there were times when patients wanted their physicians to
“turn up” the “compassion barometer” and times when they did not. Much of this they felt was dictated by the problem that the patient was presenting with. Even with more emotionally laden issues, participants emphasized the importance of determining whether the patient was ready for compassionate communication. “Sometimes people aren’t ready. If it is an emotional issue, they may not be ready that day, that minute, when I’m ready so it may not work.”

Many participants articulated the importance of understanding the patient’s expectations for compassion. Participants felt this was essential, not just to demonstrate a desire to understand, but to better direct the physician’s demonstrations of compassion as well. “Perhaps there are patients who want a more technical approach but I think part of being compassionate is just understanding peoples’ expectations and dealing with those.”

Sometimes these expectations were openly voiced and sometimes physicians would ask what they were but more often than not the physician gleaned expectations through observation. This participant described the process: “The patient is the one that would give the signals and signs whether the physician needs to not turn on the compassion mode - to be more responsive to their needs.”

The following participant described what happens when the physician doesn’t understand expectations for compassion.

It’s about listening to the patient. Understand expectations that the patient has because some people want a lot of support from their physician and expect their physician to guide them. Other patients are more independent or have other support networks or would rather rely on those other external networks than their physician. So it’s about knowing what they need. If you are overly compassionate to the more independent patient that can hinder the relationship a bit because you’re giving them more than they are asking for.

**Summary**

Participants described numerous ways that they show compassion to their patients. Participants described specific verbal and non-verbal communication skills they used to demonstrate compassion across five categories (see Table 1, p107).
Table 1 - Communication Skills to Demonstrate Compassion

<table>
<thead>
<tr>
<th>Categories</th>
<th>Verbal communication</th>
<th>Non-verbal communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Demonstrating openness</td>
<td>- verbal permission for patient to express feelings</td>
<td>- use open body language</td>
</tr>
<tr>
<td></td>
<td>- being honest with patient</td>
<td>- cues to allow expression of feelings (Kleenex box)</td>
</tr>
<tr>
<td></td>
<td>- showing respect for the patient even when their views differ</td>
<td></td>
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<tr>
<td></td>
<td>- being non-judgmental</td>
<td></td>
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<tr>
<td></td>
<td>- validating the patient’s experience</td>
<td></td>
</tr>
<tr>
<td>2) Being available</td>
<td>a) taking time</td>
<td>- eye contact</td>
</tr>
<tr>
<td></td>
<td>- letting patients &amp; families talk &amp; tell their story</td>
<td>- body position (listening pose)</td>
</tr>
<tr>
<td></td>
<td>- answering their questions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) being there</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- when things are difficult for the patient even if it is difficult for the physician</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- being focused on the patient, listening actively, reiterating</td>
<td></td>
</tr>
</tbody>
</table>
| 3) Endeavoring to understand | - speaking on the same level as the patient  
- explaining when the patient has questions  
- asking the patient about their illness experience | - nodding  
- facial expressions  
- using small gestures to promote comfort or show understanding |
|---|---|---|
| 4) Being supportive | a) making a plan that indicates the physician is taking the problem seriously  
- advocating for the patient  
- getting people involved  
- obtaining services for the patient  

b) motivating the patient  
- encouraging them  
- giving them hope | |
| 5) Relating as one human being to another | - discussing social issues  
- sharing a personal experience (dropping boundaries)  
- using humor | - sitting level with patient  
- correct physical distance between patient & doctor  
- touch (examination or small gestures) |
Both patient characteristics and reasons for the visit were cited by participants as factors which affect how much compassion to show. Patient characteristics mentioned by participants included patient age, gender, personality, religion, social environment, culture, where they were raised and family. Visit related factors included time, type of problem or illness, and patient openness at that point. Participants felt the key to knowing how much compassion to express was to understand patient expectations. Without this participants felt the physician ran the risk of hindering the relationship with inappropriate demonstrations of compassion.

The above summarizes thoughts of the participants on how a physician, using good verbal and non-verbal communication skills, can convey openness, availability, understanding, support, humanness and ultimately their compassion.

4.5.3 Relationship, Connection and Compassion

Participants described the role compassion had in developing the patient-doctor relationship. They expounded on how caring, trust and rapport were central to forging connections through compassion. Participants also observed how certain patients were more difficult to connect with and how compassion enabled them to work on these relationships. In addition, participants described many factors within medical culture and systems that affected how they connected with patients and challenged patient-doctor relationships.

**Compassion and the foundations of the patient-doctor relationship**

Participants described relationships between patients and physicians that were built on compassion as ones that evolved over time through caring and trust. This participant described the circular and evolutionary link between these components.

Compassion builds the relationship, strengthens it and it also fosters the trust that’s there. I don’t see them as a linear thing - they are more circular. There’s compassion and trust and caring and they are all linked. They all form this
Participants reflected on how a compassionate approach to their patients demonstrated caring. They described how being compassionate and demonstrating caring builds trust in the patient–doctor relationship.

*If I was a patient and I didn’t feel that I was being cared for then what would the relationship be like? How much could I trust my family physician? If there wasn’t compassion there, it would be very hard to develop a deep last relationship and part of that relationship would be trust, or lack of [trust].*

Participants also articulated how developing trust was vital to the continuation of the relationship.

*I think it’s partially trust because if someone you meet for the first time is telling you that you have got this bad thing you might go through denial. And then your first instinct is to say “Well I don’t know you. You’re just talking crap”. You can at least establish rapport when they have come to see you several times. They must trust you enough to keep coming back so they are not going to blow off what you say.*

Some participants elaborated further on how patient–doctor relationships evolved over time. They stated that, as trust and rapport became established, a deeper human connection developed between patient and doctor. The following participant described this process:

*Being a family practitioner is such a wonderful thing because you are able to establish a relationship with these people and they keep coming back. You see one of them reticent at the beginning, distant, and slowly once they see that you’re human beneath and you’re not a machine, you see them not as a liver or a lung but as a human being and then slowly you see a change in the face and the expression is softer, even a smile.*

In addition, when patients had a good rapport with their physicians they also felt more compassion towards their physician. Several participants pointed out that as their relationship with their patients developed over time their compassion was sometimes reciprocated. This added to the enjoyment and the bond they had with their patients.

*It’s a two way street. So my patients express compassion for me in my life as well and that is a wonderful bond. They will say “Oh you look like you’re working
hard today. I’m sorry that I needed to come in and bother you.” or “How is your son doing at school? You told me last time that things were a little bit rough.” It is the human part of our relationship that is a two way dimension.

Participants also stated that this reciprocity of compassion was important for resolving the outcomes of physician error. They believed patients who had a compassionate rapport with their physicians were more inclined to demonstrate understanding in these situations.

When people are unhappy with your care it is not necessarily always something you do, or don't know, it's the way it's presented. If you make a mistake and you explain, because you have a good rapport with them, I find they are much more understanding.

Connecting with difficult patients

Participants acknowledged that there were some patients who were easier to connect with than others. They found that if they identified with the patient, they could empathize easily and this facilitated the connection.

It’s the understanding of someone’s life situation that tends to make [it] easier for me to be compassionate. I feel like I can understand where they’re coming from as opposed to [seeing them as] a medical problem and a diagnosis... We maybe have some similar interests. There’s something that connects the patient and the physician- in that case there’s more compassion.

Participants also described how a good rapport and an established relationship with their patient made connecting easier. A better understanding, mutual appreciation and trust were the facilitators.

It’s easier to be compassionate with patients that you have a good rapport with because that kind of sharing is already set up. You have that relationship and so they’re able to tell you a little bit more about what’s going on and how they feel and what problems they’re having. It’s much harder when you are brought into a new situation and you don’t really know them very well because you have to develop that rapport first. I think that’s the situation where maybe the compassion is almost pity than the empathy because you’re not in it far enough to be a part of it.

However, many participants related stories of “difficult” patients with whom connection was more challenging. These were patients who participants painted as having very
different values compared to their own like physical and psychological abusers, for example. They perceived they had to work hard in these situations to find a “kernel”, something likeable or they could understand, in order to care for these patients.

There are people within everybody’s practice who if you weren’t the doctor you wouldn’t be friends with. They are not people who you would be drawn to. They have personal characteristics and moral standards or a belief system that clashes with your own. Those are people that are harder. I think that if they were in desperate straits it would still be possible, but it doesn’t come as easy maybe.

Drug-seekers were another group of patients participants identified as challenging in terms of connection. They viewed the lack of trust the physician had in the patient as central here; for example, whether their request for narcotics was drug-seeking behavior rather than medically necessary. In essence, it was not just the patient who must trust the physician but the physician who must trust the patient for a good connection to be forged.

I tend to be very trusting and tend to give people the benefit of the doubt and want to try to help...But on the other hand you worry that you’re being taken advantage of. You worry that people think you are out there selling their prescriptions.

