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Editorial

Compassion in Clinical Care

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Special Issue: How Compassion Benefits in the Healing Process

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1. Introduction

It is a truism, if not a cliché, to say that health care professionals should be "compassionate." Who would argue with that seemingly obvious proposition? But when we examine the claim more closely, we find many questions arising. What do we mean by "compassion"? How does compassion differ from *kindness, empathy,* and *sympathy*? What empirical evidence bears on the need for compassion in general medicine, consultation-liaison psychiatry, and psychotherapy?

How does compassion enter into end-of-life care? What do the major faiths and spiritual traditions teach us about compassion? And how might compassion differ among persons of different faiths or cultures? We would suggest that while there are no short and simple answers to these questions, it is vitally important for physicians and other health care professionals to reflect on them.

2. Some Provisional Definitions

There is considerable controversy in the literature, with respect to the meaning of the terms, *kindness, sympathy, empathy* and *compassion*. As a first approximation—subject to some caveats—we can distinguish the terms as follows. *Kindness* is simply the quality of being friendly, generous and considerate. *Sympathy* involves a feeling of concern and sorrow for another person, who—according to some scholars--is sometimes viewed with a degree of condescension. *Empathy* entails a felt sense of what another person is experiencing.

"Compassion" is a complex term, derived from the Latin roots *com-*, which means 'together with'; and *pati*, 'to bear or suffer.' Compassion involves both the felt experience of another's suffering (empathy), *and the wish and intent to alleviate it*. Thus, compassion entails empathy, but goes beyond it, to some act of caring or comforting. In the words of Archbishop Desmond Tutu, "If you are going to be compassionate, be prepared for action!"[1]

It is important not to confuse compassion with *pity*. As Dr. Robin Youngson has stated, "Pity is a form of judgement [and] an assertion of superiority – 'Oh, you poor thing!' Pity is no part of compassion. Compassion always brings deep respect and non-judgment."[2]

As alluded to earlier, some writers have argued that "sympathy" resembles pity, in its tendency to patronize the recipient. Indeed, it is increasingly recognized that sympathy separates and puts distance between us and the one who suffers, such that we take a superior position *outside of the sufferer*; in contrast, empathy places us on an equal footing with the one who suffers, *inside* his or her experience. Thus, therapist Kate Thieda discusses Dr. Brené Brown's view that "Empathy fuels connection. Sympathy drives disconnection."[3]

3. Challenges in Clinical Care

The American Medical Association *Code of Ethics* states, "A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights."[4]

But in an age of increasing stress and "burnout" among physicians, compassion requires a careful balancing act. As medical humanities professor Johanna Shapiro has observed, "...physicians should have the capacity to be affected by, but also to be able to contain, the patient's distress...[and] not to be overwhelmed by the patient's plight, while simultaneously being moved by his or her suffering." [5] In this regard, Dr. Jack Coulehan has described clinical empathy as a combination of "tenderness and steadiness."[6]

Maintaining a compassionate attitude toward patients is difficult in today's high-pressure medical environment. As Dr. Antonio Fernando has observed, "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." Dr. Fernando points out that *empathy alone* is potentially unhelpful, since the physician is likely to feel the patient's pain and distress,

but have no means of processing and working through these emotions. Constructive action is also necessary. Dr. Fernando writes,

> *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 .[7]*

4. The Therapeutic Uses of Compassion

Compassion is often viewed as a three-fold experience; or, as "flowing" in three directions*: there is compassion we can feel for another person; compassion we can feel coming from others to ourselves; and self-compassion*. There is a growing research literature on the role of self-compassion in general medicine, consultation-liaison psychiatry, and—not surprisingly—in psychotherapy. Most therapeutic applications of self-compassion draw on the work of psychologist Dr. Paul Gilbert, who developed a treatment called Compassion-focused therapy (CFT). This was originally developed for people whose mental health problems are primarily linked to high levels of shame and self-criticism. CFT aims to help such individuals respond to self-criticism with self-kindness and self-compassion. [8]

