

Understanding compassion in family medicine: a qualitative study

Abstract

Background

Patients and physicians have traditionally valued compassion; however, there is concern that physician compassion has declined with the increasing emphasis on science and technology in medicine. Although the literature on compassion is growing, very little is known about how family physicians experience compassion in their work.

Aim

To explore family physicians' capacity for and experiences of compassion in practice.

Design and setting

This was a qualitative study designed using a phenomenological approach in rural and urban Ontario, Canada.

Method

In-depth interviews were audiotaped and transcribed verbatim, followed by independent and team coding. An iterative and interpretive analysis was conducted using immersion and crystallisation techniques. Purposive sampling recruited 22 participants (nine males and 13 females aged 26–64 years) that included family medicine residents from Western University ($n = 6$), and family physicians practising <5 years ($n = 7$) or >10 years ($n = 9$) in Ontario, Canada.

Results

From the data, the authors derived the Compassion Trichotomy as a theoretical model to describe three interrelated areas that determine the evolution or devolution of compassion experienced by family physicians: motivation (core values), capacity (energy), and connection (relationship).

Conclusion

The Compassion Trichotomy highlights the importance and interdependence in physician compassion of motivation (personal reflection and values), capacity (awareness and regulation of energy, emotion, and cognition), and connection (sustained patient–physician relationship). This model may assist practising family physicians, educators, and researchers to explore how compassion development might enhance physician effectiveness and satisfaction.

Keywords

compassion; family practice; medical education.

INTRODUCTION

In medical ethics, compassion is 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'.¹ Definitions vary from author to author, and often overlap with other terms, most notably empathy.^{2–4} Although physicians have traditionally valued compassion, there is considerable literature describing the decline of compassion associated with an increased emphasis on science and technology in medicine.^{5–8}

Research shows that patients want a compassionate physician; and that compassionate care is central to patient satisfaction.^{9–11} Compassion can also improve quality of care and physician effectiveness.^{12–15} For example, physician empathy and compassion have been shown to decrease the length of the common cold, increase patient enablement, and reduce return visits to the emergency room.^{13–15} There is also evidence of a correlation between 'compassion satisfaction'¹⁶ and lower risk for burnout in child protection workers,¹⁷ palliative care workers,^{18,19} trauma therapists,²⁰ and general practice registrars,²¹ which may have

implications for family physicians.²²

Over the last decade, there has been an increase in literature on compassion in areas such as psychology and neuroscience, enhancing our understanding of what compassion is and how it develops. But little is known about physicians, particularly family physicians, and how they develop and experience compassion in their work. Some research indicates that family physicians value compassion,^{23–26} though there is limited understanding of how they come to value it and what motivates them to be compassionate. Compassion fatigue has been shown to be a significant issue for those who care for the traumatised, including family physicians,^{27–29} but there is not much evidence in the current literature exploring how family physicians experience compassion satisfaction and compassion fatigue. Although research indicates that good communication is important for the development of the patient–doctor relationship,^{30–33} few studies have explored how family physicians view compassion in developing these relationships.

The purpose of this phenomenological study was to address some of the identified gaps in the extant literature by exploring family physicians' perceptions, experiences,

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How this fits in

Research indicates that patients and physicians value compassion, but there is concern that physician compassion is on the decline. Although compassion fatigue and compassion satisfaction are concepts that have been explored in other healthcare professionals, little is known about how family physicians experience compassion in their practice. The Compassion Trichotomy, a theoretical model developed in this study, highlights three areas that impact physician compassion: motivation, capacity, and connection. This will provide family physicians with a framework to explore the values, ideas, and environment that impact their ability to demonstrate compassion, enabling them to bolster their effectiveness and job satisfaction.

and ideas of compassion in the care of patients.

METHOD

Qualitative methodology, using a phenomenological approach and in-depth interviews, was used in this study. Phenomenology focuses on the commonality of a lived experience within a particular group, resulting in an in-depth description of the nature of the particular phenomenon. In-depth interviews have been used to explore a variety of issues in primary health care and have been proven to be effective for data collection.^{22,34-38}

Participant recruitment

Purposive sampling of participants aimed to gather a wide range of views on compassion by recruiting participants at different career stages, and with differing interests (that is, acute versus chronic care) and career paths (those who had left family practice, or stayed full- or part-time). Participants were recruited through professional contacts. Family medicine residents (trainees) were identified through the Directors of the Family Medicine Residency Program and the Masters of Clinical Science Program (MCIsc) at Western University, and were invited to participate in the study by email. Family physicians practising <5 years (transition from training to practice), and family physicians practising >10 years (extensive practice experience) were identified by the researchers based on previous knowledge and using snowball sampling, which has been shown to be effective for sampling^{39,40} to the point of saturation.⁴¹ The researchers sought participants who were articulate, reflective, fluent in English, and interested

in sharing their personal experiences about compassion in family practice.

Data collection

In all, 22 in-depth confidential interviews were conducted at convenient locations within participants' communities. The interviews used a semi-structured framework of open-ended questions, and lasted from 55 to 75 minutes. Two audiotapes recorded interviews while the investigator took detailed field notes.