Participants also viewed patients who were threatening, demanding, critical, disrespectful or unappreciative as hindering connection. Participants described having to overcome visceral responses to access their compassion in these instances. “When they’re being difficult or demanding, it’s just a bit of a childish mechanism but it’s ‘you’re not being nice to me, why would I be nice to you back’ which isn’t ideal, you’ve got to be nice to them all.” Participants believed “non-compliant” patients also sent negative messages to physicians that hampered connection. “I think a patient with a history of non-compliance... I try to do my best but I feel that my efforts are not being acknowledged and respected so that makes it a little bit more difficult to be compassionate.”

Although participants remarked on how “difficult patients” hampered connection, they also commented on how compassion allowed them to push through these barriers to make a connection. Participants stated that compassion enabled them to “live beyond” their “own personal counter-transference”. In other words, they were better able to put aside the reflex emotions brought about by negative patient behavior.
Participants also described how compassion allowed them to relate patient behavior to past misfortunes thereby eliciting empathy. “Everybody has those patients that just drive you nuts. It helps me to go back and think of their situation and say, ‘that person has a hard life’ and ‘whatever’ factors led them to be this way”.

In addition, participants observed that compassion drove them to look beyond negative patient qualities to the core of humanity within each patient. The motivation to connect with the patient was stronger because part of their compassionate view was the importance of connecting with fellow humans. “They still deserve that human connectedness, to feel like it matters - what they’re going through is important. They can still be heard despite being nasty or having had bad interactions with you in the past.”

Finally, participants emphasized that compassion was a big driver in continuing to work on these more difficult relationships.

> Every contact with them is an opportunity to improve your relationship and not continually carry the grudge. There are people that you just don’t like but at some point in their life just need to hear that somebody is there and cares.

**Challenges for patient-doctor relationships**

Participants illustrated how our cultural bias towards the scientific and technological and the lack of continuity in our current medical system impaired connection and impacted the patient-doctor relationship.

**Science and technology**

Participants believed science and technology, despite its advantages, had made care in the medical culture less personal and as a result physicians felt less connected to their patients. The following participant described this in the context of family medicine:

> I think there is a trend in our system away from being personal to being more technical...Family medicine...involves a lot of understanding of the other person and the context words. Words have extra meaning and there is a tendency in healthcare to go toward low context situations where you’re dealing with machines and teams and systems rather than person to person.
A few participants also commented on the proliferation of clinical practice guidelines. They were concerned that guidelines led to less personalized care, which they saw as less compassionate.

*I think that we now are in these binds - who in their right mind stands up and says “I want to go against the evidence. I want to go the opposite way of the clinical guidelines”? The whole malignancy of all of that seems, to me anyway, to be an economic sponsorship that has created this. I think it leads away from personal one to one contact, doctor-patient contact which is where compassion exists. It’s very hard for compassion to be included in a clinical practice guideline.*

**Continuity**

Participants also described how continuity impacted connection to their patients. They illustrated many ways that hospitals and practices functioned with little patient continuity. For example, academic hospitals had the challenge of multiple physicians rotating through different specialties at various intervals. Participants viewed this as making it very difficult for patients to connect with physicians. This participant described how this affected compassion from the patient’s perspective:

*It’s the way the hospital structure is set up. If you have somebody in acute care hospital for 3 months with an illness you go through three sets of residents, four sets of specialists - you have to receive them. You just don’t want to talk to anybody any more.*

Participants believed family physicians in general were becoming better at limiting their hours to create work-life balance and restore their internal resources of compassion. However, some believed physicians who were less “present” also missed out on critical opportunities to connect with their patients.

*Family doctors always used to be present at the births of babies. One of the most emotional times I ever had was [when] a patient of mine came in and thought she couldn’t feel her baby move. We found out the baby was dead and that it was about 35 weeks along. We had to induce her to get her into labor…they wanted the baby wrapped up so we passed the baby around and looked at it. Go[ing] through that with people was something, and I think that being present at deaths is something that happens less and less. Because of that, I think people’s expectations of our ability to not be a technician but be a person [is lower].*
Summary

Participants believed compassion enabled them to care for their patients. They felt this in turn built trust, rapport and ultimately connection. They noted that the compassionate patient-doctor relationship grew over time and patients often reciprocated compassion. This also furthered the connection between patient and physician.

Participants also described how it was easier to connect with patients with whom they identified or had rapport. However, patients who were threatening, demanding, critical, disrespectful or unappreciative were more challenging. These “difficult” patients, drug seekers and abusive patients all challenged physicians to seek out a “kernel” of understanding to make a connection. Still, participants argued that compassion allowed them to suppress their reflex emotions and look beyond these behaviors to the common link of humanity, spurring them on to forge a connection with the patient.

Participants brought up several issues related to the medical culture and systems that affected how they connected with patients. They believed these impacted physicians’ ability to be compassionate with their patients. Participants illustrated how our cultural bias towards the scientific and technological decreased connection with patients, clinical practice guidelines as an example. They also remarked on the lack of continuity in the health care system and how that affected compassion. They gave examples of this in both hospital care and primary health care.

The key finding in this section was that compassion enabled connection between patient and doctor which in turn boosted both physician and patient compassion.

4.5.4 Time, Connection and Compassion

While describing the challenges to connecting with their patients, participants universally referred to time as an impediment. They expressed how physicians often had many commitments both at work and at home. In addition, participants viewed many aspects of the medical system inefficient and as a result, obstacles to forging connections with their
patients. However, when questioned further on whether compassion required more time, participants gave differing opinions. It became clear that there were certain aspects of connecting that participants believed took time and others that did not. Participants then described their anxieties around time and compassion and how compassion could save time in the big picture.

Factors that impact time and connection with patients

Participants agreed there were aspects of running a practice that limited their time with patients for example, scheduling, going to meetings and especially paperwork.

You might lose a little bit of compassionate ground when you’re there Saturday afternoon doing 2 hours of forms...it’s a real struggle for all of us, how to get the boring part of medicine, which is the forms and the paperwork, done and not allow it to make you jaded for the patient interaction part which is still amazing.

Part of the reason that time was such an issue, according to participants, was that many of them were remunerated under a fee for service system. Because of this system, time literally was money. For example, if they saw fewer patients because they had to block of two hours to do paperwork, they received no compensation for that time. This participant described how fee-for-service, time, relationships and compassion interfaced:

Although it’s always nice to make more money I don’t think that necessarily leads to a more compassionate approach. That probably is a disincentive to compassion because here we’re talking about how compassion is based on relationships and relationships take time. In fee for service the whole idea is that you spend less time with everyone so that you can see more and make more money. Fee for service is a disincentive to compassion.

A few participants were salaried rather than working in a fee-for-service system. These participants were positive about the impact of having a salaried income on providing more compassionate care. Some participants believed salaried positions, by disconnecting monetary gain from number of patients seen, increased physician freedom to spend more time with their patients. This participant also described how it allowed her to be an advocate which she felt was part of compassion: “I can spend more time with people. I get to do a bit more program planning and advocacy that I wouldn’t be able to do in a fee-for-service clinic.”
On a larger scale, participants identified many shortcomings in the healthcare system that made it inefficient and therefore time-consuming for physicians. Participants had many concerns about hospital amalgamations, physician and staff shortages, waiting lists for specialist investigation and treatments, funding cuts to social programs and the overriding concern of meeting budget requirements over providing good care. Participants believed these issues put more pressure on physicians, gave them less time with their patients and led to the frustration of physicians and patients alike. “The more frustrating a system is, the harder it is to be compassionate because so much time is taken up dealing with those frustrations. The fact that we are over-worked certainly can’t lead to compassion.”

Frustrations and stress related to time pressures were a central theme for participants when describing how connection and compassion were impacted by time. Participants described challenges that could impact them on any given day at the office: computer crashes, an absent staff member or colleague, a series of patient crises. These challenges could result in lack of access to information, longer waiting times and frustration for patients. Participants articulated how a day filled with these mishaps distracted them, increased their stress levels and made them feel more rushed and emotionally drained. They believed all of these things negatively impacted their ability to connect with patients.

*Just how crazy the office might be particularly - if it’s very busy or if I don’t have a great amount of time to spend with a patient, that may also decrease it. If I’m hurrying in any way, that’s going to decrease my ability to feel it. Generally I need to be very relaxed and not hurried and not stressed to be able to feel that same compassion. So anything that makes me feel rushed and stressed or distracted – thinking about other things, is going to affect it.*

For this reason, several participants stated they were more compassionate at the beginning of the day than the end and felt hospitals were less conducive to compassion, especially the emergency room. They believed nursing homes were more conducive to making a connection because they were less busy.

*Whereas you get to the nursing home and there’s work to do - it’s such a calmer more serene environment. It’s not the beehive of activity that the hospital is, and that’s more conducive to you sitting on the side of a bed and listening to a war story or listening to some older person’s tale of years gone by.*
Does compassion take time?

Participants believed it was possible to connect in a short period of time. They found demonstrating a compassionate attitude by being respectful, non-judgmental and validating patients’ feelings did not require a great amount of time. This participant viewed acknowledging patients’ difficulties as a method of demonstrating compassion: “I don’t think that takes that long. There are times when it does but I think sometimes it just takes [saying] ‘It sounds like things are really difficult for you right now’ and that’s almost all you need.”