Some forms of CFT incorporate the insights of cognitive therapy. For example, Cognitively-based compassion training (CBCT) has been used to treat veterans with Post-traumatic Stress Disorder. Treatment makes use of breathing meditation techniques; examination of sources of stress; learning to accept personal flaws and failings; and practicing self-kindness.[9]

Compassion-based therapy has also been used to help breast cancer patients deal with some of the negative emotions, including anxiety and depression, associated with cancer-related changes in body image. In one study of breast cancer patients, 8 weeks of compassion-focused therapy was associated with a significant reduction (vs. control group) in depression and anxiety. As the authors observed, "When there is no shame or…fear, regardless of breast cancer-induced bodily changes, like removal of breast, a reliable basis for courage, curiosity, sociability, and flexible response to the challenges [of cancer] can be developed." [10] Compassion-focused therapies may also play a role in treating patients with chronic pain—a common complaint in primary care and on C-L services. One pilot study found that compassion meditation helped reduce anger and pain severity in a small group of patients (N=12) with chronic pain. [11]

Self-compassion also seems to be important in coping with the phenomenon of "burnout" in physicians, which has now reached very high levels in some medical specialties. For example, in one study of 872 pediatrics residents, the rate of "burnout", as measured by the Maslach Burnout Inventory‘ was 58%. Using a standardized measure of self-compassion, however, the researchers found that self-compassion was protective for burnout and stress, and was correlated with greater confidence in providing compassionate care.[12]

5. Compassion in End-of-Life Care

Compassion, as we have seen, is an integral aspect of the humanistic delivery of health care. Nowhere is compassion more essential than in hospice and palliative medicine. It is also among the areas in medicine that have shown more interest in compassion, though empirical studies--even in palliative care--are in the early stages of discovery. Nonetheless, the results resonate with themes from the research cited earlier.

A recent comprehensive review defined compassion in palliative care as a ”a complex and multifacted response to suffering” involving, ”sensitivity, recognition, understanding, emotional resonance, empathic concern, and distress tolerance for another’s pain or suffering, coupled with a motivation, and relational action to ameiolorate it.”[13]

A grounded theory study of the perspectives of patients with advanced cancer regarding the differences between empathy, sympathy and compassion found that patients associated compassion with themes of being motivated by love; expressing an altruistic response; being action-oriented; and expressing a form of supererogatory kindness. Echoing the earlier commentary on the ambivalence of sympathy, patients considered it to be largely unhelpful, especially when compared to *empathy* and *compassion* which were viewed positively by patients, with most preferring compassion’s orientation toward action- and virtue-based motivators. One patient with advanced cancer described a key difference outlined earlier: that between a *compassionate* response focused on the patient; and an *empathic response* driven primarily by the clinician’s own feelings, which can sometimes be overwhelming:

> *I think I’ve come across a lot of people who have been very, very compassionate in understanding where I’m coming from, in accepting who and what my decisions are without, sort of, throwing their own feelings and empathy into this situation; [instead] they’re thinking about me. [14]*

Palliative care practitioners are committed to relieving the intense suffering of patients and their families, and their repeated experiences of grief and loss. This deep commitment places practitioners at high risk for what is ironically called “compassion fatigue.” Notably, increased self-care ability among Australian palliative care nurses and doctors was associated with an increase in self-compassion; i.e., attention to self-care enhanced compassion for oneself. But while 86% of practitioners believed self-care was important, less than half had received training in how to do so, underscoring the need for greater emphasis on self-care in the education of palliative care professionals. [15]

There is encouraging evidence that such interventions can enhance both self-care and compassion for others. Thus, a 10-week “on the job” program of mindfulness and compassion-oriented meditation for a multidisciplinary palliative care team led to significant improvement in several core components of burn-out; for example, emotional exhaustion was reduced, while sense of personal accomplishment increased. The authors suggest that, having learned these skills, practitioners may then teach the resources to caregivers of patients suffering similar distress, creating a circle of compassion.[16]

End-of-life care is also the area of health care in which a spirituality of compassion has been the most developed and welcomed. Christina Puchalski, MD—a pioneer in integrating spirituality into medical education--has developed a set of behavioral competencies, teaching methods, and assessment strategies for medical school spirituality curriculum in which compassion is central:

