

Enhancing compassion in general practice:

it's not all about the doctor

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

The crisis of compassion in medicine is multifaceted in origin and no universal panacea is likely to be found. Many of us cannot define compassion or articulate the differences between compassion and empathy. Others might argue that compassion training is redundant as doctors are either compassionate or not. We remain remarkably ignorant about compassion, unsure of what it is, where it comes from, or what might influence compassion in our practices.

DIFFERENTIATING COMPASSION FROM EMPATHY

Compassion comes from the Latin roots *com*, which means 'together with', and *pati*, 'to bear or suffer'.³ Compassion is built on the capacity to empathise — a form of cognitive and emotional perspective taking — but involves the additional step of wanting to alleviate suffering.⁴ The distinction is important. An after-hours GP may recognise and feel the distress of a crying child having an asthma attack but, because he is now 30 minutes late in picking up his wife at the airport, rushes to the car park and lets colleagues manage the child. The family concerned might feel fobbed off and is unlikely to have experienced compassion as part of the clinical interchange. The doctor was empathetic but, technically, was not compassionate. Empathy without compassion is not only out of step with professional requirements but also is differentially likely to sustain negative emotional states (for example, distress), which may contribute to emotional fatigue and burnout. When confronted with intense suffering, shifting from empathy to compassion fosters positive emotions in the clinician rather than creating a situation in which empathetic misery results. We feel good when we are compassionate.

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The literature on medical compassion has focused mainly on compassion fatigue. Viewing compassion via the lens of compassion fatigue has tended to imply a finite reservoir of caring 'resource' and led to a focus on doctors as the only determinant of medical compassion. There is, however, no proof that compassion 'runs out' or that compassion is a unitary function of the doctor. Indeed, our assertion here is that this way of thinking has both 'blamed' doctors and blinkered us to a broader view of compassion as emerging from the interactive influences of patient, doctor, clinical, and institutional context.^{5,6}

LET'S NOT OVERSIMPLIFY THE ORIGINS OF MEDICAL COMPASSION

Being compassionate is not as simple as flicking on a switch or turning on a tap. Despite the best of intentions, compassion like other mental states (for example, joy, fear, sadness, gratitude, awe) is transient and impacted by internal and external variables. A doctor rushing to an important meeting might notice (but not act on) a crying pregnant woman in the waiting room. Psychological studies suggest that, when we are pressured to perform tasks seen as important, helping is reduced.⁷

The Transactional Model of Physician Compassion⁶ suggests that compassionate care stems from the interactions between doctor factors (for example, calm, refreshed, fatigued, burnt out), patient factors (for example, cheerful, angry, difficult), environmental and system factors (for example, noise, distractions from medical students, quiet consultation room), and clinical factors (for example, case complexity, presence of unexpected side effects). The emergence of compassion is not only determined by the doctor but is also profoundly influenced by context.

A toxic, soul-sapping weekend night shift in an understaffed after-hours clinic makes remaining compassionate towards patients who are abusive, intoxicated and narcotic-seeking difficult. This example serves to

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

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

Like other social primates, doctors have a strong primitive and altruistic impulse that emerges in infancy.⁸ For many of us, this impulse is why we chose medicine. Social neuroscience is progressively unpacking the brain regions, circuitries, neurotransmitters, and hormones involved in compassionate behaviour. We may be 'wired' to feel good when we help. Below, we briefly revisit the Transactional Model, using it to organise a series of practical suggestions regarding sustaining and improving compassion in general practice.

THE ORIGINS OF COMPASSION

Doctor factors

Earlier evidence suggests that interventions may enhance compassion and mitigate burnout and compassion fatigue.⁹ Even simple self-reminders may reinforce the motivation to be compassionate. Rather than the neutral maxim '*primum non nocere*' or 'First, do no harm', silently repeating 'May I be of benefit' when hand sanitising, touching a patient, or auscultating is a more proactive approach to daily professional practice. In many contexts, a significant proportion of our patients will be nearing the limits of what conventional treatment can accomplish and the most important thing we have to offer is our presence and compassion.

Mindfulness training increased objectively assessed helping behaviour in a randomised control trial.¹⁰ Greater mindfulness allows the doctor to remain calm, objective, and non-judgmental despite

the busyness of the clinical environment. Like any new skill, however, mindfulness requires training and regular practice. Similarly, compassion meditation has been incorporated into training protocols that aim to develop spontaneous empathy and altruistic responses to both the self and others. It does so by training the mind to see our common and shared desire to be happy and free of suffering.

Patient factors

Compassion flows when we like our patients and the flipside is true as well. Patients who are rude, demanding and difficult suck the oxygen from our compassion. There are several approaches to this difficulty, most of which involve a simple shift in perspective. First, we might strive to remember that the experience of a patient as 'difficult' is partly a function of our own conditioning. Patients we find annoying are seen as 'OK' by other team members. Second, we should remind ourselves that the most difficult of patients are suffering. If they were happy and content, they would not behave as such. Viewing such patients as persons who are suffering can change our defensive and threatened stance to one of wanting to care. At the very least, acknowledging patient distress may reduce our tendency to personalise any insults. No patient wakes up with the primary motivation to make our lives hell. Finally (and most ambitiously), we might try to see aspects of ourselves in our difficult patients. If you find it hard to imagine common ground, reflect on the universal likelihood that they, like us, likely want happiness and to be free from suffering.

Clinical factors

When doctors are confronted by challenging clinical scenarios, patients who are not improving, or unexpected or complicated side effects, compassion likely suffers. We shift from wanting to connect with patients to a more analytical mode. We sometimes even blame our patients for not improving. However, being unaware that our response to complex clinical situations can switch us 'offline' with our patients is neither sensible nor necessary. When doctors are cognitively or emotionally threatened by clinical situations, our minds can shift into a tunnel vision mode in which decisions like a quick pharmacological fix or an unnecessary referral are made.

Environmental and system factors

Compassion also happens (or does not happen) in particular physical and

institutional environments. Distractions during consultations including interruptions (for example, phone calls, nurses, medical students), noise, and paperwork diminish compassion.⁵ Feeling threatened by workplace issues or worries regarding patient complaints may shift the caring mind state to a defensive or aggressive approach to patients and colleagues. Many environmental factors are beyond the control of individual doctors, and management thus has an important role in addressing them. At the individual level, doctors can limit interruptions during consultations, allowing only genuinely urgent contacts. Equally, 'blocking' time as dedicated to administrative work, returning calls, and managing prescription requests should also limit disturbances during consultations. Work environments with bullying, harassment, and discrimination not only affect clinicians but also harm patients.¹¹ Addressing such issues is a complex, but increasingly necessary, challenge for doctors, likely requiring changes in leadership and culture, and ongoing professional education of all doctors.

CONCLUSION

GPs have to deal with large patient volumes, short consultation times, increasing bureaucracy, patient complaints, difficult patients, and clinic management dramas and dynamics. Not to mention personal struggles and family tussles, being a doctor is a complex biopsychosocial activity. With all these ingredients in the mix, it is easy to forget the main reason why many of us became doctors: to care. We need a broad view of compassion as occurring at the intersections between patient, doctor, clinical, and institutional contexts. Sustaining compassionate medicine is not simple. It can, however, be understood and likely trained for. By rediscovering compassion in medicine, not only may we prevent another Mid Staffordshire scandal, but also benefit our patients and ourselves.

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