Participants also believed physicians could be attentive and focused in a short period of time. This communicated to the patient that the physician was present for them. The following participant described how this forged a connection with the patient: “People don’t really need that much they just want to know that you’ve paid a bit of attention and that you see what’s going on or that you can understand that they are having a difficult time right now.”

Participants viewed motivational and encouraging statements as another way to connect in a brief visit. For example: “I think you’re doing an awesome job. Next time when you come around we’ll sit and we’ll chat some more.” Participants also commented on how nonverbal demonstrations of compassion took little time. A few participants emphasized, however, that these phrases and gestures must be genuine, unrushed and without artifice to truly form a connection.

I think there are little gestures and acts that you can do that show compassion, the laying on of the hands or rubbing a back or holding a hand or making a physical contact. There are very quick ways of showing some compassion but those can become very automatic and not have any meaning behind them.

Several participants believed physicians could connect with their patients in a brief visit through humor or a quick exchange on issues of a more social nature. A few participants viewed this as easier for experienced physicians, especially with patients who were well known to them. The following participant described how some of her colleagues managed to connect in short periods of time:
It's not even about time. I worked with a couple of older physicians who literally spend 2 minutes in each encounter but somehow they manage to make the patient feel like everything that they said was the funniest thing or the most interesting or they remembered some detail about their past. What a gift that is to be able to make that come across in such a short encounter. Whether that means that they are really good communicators or that they are truly compassionate, I don’t know, but I do think that people care a lot about “being cared for”.

Despite the above sentiments, the recurring theme expressed was that compassion and connection took time. Participants believed time to listen to the whole story, gain an understanding, explain treatments, answer questions and act as an advocate were also important. This participant described this as being “fully compassionate”:

Perhaps we can’t be as compassionate as we would like to be because of time constraints. I think you can be compassionate in a short period of time, just in the way you are talking to someone or describing something or asking a question. You can be compassionate in the way you do that but I think in order to be as fully compassionate as you possibly could be I think that does take time. It takes time to sit, to listen, to fully explore things to just be there for someone.

Participants suggested that when time was limited, physicians always had the option of asking their patients to return to the clinic to discuss things further. They viewed this as a way of showing the patient they cared despite the limits they had on their time. The following participant pointed out that from the patients perspective this could sometimes be problematic:

If you come to me and you said, “I’m really concerned about my daughter. I’ve noticed the last few days ‘this and that’” - I could say “OK but we can’t talk about that today. Why don’t you make an appointment and come back.” It would be a reasonable thing to do but how would you feel about that? How can you postpone your problem?

To avoid this problem altogether, participants noted that some physicians limited displays of compassion when they knew they had little time. They articulated how demonstrating compassion in a time-limited situation could “open Pandora’s Box” and they would be obligated to deal with an issue they didn’t have time for.

The patient all of a sudden feels more comfortable to share, not just the tidbit that was bothering them, but “Now you’re really listening and no-one else has been listening…I’m going to tell you about everything else that feeds into that problem”. And so I find that although you could be compassionate in a 5 or 10
minute visit because it opens up this huge box of other problems it turns out to be a 20 minute visit. Now I’m running behind again. Perhaps it is my perception that I need to listen or maybe I need to explore all of that.

Participants perceived the difficulty as balancing compassion for and trying to connect with everyone. If they spent more time with one patient, another patient ended up waiting longer, and was more frustrated which in turn could impact the stress of the physician and their compassion towards that patient. Some participants perceived the challenge as learning when it was critical to have that discussion and go overtime and when it could be delayed to another visit. Part of this learning involved differentiating between patients who needed more time and those for whom additional discussion would not add value to their care; with some patients, physicians had to set limits. “There’s a difference between compassion and just dealing with ridiculous patients too.”

Finally, participants also believed in the long run compassion could save time. Using compassion and taking the time to make the connection and find the hidden agenda could prevent multiple fruitless visits to the clinic and emergency room. The following participant gave the example of how taking the time to make a home visit saved him time later:

It’s actually more time efficient, if you’re going to link compassion to time, to do the house call, to see how people interact, how they get their meds, how much they can move around their house. Then you set up home care services and they can be your eyes and ears and then you know “OK that’s where the bathroom is. He can’t make it any more. He needs a hospital bed there.” and it saves so much time.

**Summary**

Participants believed that sufficient time was important to connect to their patients. They illustrated the factors that influenced the time they had with patients which they felt subsequently affected their ability to connect and their compassion. Duties unrelated to patient care, the strain of earning an income in a fee for service system, and obligations to see more patients because of shortages led physicians to spend less time with their patients. Participants believed this reduction of time with patients impaired their
compassion. In addition, the stress of time constraints and the disruptive surroundings in busy workplaces affected their ability to focus and be compassionate.

Although participants alluded to time pressures diminishing their ability to connect with patients, the relationship between compassion and time was quite complex. Participants believed physicians could connect with their patients during a brief visit by focusing, acknowledging their difficulties, motivating them, using humor, relating on social issues and through physical gestures of comfort. However, participants considered listening, explaining, achieving understanding and advocating as important parts of connecting and compassion that took time. Participants described how time pressures made them “pull back” on compassion because they were afraid of “opening Pandora’s Box”. Often it came down to trying to balance compassion among all patients in a fixed amount of time. Participants believed that understanding when it was important to let patients talk and when they could be rescheduled or redirected was an important skill in learning to balance compassion and make connections. Finally participants also noted that compassion could save time overall if it assisted physicians in reaching hidden agendas and resolving issues satisfactorily.

The key finding in this section was that physicians could be compassionate during brief visits but that to be “fully compassionate” they needed time. Learning to cope with time limitations and pressures was seen to be important in providing compassionate care within our current challenging medical system.

4.5.5 Connecting with Patients within Boundaries

Participants portrayed physicians lacking in compassion as detached. Alternatively, they described compassionate physicians as connected with their patients. Participants commented that in creating a connection with patients, however, it was important that physicians maintained boundaries around their role as physician.
Although a few participants described compassionate behavior as treating patients like “friends” or “part of the family” most participants believed it was important to differentiate their relationship with their patients from that of friendship, romantic relationships or family ties. Without boundaries, participants believed physicians could slip into what might be deemed unprofessional behavior.

Some participants believed these boundaries should be very firm. For example this participant stated: “I guess it also deals with boundaries. I’m very clear cut. I like to set my boundaries just because it’s easier for me to deal with - this is working, this is not working.” Other participants suggested boundaries were not always firm and that some leeway had to be given in different situations: “There is a balance there, a line that kind of shifts a little bit back and forth but there still needs to be a line. I’m a professional. I’m not your best friend. I’m not your family member.”

Participants who believed boundaries shifted explained that they modified boundaries to suit patient personalities and situations. In addition, some participants attributed boundary variability amongst physicians to personal preferences, cultural differences and diverse ideas around physician comportment.

However, without boundaries, roles became blurred and patients’ expectations changed. “Maybe some people can take it to mean that you are like their friend and you would go to extremes to do things for them.” Participants gave examples of how a compassionate approach could be misinterpreted by patients. The following participant described an instance where he had to “draw the line” for the patient:

_The person starts to really feel like you are their friend they have different expectations of you. Last week I had a woman who is a single Mum with two young kids, having a tough time raising them. She asked me if I could be the kid’s Godfather. I have always been very compassionate and try to understand their situation. I cannot cross the boundary so I had to say no. I just wasn’t comfortable with that._

Participants described how, with patients of the opposite sex, setting these boundaries was even more crucial. They explained that if there was any sign of interest from the patient beyond a professional relationship, the issue had to be addressed immediately.
This participant described such an instance: “There have been a couple of women feeling a ‘closeness’ [to me]. I had to make it clear that this is more of a professional relationship. I am married. I have kids. It’s not my intent at all.” Participants were clear that if the physician was not able to establish this boundary, the physician’s credibility and efficacy were jeopardized.

There were several ways participants chose to clarify their role to themselves and their patients. One way was considering how the physician should be addressed by the patient. Although the majority of participants emphasized the importance of not having a hierarchical relationship with their patients in order to show compassion, some believed that adhering to a formal title, “Dr.....” made a clear delineation between “doctor” and “friend”. Others felt the formality of the title was unnecessary as long as there was mutual respect. The following participant described the importance of taking the patient’s wishes into account when establishing these boundaries.

Some people don’t want to be on a first name basis with their doctor. I think it’s a comfort level and sometimes people get caught up in the old school. It’s a respect thing and they have to respect you.

Another example of variability in boundaries was in the arena of touch. Participants described using touch to establish a connection with their patients but some felt certain physical gestures of support crossed a boundary. The following participant described how a hug represented a boundary in her mind between “friend” and “doctor”:

If you gave someone bad news and they are bawling in your office - if it’s your friend, it’s different because you are probably going to give them a hug, but it’s a patient and I guess I would feel uncomfortable doing that.

Other participants emphasized the importance of ensuring that the touch was appropriate and would be well received.