> *The concepts of compassionate presence—a subset of compassionate care—and student wellness were determined to be essential to these courses. “Presence” refers to the contemplative aspect of our relationship with patients. While compassionate care can involve empathy, forming connections, helping patients with issues, and being respectful and caring, presence calls upon a unique set of skills in which the clinician moves to a more reflective and contemplative space with the patient. [17]*

6. Spiritual Traditions and Compassion

Pulchalski also underscores the long, intertwined history of spirituality and medicine in the vocation of healing, which draws on the thousands of years of reflection upon and practice of compassion. Indeed, a *New York Times* reporter once asked religious scholar Karen Armstrong what she considered the most important virtue. She answered, "Compassion. No question about it. It goes right across the board in all the world religions. Compassion is the key in Islam and Buddhism and Judaism and Christianity. They are profoundly similar." [18]

Compassion is a unifying virtue that transcends the many theological and cultural differences between the great religions of the world. For the Abrahamic faiths (Judaism, Christianity and Islam), the source of the three-fold human experience of compassion described above is divine compassion; or, as the Scriptures often refer to it, God's "loving-kindness" and "mercy." The Hebrew psalmist sings,

The Lord is gracious and merciful,
Slow to anger and abounding in steadfast love.
The Lord is good to all,
And his compassion is over all that he has made. (Psalm 145,8-9)[19]

This divine energy empowers and calls human beings to respond to God, self and other with a similar mercy and compassion, "Those who act kindly in this world will have kindness." (Qur'an 39.10)

Contrary to so much of what we hear and see in post-modern life, the great spiritual traditions tell us that we are to treat friend, neighbor and enemy according to the many versions of the golden rule; that is, with forgiveness, selflessness, and benevolence. In the words of the ancient *Upanishads*, "One should practice this same triad, self-restraint, giving, compassion." (*Brihadaranyaka Upanishad* 5.2.2: the Voice of Thunder)

From the Judeo-Christian perspective, human compassion must imitate that of the Divine in its impartiality, as Jesus demonstrates in the Parable of the Good Samaritan (Luke 10: 25-27.) The universal scope that divine, and hence human, compassion must encompass is increasingly recognized to be cosmic--encompassing not just human beings, but animals, and the fragile planet upon which we all depend. For Buddhism, *karuna* (compassion) is one of the two primary virtues, along with *prajna,* wisdom. Thus, the Buddha teaches, "As a mother with her own life guards the life of her children, let all-embracing thoughts for all that lives be thine." (*Khuddaka Partha*, Metta Sutra)

Dr. Armstrong believes that compassion may be the only force that can save the wounded world, and she has formed an organization-- "Charter for Compassion"--to realize this healing mission. The charter states,

The principle of compassion lies at the heart of all religious, ethical and spiritual traditions, calling us always to treat all others as we wish to be treated ourselves. Compassion impels us to work tirelessly to alleviate the suffering of our fellow creatures, to dethrone ourselves from the centre of our world and put another there; and to honour the inviolable sanctity of every single human being, treating everybody, without exception, with absolute justice, equity and respect. [20]

7. Conclusion

We have reviewed the various meanings of the terms *kindness, sympathy, empathy* and *compassion*, concluding that *compassion* is the essential and comprehensive quality required in caring for sick and suffering patients. We have seen how Compassion-focused Therapy (CFT) has found increasing support for use in people whose mental health problems are primarily linked to high levels of shame and self-criticism. We have also noted that *self-compassion* is important for health care professionals, in so far as it reduces the likelihood of "burnout" and stress. Finally, compassion in end-of-life care is important both from both a humanistic and—for many patients--a spiritual perspective. Further research into the role of compassion in medical care is likely to reveal clinically important insights.

Author Contributions

Dr. Geppert contributed mainly to the sections on end-of-life care and spirituality. Dr. Pies contributed mainly to the other sections of this paper. Both authors reviewed and edited the entire manuscript.

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