I’m careful about that (especially alone with young women in the office) just because things can be misinterpreted but in the geriatric population I deal with, there are lots of hugs and lots of hand holding - that sort of physical contact.

Touch, as described above, was considered by participants to be appropriate when the intention was to examine or reassure, when patients were unlikely to misinterpret the
touch due to gender or power differential or issues of transference, and when both the patient and physician, were comfortable with the exchange.

Participants also varied in how much personal information they revealed about themselves to patients. Some participants felt uncomfortable with this; others felt that it was appropriate if it was limited to short exchanges and developed a connection.

*I think you can also run the risk of sharing a little too much about yourself. I just read a study about physicians revealing personal information or recounting personal stories about themselves. It showed that in no circumstance did the patients feel like it was really helpful or really appreciated. They would have preferred to not have that piece because it either cut into the time that they were supposed to talk about themselves or it gave them too much information. Since I read that I've pulled back a little bit about talking about my daughter unless people ask and even then I try to keep it fairly short.*

Participants made it clear that the purpose of sharing personal stories was to show understanding and should not divert the focus away from the patient. They also commented that it was natural for physicians to have some patients with whom they had a greater connection. They believed this was acceptable as long as the patient-physician relationship remained within reasonable boundaries and did not become blurred with more intimate relationships. The following participant described a situation where boundaries and connections to certain patients raised questions for physicians:

*Do you go up to the funeral of one of your patients or are you crossing the line? I have a very frank philosophy – if I want to go, I’m going to go. I don’t really care if somebody says they wouldn’t go because that’s crossing the line. I wouldn’t say by any stretch that I go to all my patients’ funerals but sometimes I connect and I feel like I have to and I don’t care what anyone else thinks. I’ll just go.*

Participants noted that physicians who worked within boundaries and felt connected to their patients “stepped back” when their patients’ families and friends were able to provide support. For example, this participant described limiting her involvement when she saw the patient and family wanted to resolve the problem together:

*I try to really explore the feelings and try to understand what the person is going through. They appreciated that but they didn’t really want me to go any further because they see what they are going through as a problem that had to be dealt with among the family and they saw me as a sounding board, not as somebody*
who needed to be actively involved. I think as physicians we tend to want to be involved because that’s how we work. We make recommendations. We give advice.

Summary

Participants believed that to be compassionate, physicians needed to establish connections with their patients. However, they emphasized how critical it was that physicians maintained boundaries during this process. Participants remarked that without boundaries, the role of the physician could become confused with more intimate relationships like friendship. They believed this could negatively impact patients’ expectations and could lead to physician misconduct. Participants varied in how firmly they set boundaries around titles, sharing personal information and touch during interactions to clarify their role.

The key finding in this section was that, although boundaries varied between physicians, they needed boundaries to be able to connect in a meaningful way with their patients and maintain enough distance to perform in their role as physician.

4.5.6 Experience, Skill and Connecting with Patients over Career

Participants described how the skills that enabled them to connect with patients improved over their careers. They articulated how clinical experience gave them the confidence and knowledge to connect in a compassionate way. They also described how their way of connecting became more conscious and timely.

As their skills in medicine increased, participants were able to be more compassionate. Throughout training, participants recalled working to hone their skills as physicians. Because they were mastering so many things at once, they found it difficult to be engaged during their interactions with patients. The following participant described how increased comfort in her clinical skills made it easier to be attentive to her patients:

*When you’re in training you’re so focused on making sure that the patient’s comfortable, making sure that you’re getting the right piece. On the other hand*
you’re also so nervous and probably aren’t conveying as much. You’re not actively listening to the patient because you’re worrying about what you’re going to say next. It does become more intuitive the better you know the patients and the more practice and feel less worried about “Am I going to make the right diagnosis?”, realizing that everything is an ongoing process and rarely is there a situation where it’s life or death.

Participants believed as they gained experience in practice they became more confident in their clinical skills, listened more actively and became more comfortable relating to their patients. They were also able to demonstrate compassion with more ease, having practiced in many interactions. This participant described how she learned to demonstrate compassion through touch more skillfully:

The inherent qualities were probably there but I didn’t know how much to show or how much to do so I probably wouldn’t have been so demonstrative initially...Over time I got comfortable with doing that and not thinking “Am I going to get into trouble?” You’re taught not to do a lot of touching so I think I got more comfortable there....I feel more comfortable now in terms of realizing that yes compassion is there but I also have to keep limits.

Participants believed having been through difficult situations with their patients made them better able to take action and be supportive in a more compassionate way. The following participant described the process of becoming more skillful:

He was diagnosed and didn’t have a very good prognosis and he died 6 months later. That 6 months in between is a pretty difficult time and by being there and being more involved and seeing how those family dynamics work at that time you get a better understanding. It helps, I think, for when a similar kind of situation, comes up.

Having gained experience from journeying with suffering patients, participants believed physicians were less anxious about being able to respond to emotionally-laden situations. They were more comfortable asking hard questions and felt more able to respond to them.

Now I would feel more comfortable saying “How are you dealing with this?” or “Do you understand what the prognosis is?” or “Tell me what you understand is going on with you.” Before, I was a little more afraid to.

Participants suggested one reason they found it easier to engage on these difficult topics was because their emotions became more controlled over time. This participant
illustrated how demonstrations of compassion were less conscious and more emotional as a learner:

I’m doing that a little bit more consciously than I used to when I was younger. Then it was automatic. I actually did a tape once at the Family Medical Center where I was talking to somebody. I looked at it afterward. I was listening to them talk and I reached over and touched them and my hand was like I was touching electricity. It went ‘click’ like that because it was just not the right moment. I may be better at that now than I used to be. Not saying it’s artificial, but steering it a little bit more.

Other participants portrayed their demonstrations of compassion as less conscious as they gained experience. They related how demonstrations of compassion came more easily than in their earlier years. For example: “It was a conscious effort for a while and now it’s become something that’s more naturally occurring.” The following participant described how breaking bad news became more natural:

When you’re fresh out of medical school all you’re playing in your head is, “how to break bad news” …The more you do it the less conscious it becomes - like the logistics of things, taking patients into a separate room if you can or just saying to the nurses, “I need 5 minutes. Let me just talk to the family alone.”

Participants also felt they became more skilled at knowing when to be compassionate and with whom. This had the added benefit of helping them balance compassion within the time constraints of practice.

After working for so many years you know when to go into a particular area of their problem or not. You start to sense “I can go here” [or] “Maybe I shouldn’t open that door right now – I’m not going to have time to get into it.” You start to recognize the areas that you can delve into or not. I think that allows you to be more compassionate or appear more compassionate to them without feeling rushed or constrained by time.

Summary

Participants explained how as they gained more clinical experience, they became more skilled at demonstrating compassion. They considered themselves idealistic upon entering medical school but their lack of knowledge and experience hampered their compassion. When they started working with patients, the challenges of the physician role, so new to them, distracted them from being “present” for their patients. As their
skills and confidence grew, they could be more connected to their patients. They became more comfortable demonstrating compassion through touch, active support and asking the hard questions. Participants believed they became more conscious of how they demonstrated compassion; however, they also felt that with practice, compassionate responses became more intuitive and less awkward. Participants also remarked how, with experience, they were better at balancing time.

The key finding in this section was that with clinical experience physicians were better able to connect with their patients as they became more skilled at demonstrating compassion.

4.6 The Compassion Trichotomy

In the analysis, it became apparent that the participants were articulating a cyclical process which could be labeled “The Compassion Trichotomy” (Figure 1). The connection they gained with their patients fed their motivation. Their motivation replenished their energy and capacity for compassion. Finally, their capacity for compassion augmented their skills to connect with their patients.

![Diagram of the Compassion Trichotomy]

Figure 1 - The Compassion Trichotomy
Participants remarked upon how the human connection that comes from compassionate interactions further fed their motivation to be compassionate.

*For me it’s that human connectedness. It makes you feel like you’re making a difference. At the end of the day somebody will have suffered through something difficult and they have died but you brought something good to that. That feels good and it makes you want to keep doing it.*

Other participants described how this motivation also fed their energy and capacity for compassion. Some felt compassion provided the “fuel” for them to continue their work. Others described it as an “endorphin” or something that “replenished” their energy.

*The impact it has on those that you’re compassionate with, the response that you get, makes you feel good. It’s its own little endorphin if you want. It feels good and so it makes you want to keep doing it. It feeds me - it helps me replenish myself so that I can keep doing it. It’s not something that just keeps sucking you dry. If you do it, it gives back in spades.*

However, a few participants also commented that when physicians didn’t nurture their capacity for compassion by caring for themselves, their motivation for compassion could become diminished. “*What you don’t want to do is start developing resentments...If you start resenting certain aspects of your job... then you might become less compassionate in a way... because you’re working too much.*”

Participants also described how their capacity for compassion could impact their ability to connect. They believed their personal experiences which developed their empathy and capacity for compassion honed their skills to connect with people.

*Your life experiences develop the skills you’ve got...Maybe you know a little bit more but basically you are more comfortable asking the questions. You can relate more to the person so they open up more....You have more empathy with what’s going on...and the fact that you know what questions to ask helps them open up.*

Through their stories, participants expressed how motivation, capacity and connection related to physician compassion, and generated a virtuous cycle. The following participant summarized some of the key components and how they related to finding meaning in his work.
It probably provides about 98 per cent of the fuel. I think if I had to be just a
doctor technician it wouldn’t interest me at all. It’s really the ability to feel that
you’ve done something for somebody because you not only know what is
necessary, but you understand enough about human beings to know what it means
for them. So it’s about meaning. Adding meaning to someone’s life is like
creating something - like Erikson used to say: “to be an adult is a time to be
generative”. The adult’s job is to care for the world, to be creative. When you do
something for somebody it creates a feeling, so it’s special.

Summary

Participants observed that the human connection they experienced through compassion
further motivated them to be compassionate. This motivation energized them and fed
their capacity for compassion. However, they did note that if they neglected themselves,
their capacity diminished and they became less motivated. Finally participants
articulated how their capacity for compassion built on experience and empathy enhanced
their skills to connect with their patients.

The key finding in this section was that physician motivation fed capacity for compassion
which enhanced connection with patients. This connection in turn supplied physicians
with renewed motivation for compassion. In summary, this cyclical process reflected
“The Compassion Trichotomy.”
Chapter 5

5.1 Discussion

This study has illuminated the experiences of family physicians providing compassionate care. Through this work, we have developed a definition of compassion in family medicine, the concept of “The Compassion Barometer” and an understanding of the generative nature of compassion in “The Compassion Trichotomy”.

Definition

Although compassion has been considered an important quality in physicians throughout the history of medicine, interest in defining compassion has been focused mostly in relation to medical ethics and philosophy. However, growing concern in medical education about professionalism and the decline of empathy during training has increased the research interest in empathy and compassion. In addition, sociological, psychological and neuroscientific findings regarding emotion have increased our understanding of the processes involved in compassion and empathy.

In our study, although participants unanimously agreed that compassion was not related to pity, they initially struggled to define compassion. There seemed to be three reasons for this: 1) compassion was not something they discussed, read about or reflected on regularly in terms of work and possibly even daily life; 2) the terms they used to describe compassion, such as empathy and sympathy, also had conflicting definitions amongst participants and in the literature; and 3) the cognitive and affective components of compassion were weighted differently by different participants. However, their descriptors of compassion evolved into a definition: “Compassion is the development of emotional resonance and cognitive understanding regarding the suffering of a fellow human being that evolves into a desire to alleviate said suffering.” The three key aspects of this definition are: 1) the role of both cognition and emotion in the process; 2) being grounded in a non-hierarchical relationship; and 3) the resultant desire for prosocial action. This definition is in alignment with other definitions of compassion in the medical literature.13, 16, 17 There is also some overlap with definitions of empathy reported
in the literature, for example, Mercer and Reynolds\(^{15}\) defined empathy in the context of primary care and identified four components: emotive, moral, cognitive and behavioral. Ekman\(^{110}\) also described a third type of empathy, in addition to affective and cognitive, called compassionate empathy which occurs when empathy moves us to act. Classically, however, empathy is defined as the emotional and cognitive capacities that are part of compassion.\(^{16,19}\) It can be argued that the motivation, or moral aspect, and the action component are what differentiate compassion from empathy. As described below in the Compassion Barometer, action may not always be required but the intention must be there should the need arise. Indeed, it can be argued that compassion may be present when there is no suffering but might also exist as a desire to prevent future suffering of the patient. Further studies with family physicians, patients and other medical personnel would validate the definition generated in this project. Because of the complexity of compassion, broad discussions on the topic are more informative; however, this definition of compassion provides a starting point for discussions around research, education, policy and standards of care in family medicine.

**The Compassion Barometer**

The Compassion Barometer was another key finding that emerged in this study. Participants believed that patients expected their physician to have the capacity for compassion at all times but to demonstrate compassion only when the situation demanded it. Participants articulated that specific factors, such as intimacy, fear, psychosocial aspects and complexity of the problem, were reasons why patients wanted compassion. Furthermore, these factors could impact the patient’s vulnerability. Participants described how age, sex, culture, religion, social environment and personality influenced the way they showed compassion. They also explained how some of these factors made the patients more or less vulnerable in the eyes of physicians. These findings are consistent with the literature on the role of compassion in instances like medical error,\(^ {27}\) palliative care,\(^ {38}\) breaking bad news\(^ {260}\) and mental health.\(^ {30}\) These are areas that are much more emotionally laden, where the patient may be more vulnerable. Figure 2 depicts The Compassion Barometer, illustrating the relationship between the capacity for and demonstration of compassion and patient vulnerability:
Physician Capacity for Compassion

Figure 2: The Compassion Barometer

Participants believed patients expect their physician to have the capacity for compassion at all times but to increase their demonstrations of compassion when patients feel more vulnerable.

Vulnerability relates to susceptibility to emotional or physical injury and therefore is clearly linked with suffering. Cassell describes suffering as, “the state of severe distress associated with events that threaten the intactness of the person.”\(^{261}\) However, when patients visit their family physicians they are not always suffering. Miller\(^{262}\) describes the kinds of visits encountered in family practice as: routines, ceremonies or dramas. Routines are new, simple, single concerns that are easy to resolve. Maintenance ceremonies are visits concerning stable or chronic issues. Dramas occur when there is a potential turning point in the patient’s story. They may be complicated, uncertain, conflicted and require several visits to address. The latter category is the most likely to involve both vulnerability and suffering and it is in these visits that we propose that patients might desire more compassion. Further studies are needed from the patient perspective to confirm this finding.

The Compassion Trichotomy

The main conceptual finding in this study was what we have termed The Compassion Trichotomy. Physician compassion in family medicine is influenced by three main elements: 1) motivation for compassion; 2) capacity for compassion; and 3) patient-
doctor connection related to compassion. These three areas inform distinct developmental areas for compassion in the physician. Motivation, capacity and connection are also linked by feedback loops that can promote the evolution or devolution of compassion in the physician.

These three areas parallel specific appraisals described in emotion research. These appraisals track an individual’s interaction between the self and the environment and give rise to emotion. Goetz et al.\textsuperscript{25}, in their evolutionary analysis of compassion, identified how specific responses to these three appraisals result in compassion. Although we understand that compassion is oriented to reducing the suffering of others, from an evolutionary perspective it is not unconditional but shaped by cost-benefit ratios and hence the need for appraisal. The study findings can be tied to three appraisal areas described by Goetz et al.\textsuperscript{25}:

1) The relevance of sufferer to the self - \textbf{motivation}
2) The individual’s ability to cope with the situation at hand - \textbf{capacity}
3) The sufferer’s deservingness of help - \textbf{connection}

In the following sections we will explore the three areas of motivation, capacity and connection in relation to these appraisal systems and how they inform the development of compassion in the family physician.

\textit{Motivation and relevance}

Participants in this study described how patients want compassion and how compassion improves physician efficacy and quality of care. As a result, they identified the patient and physician satisfaction derived from compassionate interactions as motivators for continuing to provide compassionate care. In essence, they were describing the evolutionary basis for compassion, mutual benefit.\textsuperscript{25} Research into patient preferences\textsuperscript{27-33} and the outcomes of compassionate care\textsuperscript{4,41-44} confirm these findings. However, evolutionary theory would also dictate that compassion would be most intense in response to those who are most important to one’s well being, for example: relatives, reproductive partners, friends or group members. Indeed, studies have shown that we are
more likely to feel compassion for those who are related or emotionally close. In addition, we know that people are more likely to help those who are similar to themselves in terms of personal values, preferences, behaviors or physical characteristics.

Participants explained that they had difficulty showing compassion to patients who had different values and preferences or difficult behaviors. And yet some participants also described how compassion helped them overcome difficulties with these patients. Some participants did this by referring back to their value system, specifically the “Golden Rule,” “doing unto others as you would have done to you.” This is an example of how another’s suffering can be appraised as relevant to the individual’s broader goals and values allowing them to feel compassion. Consistent with the research on prosocial behavior, participants described how their family upbringing, role models, life experiences, religion and spirituality developed these values. It is recognized that family physicians value beneficence but that there are many tacit values of self-interest in the medical environment that can erode these values, especially during medical training.

Participants described how helping others can outwardly appear to be compassionate but may be driven by self-interest. In these instances, the desire to appear compassionate or the need to control death and disease and be the “hero healer,” are at the core of these behaviors. Because the behaviors were less patient-centered and more doctor-centered, participants felt they led to less favorable outcomes for patients as patients were rendered more dependent. In addition, they felt these motivations were more likely to lead to exhaustion and disappointment for physicians. This parallels the findings of Marcus and Halpert as well as the ideology of Remen who emphasize the importance of letting go of egoistic motivations to enable empathy and compassion and diminish burnout. Further research into the role of physician self-interest versus other-interest motivations would broaden our understanding of the role these motivations play in compassion, satisfaction and burnout.

Another important aspect of the self-relevance appraisal is that there is a clear delineation between self and other. To be compassionate, an individual must be aware of their
separateness from the sufferer. Without this distinction, the individual will experience sadness or distress, rather than compassion, when witnessing another’s suffering. Thus there is a delicate balance in this stage of appraisal. In order to experience compassion the physician must feel connected enough to the patient that they can feel compassion, but sufficiently distinct from them so they feel compassion rather than distress. This relates to how developing connections with patients, within boundaries, can feed the motivation for compassion as discussed below.

**Capacity and coping**

Findings in this study indicate that empathy is the central factor in determining capacity for compassion. Although participants believed capacity for compassion was determined partly by innate qualities, they also considered experience crucial to the development of empathy. This parallels findings in the literature with twin studies\(^{128-130}\) showing that some aspects of compassion are inherited, while other studies demonstrate that empathy is developed in families through role modeling\(^{133-136}\) and the way emotions are discussed and managed.\(^{136, 140-142}\)

The development of empathy is crucial to an individual’s assessment of whether they can cope with emotionally laden issues such as suffering. As part of the appraisal system of compassion described by Goetz et al.\(^ {25}\) individuals need to assess the cost of acting on behalf of others. As a result, if an individual feels capable of coping with someone’s suffering they are more likely to feel compassion. If they feel unable to cope, they are more likely to feel personal distress which will diminish tendencies towards compassion.

Participants’ descriptions of developing empathy through experience mirror the concepts of affective and cognitive empathy described by Ekman.\(^ {110}\) Participants described emotional development (affective empathy) within early family life that may relate to emotional intelligence and emotion regulation. They also described gaining greater perspectives on others’ experiences (cognitive empathy) through life events, illness and exposure to the humanities. Studies examining emotional intelligence,\(^ {154, 155, 267}\) prosocial behavior,\(^ {133-136, 140-142}\) illness narratives\(^ {28, 34, 191, 268}\) and medical education\(^ {192-195}\) lend credence to these findings.
Emotion regulation is a reflection of an individual’s sense that they have the psychological resources to cope with the situation at hand. Studies exploring emotion regulation and compassion suggest that those who are able to regulate their emotions report compassion rather than distress when responding to others suffering. Other studies indicate that individuals who reported empathetic self-efficacy were more likely to share, help and care for others. In other words, if they felt they were able to empathize, they were more likely to be compassionate.

Developing both the affective and cognitive aspects of empathy may allow physicians to engage in compassionate care effectively. Promoting detachment as a means of dealing with the emotions involved in suffering is more likely to lead to avoidance of emotional issues, emotional distress and less patient-centered care. Evidence supporting this is abundant in the studies conducted on decline in empathy in medical training.

Finally, participants also described how their energy levels influenced their empathy and therefore their capacity for compassion. Energy levels were considered important to maintain the emotional stamina and mental focus required to be compassionate. Physical, psychosocial and spiritual health were mentioned as factors that impacted energy levels and work-life balance, which were central to maintaining energy. Studies on compassion fatigue and burnout corroborate these findings. In addition, participants described how compassionate interactions energized them because compassion resulted in satisfactory outcomes for both patient and doctor. Compassion also provided meaning to their work which parallels Stamm’s concept of compassion satisfaction. It is through this feedback loop that motivation for compassion stimulates capacity for compassion. Further research into compassion fatigue and satisfaction in family physicians would provide a better understanding of how to bolster and maintain capacity for compassion.

Connection and “deservingness”

Participants articulated how compassion enabled them to develop connections with their patients. Connections were formed through methods that required little time and those that required more time. They identified verbal and nonverbal communication skills that
can be grouped into five categories: demonstrating openness, being present, endeavoring to understand, being supportive and connecting on a human level. The research within medicine and nursing regarding empathetic and compassionate communication resonate with the skills identified by participants.\textsuperscript{207-213, 215-217}

A key component to these communication skills was an underlying non-judgmental and respectful attitude. It is this attitude that is crucial to the third appraisal process that is present in compassion, “deservingness”.\textsuperscript{25} Evolutionary theory suggests that if compassion is based on mutual benefit, individuals will choose to be compassionate to others who are likely, in turn, to be compassionate and therefore deserving.\textsuperscript{25} Therefore, if individuals believe the sufferer is to blame for their problems, they may not see them as deserving and may become angry instead of compassionate. Indeed studies show that diseases rated as having low controllability (blindness, Alzheimer’s disease) elicit more compassion than diseases that have higher controllability (drug abuse, obesity) which elicit more anger.\textsuperscript{273, 274} Our findings, related to participants’ views on the challenges of being compassionate with difficult patients, also support this theory.

It is possible that the feedback loop between capacity and connection has an impact on the appraisal of deservingness in compassion. As cognitive empathy develops through experience, individuals may be better able to empathize and understand the reasons behind behaviors that have led to suffering. As empathy develops and physicians feel they can cope with suffering, they are more willing to engage in addressing suffering, thereby gaining more experience and improving their perspective-taking abilities. This ability then translates to a non-judgmental and respectful attitude toward their patients. This is in alignment with what participants in this study articulated regarding the relationship between gaining experience and being better able to connect with their patients. Additional qualitative research exploring the link between empathy, experience and attitudes in family physicians would verify this proposition.

Studies have shown that the sufferer’s trustworthiness and warmth are important in determining “deservingness”.\textsuperscript{275, 276} Therefore, if the physician finds the patient warm and trustworthy, they are more likely to feel compassion. Participants in this study also
described in their encounters with difficult patients, the role that trust played in enabling compassion. Furthermore, they explained how important trust was from the patient perspective, that trusting the physician was crucial in developing rapport and ensuring continuity in the relationship. The importance of trust in the patient-doctor relationship has been described in many other models.\textsuperscript{5, 228, 229}

In The Compassion Trichotomy, trust has its own feedback loop between connection and motivation. As physicians communicate and take action in a compassionate way, patients leave the encounter feeling satisfied that the physician is caring for them and relieving their suffering. Because of this satisfaction and caring, patients trust their physicians and return to them. This leads to continuity in the relationship and further opportunities for the physician to build on compassionate care. Future research to explore the patient perspective on the role of continuity, trust and compassion in the patient-doctor relationship is needed to corroborate this feedback loop.

The longitudinal component of the patient-doctor relationship provides further feedback. As relationships develop, the self-relevance appraisal is altered in the motivation aspect. Long-term patients, with whom physicians have developed rapport, will become more “relevant” and therefore physicians will be more motivated to be compassionate. In addition, the increased understanding of the patient developed by the physician over time improves their ability to empathize. Therefore, physicians feel able to cope and engage in compassion. The ability to empathize, in turn, impacts the physician’s view of patient “deservingness” and informs a non-judgmental attitude enabling connection and so the cycle continues.

The impact of relationship over time may be an important factor in understanding why some participants perceived compassion as taking time. However, they clearly articulated that one could show compassion in a short period of time by being open and non-judgmental, being present mentally, endeavoring to understand, showing support and engaging on a human level. Understanding, supporting and being present and available can also have a longitudinal aspect that allows for further development of compassion. Studies describing the efficacy of empathy and compassion\textsuperscript{41-44} and those demonstrating
the time-efficiency of patient-centered care, corroborate the message expressed by some of the participants that compassion may save time. Some participants were concerned about “opening Pandora’s box” and running out of time which decreased their desire to engage compassionately. This may reflect their perception that compassion takes time but may also reflect their concern about their ability to cope with the emotional content. Further studies should compare efficiency and effectiveness of compassionate communication with standard communication.

Participants also discussed the role of boundaries in keeping compassion in balance when connecting with their patients. There is minimal research on this issue but boundaries have been traditionally promoted to ensure that physicians act in the best interest of the patient. The extant research indicates that boundaries vary from physician to physician and not maintaining boundaries can lead to unprofessional behavior and burnout.

Participants in this study believed boundaries were vital to differentiate between compassionate professional relationships versus more intimate relationships. Boundaries were described for each area of The Compassion Trichotomy and varied a great deal from participant to participant. Some of this variation may be related to how many years participants were in practice. It may also reflect their awareness and abilities around the appraisals that occur in each of the three areas. For example, in motivation, the physician’s ability to consider the patient “relevant” depends on their value system and their relationship with the patient. Boundaries around availability may be important to physicians who are aware that their own desire to be the healer might jeopardize the care of the patient by making them dependent. In capacity, the physician’s ability to cope depends on their emotional regulation and ability to understand the patient’s perspective. The type of boundaries around emotional engagement may be related to how well the physician can cope with emotional engagement. Finally, in connection, the physician’s facility to see their patient as deserving depends on their ability to be non-judgmental which is in turn dependant on seeing the patient’s perspective. Boundaries in this area may reflect the physician’s desire to connect in such a way as to be close enough to understand and empathize but separate enough to maintain the clear delineation between
self and other required in self-relevant appraisal. Further research is needed to explore the role of appraisals associated with compassion in boundaries set by family physicians.

**Implications for Medical Education**

As reports on medical education are calling for more focus on empathy and compassion in undergraduate and postgraduate medical education, the current study findings could be useful in informing educational policies and practices.

**Admissions**

Evaluation for admission to any medical faculty is usually a multi-pronged process. This involves some evaluation of academic performance through grades, Medical College Admission Test (MCAT), essays and personal interviews to capture motivations, relevant experiences and interpersonal skills. Essays and personal interviews may be able to identify candidates who are motivated by compassion and have the capacity and skills required. However, other methods may also be useful. For example, the Medical Situations Questionnaire developed used by McManus et al. could provide better insight into candidates’ motivations for entering medical school. Emotional intelligence testing may provide a better indicator as to candidates’ capacities for compassion. Finally, observation of communication skills, such as those listed in Table 1 “Communication Skills to Demonstrate Compassion” (p107), may provide better information on how well candidates are able to connect compassionately. This could be done by observing candidates interact with each other while participating in a mock problem based tutorial.

**Faculty development**

In order to effect change in medical education, the faculty needs to value compassion, act as role models and develop the skills to teach learners compassion. Recognizing faculty who demonstrate and teach compassion through awards and bursaries, as well as recruiting faculty members who are renowned for compassionate care, may increase the value of compassion in medical faculties. If evaluation of faculty takes into account their capacity for compassion, this may also raise institutional awareness of the need for compassion. Faculty may also benefit from exposure to recent progress in compassion
research and the relevance to medical training and practice. Role modeling has been identified as one of the core issues in perpetuating values incompatible with compassion\textsuperscript{3, 7} and has also been shown to be effective in the early development of compassion.\textsuperscript{133-136} For this reason, the core concepts discussed below for developing compassion in students need to be developed in faculty members.

**Curricular Objectives**

Medical educators have identified that the teaching of compassion has been superseded by the focus on the biomedical aspects of disease. Medical technology, medications and our understanding of disease processes are constantly evolving and the need to remain current can crowd out education around “softer elements” such as compassion. Setting objectives centered around compassion at each stage of training may help to counteract this tendency. This would also ensure that evaluations of students would regularly focus on their ability to be compassionate and reinforce the ethos that compassion is valued in the medical environment.

**Professionalism and reflection**

Some medical educators have addressed the concerns regarding decreased empathy in training by developing courses in professionalism. However, critics of this approach argue that training in professionalism requires more than learning lists of rules and behaviours.\textsuperscript{3, 7} Classroom time devoted to compassion might include courses in professionalism and ethics but perhaps should also include more reflective exercises, allowing students to explore their own values within the context of medical practice. Haidet argues that although much time had been spent defining professionalism in medical education, we are only just starting to address the development of professionalism. In his view, reflection is central to this process.\textsuperscript{286} Rabow et al.’s\textsuperscript{89} course “The Healer’s Art” would be an example of this approach. Another example would be conducting a “Mission Statement Day”, as described by Kenyon and Brown,\textsuperscript{287} that helps students in the initial week of their medical education articulate the goals and aspirations of their training. Finally, Nisker promotes the use of narrative as a tool for
reflection and a way to conserve compassion as medical students navigate through the medical environment.\textsuperscript{268}

**Developing Capacity for Compassion**

**Developing emotion regulation**

Developing emotion regulation was identified in this study as an important factor in developing empathy. Mindfulness training is being explored in some medical centers towards this end with some success.\textsuperscript{167, 168} Others have started looking at the emotional intelligence model which develops emotional awareness and emotion regulation.\textsuperscript{155, 267} Models like the one described by Meier et al.\textsuperscript{171} may also be useful tools to improve emotional awareness in the clinical setting.

**Developing perspective-taking**

Some medical educators have emphasized the importance of providing medical students with an education in the humanities to develop compassion.\textsuperscript{192-195} Findings in the current study would concur with this reasoning as participants described how this type of learning cultivated compassion. Exposure to the arts may develop emotional awareness whereas learning about other cultures, social issues and psychology may develop perspective-taking and empathy.

Reading patient and physician narratives and writing narratives have also been recognized as developing empathy by increasing insight into the illness experience.\textsuperscript{268, 288, 289}

**Maintaining energy**

The stressors of medical training are well documented.\textsuperscript{9} These stressors impact students in many ways and there is some evidence to suggest that anxiety, tension and stress can alter the signal rate of mirror neurons that are linked with empathetic ability.\textsuperscript{187} This study, however, also illuminates the role that energy levels have on the capacity for compassion. Students in training programs which are physically exhausting and leave them with no time for a personal life will have less capacity for compassion.
**Communication Skills**

Participants in this study identified a clear set of communication skills, listed in Table 1 “Communication Skills to Demonstrate Compassion” (p107), that convey compassion and these are verified by the literature. Understanding the components of compassionate communication will make it easier for educators to teach and evaluate compassionate communication skills. This can be done in settings with both simulated and real patients. In addition, linking these communication skills with the key areas of physician development noted above will add further depth to the teaching of genuine and compassionate communication.

**Continuity**

Another important finding of this study is that compassion develops through the patient-doctor relationship. For this reason, it is crucial that students have some experience of continuity with patients throughout training in order to experience relationships with their patients.

5.2 Limitations

The purpose of the study was to develop an understanding of compassion in family medicine. Given the lack of previous work in this area, it was appropriate to use a qualitative methodology to explore ideas and generate hypotheses. However, given the small sample size and the nature of the research method, these findings may not apply to all family physicians. Both male and female participants were purposefully selected to provide a rich description of their experiences and beliefs to inform the research question. Although participants had a broad range of years in practice and practice profiles in both rural and urban settings, the sample did not represent a full range of ethnic, religious or cultural groups. Participants were only practicing in Ontario and the fee for service structure has changed since participants were interviewed, therefore, their reflections on how this system influences compassion may no longer apply. Although transcripts were
analyzed by the interviewer and another researcher, this may not have fully compensated for the impact of a single interviewer’s bias on participant responses.

5.3 Conclusions

The purpose of this study was to explore family physicians’ experiences of compassion in the care of their patients. There were three main findings from this research: the definition of compassion in family medicine, The Compassion Barometer and The Compassion Trichotomy.

1) Compassion in the family physician can be defined as: “the development of emotional resonance and cognitive understanding regarding the suffering of a fellow human being that evolves into a desire to alleviate said suffering.”

2) The Compassion Barometer portrays how patients expect their family physicians to have the capacity for compassion always but to titrate their demonstrations of compassion to their suffering and vulnerability.

3) The Compassion Trichotomy describes the three key developmental areas of compassion (motivation for compassion, capacity for compassion and patient-doctor connection related to compassion) and how they are linked by feedback loops that determine the evolution or devolution of compassion in the family physician.

These findings provide insight into how compassion can be taught in medical education.
References


82. Armstrong K. *Twelve steps to a compassionate life*. The Bodley Head: 2011.


107. Marcus E. Medical student dreams about medical school: the unconscious developmental process of becoming a physician. *The International Journal of*


   <http://net.acpe.org/Resources/Articles/Doctors_Say_Morale_is_Hurting.pdf>
   [Accessed March 15, 2012]


Appendices

Appendix A: Letter of Information

Letter of Information

Understanding Compassion in Family Medicine: A Qualitative Study

Introduction and Purpose of Study:

The Center for Studies in Family Medicine is conducting a study exploring compassion in the patient doctor relationship. We invite you to participate in this study. The purpose of this letter is to provide you with the information you require to make an informed decision on participating in this research.

Who Can Participate?

You are invited to participate in this research if you are a family medicine resident or a family physician who has been in practice for less than five or more than ten years. In order to be eligible to participate you must be between the ages of 20-80, understand English, and speak English well enough to convey your opinions and ideas. You must be someone who is able to openly share their professional and personal experiences around compassion in your interaction with patients.

What Will the Study Involve?

Dr. Jane Uygur will follow up this letter with a phone call to you. At that time should you agree to participate, you will be asked to have a 60 minute one-to-one in-depth interview with her. This interview will be conducted in a quiet place of your choosing, at your convenience. The interview will explore your notions of and experiences of compassion in your interaction with patients. The interview will be audio-taped, transcribed verbatim and analyzed.
Qualitative analysis will be conducted on the data collected. You may be asked to review your interview for verification of data collected.

Participation in the study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no effect care.

**Confidentiality**

The information that you share will be kept strictly confidential. The audio tapes will be numbered and identifying information about you will be kept in a locked cabinet. All taped and transcribed data will be destroyed at the end of the study. Your name will not be used and your identity will not be disclosed should the study be published. Your name will not be used and your identity will not be disclosed should the study be published.

**Risks and Benefits:**

We see no risks associated with this research. This study may help physicians, medical teachers and the public understand better what impacts physicians’ compassion. This may provide insight into how medical teaching and medical infrastructures might evolve to provide more compassionate care for patients.

**Do you Have Questions?**

If you have any questions about this study or require further clarification you may contact Dr. Judith Belle Brown (Co-Principal Investigator) at the Center for Studies in Family Medicine or Dr. Jane Uygur.

If you have questions about the conduct of this study or your rights as a research participant you may contact the Director, Office of Research Ethics, at the University of Western Ontario. Representatives of The University of Western Ontario Health Sciences Research Ethics Board may require access to your study-related records or may follow up with you to monitor the conduct of the research.

If you agree to participate, please contact Dr. Jane Uygur by email or phone as above.
Thank you for your consideration.

Dr. Judith Belle Brown, Ph.D.  Dr. Jane Uygur, M.D., M.Cl.Sc.(candidate)
Professor (Co-Principal Investigator) (Co-Principal Investigator)
Center for Studies in Family Medicine Center for Studies in Family Medicine
Schulich School of Medicine & Dentistry Schulich School of Medicine Dentistry

Dr. Carol Herbert, M.D.
Dean (Supervisor)
Schulich School of Medicine
Center for Studies in Family Medicine
Schulich School of Medicine & Dentistry
Appendix B : Consent Form

**Participant Consent Form**

**Understanding Compassion in Family Medicine: A Qualitative Study**

You do not waive any legal rights by signing this consent form.

I have read the accompanying Letter of Information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

I agree to take part in the study.

Printed Name of Participant: ________________________________

Signature of Participant: __________________________________

Date: ________________________________

Printed Name of Person Obtaining Consent: ___________________________

Signature of Person Obtaining Consent: _____________________________

Date: ________________________________
Appendix C : Semi-structured Interview Questions

Understanding Compassion in Family Medicine – A Qualitative Study Semi-structured Interview Questions for Key Informant Interviews

The semi-structured interview will include the following questions:

1) A definition of compassion is: sympathetic pity and concern for the sufferings or misfortunes of others. Does this describe compassion adequately for you? If not provide another definition.
2) Do you think it is important for a physician to be compassionate?
3) Do you think that patients want their physicians to be compassionate?
4) What role does compassion play in the relationship you have with your patients?
5) What impacts your capacity for compassion? Give some examples.
6) Has your compassion for your patients changed since you started studying medicine? If so, in what way? Points of change in time over career.
7) Are there times in your career where you felt more or less compassionate? Give some examples.
8) What aspects of the system (i.e. medical training, medical culture, family practice, the health care system) do you think have impacted your capacity for compassion?
9) Do you think that physicians can be taught to manage their capacity for compassion?
10) Can you share with me a clinical example of when compassion played a critical role in the care of a patient(s)?
Appendix D: Ethics Approval

Office of Research Ethics
The University of Western Ontario
Room 00045 Dental Sciences Building, London, ON, Canada N6A 5C1
Telephone: (519) 661-3036 Fax: (519) 850-2466 Email: ethics@uwo.ca
Website: www.uwo.ca/research/ethics

Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. J.B. Brown
Review Number: 13171E
Review Date: April 1, 2008
Revision Number: 1
Revision Level: Expedited

Protocol Title: Understanding compassion in family medicine - a qualitative study
Department and Institution: Family Medicine, University of Western Ontario
Sponsor:
Ethics Approval Date: April 1, 2008
Expiry Date: September 30, 2008
Documents Reviewed and Approved: Revised study and date.
Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICHI Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced revision(s) or amendment(s) on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the HSREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the HSREB:
   a) changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
   b) all adverse and unexpected experiences or events that are both serious and unexpected;
   c) new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes/adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information/consent documentation, and/or advertisement, must be submitted to this office for approval.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

Chair of HSREB: Dr. John W. McDonald

Ethics Officer to Contact for Further Information

☑ Janice Sutherland
(janics@uwo.ca)  ☑ Jennifer McEwen
(jmcewen@uwo.ca)  ☑ Grace Kelly
(gkelly@uwo.ca)  ☐ Denise Grafton
(dgrafton@uwo.ca)

This is an official document. Please retain the original in your files.

UWO HSREB Ethics Approval - Revision
V.2007-10-12 (ppApprovaNotices/HSREB_REV)
13171E
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# Curriculum Vitae

**Dr. Jane Uygur BA, MD, CCFP**

## EDUCATION AND QUALIFICATIONS

### UNIVERSITY QUALIFICATIONS

*McMaster University, Hamilton, Ontario, Canada*
- Medical Degree  
  1989–1992

*Queen’s University, Kingston, Ontario, Canada*
- Bachelor of Arts in Life Sciences  
  1986–1989

### POSTGRADUATE EDUCATION

*The Sisters of Charity Ottawa Health Service – Bruyere Continuing Care*
- University of Ottawa, Ottawa, Ontario, Canada
  - Care of the Elderly Fellowship  
    1996 -1997
  - R3 in Family Medicine – 6 months

*Wellington Hospital*
- University of Otago, Wellington, New Zealand
  - Senior House Officer – Obstetrics and Gynecology – 8 months  
    1994-1995
  - Registrar – Geriatrics – 3 months

*St. Mary’s Hospital*
- McGill University, Montreal, Quebec, Canada
  - Family Medicine Residency – R1 and R2  
    1992-1994

### QUALIFYING EXAMS

- Canadian College of Family Physicians  
  April 1994
- Quebec Family Medicine  
  April 1994
- Licentiate of the Medical Council of Canada
  - Part 2  
    Oct 1993
  - Part 1  
    April 1992

### CURRENT STUDIES

*University of Western Ontario, London, Ontario, Canada*
- Masters of Clinical Science in Family Medicine  
  2002-2012
  - Coursework completed successfully
  - Thesis ongoing - projected completion 2012
CLINICAL EXPERIENCE

TORONTO, ONTARIO, CANADA 2002-2006

Clairhurst Medical Building
Family Physician - Group Practice 2003-2006

Baycrest Geriatric Care Center
Long Term Care Physician 2003-2006
Day Treatment Center Physician 2002-2006

Family Medicine Consultant
- Geriatric Psychiatry Inpatient Unit 2002-2005

LONDON, ONTARIO, CANADA 2000-2002

Dr. Bill Payne’s practice
Family Physician 2000-2002

Chateau Gardens, London, Ontario, Canada
Long Term Care Physician 2000-2002

TIMMINS, ONTARIO, CANADA 1997-2000

Golden Manor and Extendicare
Long Term Care Physician 1997-2000

Community Care Access Center
Medical Advisor 1997-2000

Timmins and District Hospital (TDH)
Hospitalist 1999-2000
GP Geriatrician (TDH) 1997-2000
in Continuing Care, Geriatric Consultations, Geriatric Outpatient Clinic

OTTAWA, ONTARIO, CANADA 1995-1997

Locum Family Physician 1997

The Sisters of Charity Ottawa Health Service – Bruyere Continuing Care University of Ottawa
Care of the Elderly Fellowship 1996 -1997
R3 in Family Medicine - 6 months

Harmony Family Health Center, Ottawa, Ontario, Canada
Replacement Group Physician 1995-1996

The Sisters of Charity Ottawa Health Service – Bruyere Continuing Care
Geriatric Day Hospital Physician 1995-1996
Chronic Care Physician 1995-1996
WELLINGTON, NEW ZEALAND 1994-1995

Wellington Hospital - University of Otago
Senior House Officer – Obstetrics and Gynecology – 8 months 1995
Registrar – Geriatrics – 3 months 1994

MONTREAL, QUEBEC, CANADA 1992-1994

St. Mary’s Hospital
McGill University, Montreal, Quebec, Canada

MANAGERIAL EXPERIENCE

Chateau Gardens, London, Ontario, Canada
Medical Director 2000-2002

Timmins and District Hospital, Timmins, Ontario, Canada
Acting Medical Director for Psychiatry 1999-2000
Medical Director for Geriatrics (Continuing Care) 1998-2000

TEACHING EXPERIENCE

Baycrest Geriatric Care Center, Toronto, Ontario, Canada
Education Coordinator 2004-2006
Clinical Teacher 2002-2006

Timmins, Ontario, Canada
McMaster Problem Based Small Group Facilitator 1998-2000
Multi-dimensional Assessor (MDA) Trainer 1998-2000
Northern Ontario Family Medicine (NOFM) Preceptor 1997-2000

CONFERENCE PRESENTATIONS

Baycrest, Toronto, Ontario, Canada
Dr. Ira Pollock Clinic Day: Clinical Issues in Geriatrics and Long-Term Care 2006
“Practical Practice Management for Community Older Patients”

PUBLICATIONS

RESEARCH PROJECTS

University of Western Ontario, London, Ontario, Canada
Masters of Clinical Science in Family Medicine Thesis 2007-2012
“Understanding Compassion in Family Medicine - A Qualitative Study”

University of Ottawa, Ottawa, Ontario, Canada
Care of the Elderly Fellowship Research Project 1997
“Management of Sexually Inappropriate Behaviour in Long Term Care”
- literature search, focus group discussion and draft guideline

McGill University, Montreal, Quebec, Canada
Family Medicine Residency Project 1994
“Practice Management Training in Family Medicine Programs”
- survey of Canadian Family Medicine Program Directors and McGill Family Medicine Residents about practice management training