Data analysis

Audiotapes were transcribed verbatim. The transcriptions and notes were independently reviewed by two of the investigators. Thereafter, the investigators communicated frequently to compare, corroborate, organise, and re-organise 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. Interviews were conducted until all probable themes were uncovered and saturation was achieved. Immersion and crystallisation techniques were used to identify themes and interpret the data. This technique involves 'immersion into' and experiential understanding of the text, followed by continued reflection and 'intuitive crystallisation'.⁴² In this method, reading the data (immersion) is temporarily suspended to allow for reflection, analysis of the experience, and emergence of themes. Hence, data analysis occurred before, during, and after data collection.⁴³

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 role in the study and appraise these influences on findings and interpretations, was essential. Other means for assessing trustworthiness and credibility included verbatim transcription of interviews, rigorous field note use, independent review of data by researchers, team analysis, and member checking during later interviews with participants. A third researcher provided a peer audit of the study findings, thus advancing the conceptual understanding of the emergent themes.

Final sample and demographics

The final sample consisted of 22 family physicians, nine males and 13 females, aged 26-64 years (average age 37 years). Of these, 19 participants were married, and 14 had children. Participants had varied

religious backgrounds: 19 had been raised as Christians, though only five considered themselves to be currently practising. Two participants had practised Islam at some point, one had practised Sikhism, and one Judaism. Six participants were family medicine residents at Western University ($n=3$ postgraduate year 1, $n=3$ postgraduate year 3 who were MChSc candidates). Seven participants had been practising for <5 years (0.5–4.5), while nine had been practising for >10 years (10–40 years); 13 participants worked full or part time in community family practice. Three participants who had considerable training or experience in community family practice now worked in institutional settings as a family physician. In addition to family practice, many participants also worked in one or more other areas as a family physician, including 12 in geriatrics/long-term 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 others did some teaching. Participants practised in both rural ($n=6$) and urban ($n=16$) settings.

RESULTS

Throughout the interviews, participants explored how they defined compassion (these findings will be outlined in a future journal article currently in the process of submission) and what factors impacted their ability to be compassionate as physicians. During the analysis of participants' experiences, understanding, and ideas of compassion, three areas emerged that impacted their ability to be compassionate: motivation for compassion, capacity for compassion, and the patient–doctor connection related to compassion. The interrelationship of these three areas was given the title the Compassion Trichotomy.

Motivation

When participants described whether they thought compassion was important, three sub-themes emerged that indicated motivation for providing compassionate care: desire of patients for compassion, impact of compassion on physician effectiveness and patient care, and core values.

Desire of patients for compassion.

Participants were adamant that patients want their physician to be compassionate: to listen, communicate well, show understanding, and be caring and supportive. They believed patients desired these qualities because the illness experience could be intimate,

emotional, and multifactorial, leaving the patient feeling worried and vulnerable:

'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), honouring your values and choices.' (Female [F], 26 years [age], family medicine postgraduate [FMPG], 1 year of postgraduate year programme [PGY-1])

Participants thought patients wanted to be seen as a human being with an illness rather than simply a disease:

'I think the patient wants the physician to see them as a person, and 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.' (F, 27 years, FMPG, PGY-3)

Impact of compassion on physician effectiveness and patient care.

Participants described how compassionate physicians achieved a better understanding of their patients' issues as communication was open, with trust between patient and physician:

'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.' (F, 26 years, FMPG, PGY-1)

In subsequent interactions, compassion facilitated diagnosis when there were hidden agendas, psychosocial issues, or multifactorial problems:

'It helps with those more emotionally charged issues; the psychosocial stuff, the chronic illness, and the impact it has on peoples' lives. Those are the people that I tend to be more compassionate with.' (F, 38 years, family physician [FP], years in practice [YP]-10)

Participants also remarked that a compassionate approach resulted in more supportive and caring treatment plans which patients were more likely to follow.

Core values. Participants believed compassion was a core value that drew many physicians to medicine:

'It makes a lot of impact on how compassion might be; the way we were brought up, family, religion, maybe, moral values.' (F, 39 years, FMPG, PGY-1)

They described how they came to value compassion through family upbringing, role models, life experiences, and religion. The central value that was common among participants from different religions and spiritual inclinations was to 'do unto others as you would have done to you'. Participants also described the challenges they faced to adhere to their values in practice:

'You're too busy doing the minutiae of really employ or have time to think about compassion. So I think you lose it for a while. You're focusing on "How does this engine work? How do I function as a doctor? 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.' (Male [M], 39 years, FP, YP-10)

Capacity

Participants described three main areas that impacted their capacity for compassion: development of emotions and empathy, emotional and mental energy, and self-care and cultivating compassion.

Emotions, empathy, and capacity for compassion. Participants believed that a physician's capacity for compassion was both innate and learned:

'Maybe it would be easier for people to turn on that compassion ... if they have it within them. Their personal traits and their upbringing, all that stuff supports the compassion.' (F, 31 years, FP, YP-3)

They described how being comfortable expressing feelings and dealing with emotions was important for developing the capacity for compassion, and depended on family upbringing and spiritual development. Participants also divulged how experiences of caring inside or outside of the home further developed their comfort in dealing with emotions and their ability to empathise.

Finally, they emphasised how personal experiences of birth, illness, and death developed their empathy and capacity for compassion:

'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 ageing parents, dealing with dying parents.' (M, 40 years, FP, YP-13)

Energy and capacity for compassion. Participants observed how compassion motivated them in their work but also required energy. It took effort to balance compassionate engagement and appropriate distance:

'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.' (F, 32 years, FP, YP-5)

Participants articulated how compassion called for focus and attention, which required energy. Their energy to give compassion was affected by physical, mental, and emotional factors, including sleep, diet, and general health, stressors at home, and marital and financial issues. Work-life balance was considered crucial to maintaining energy for compassion:

'If I get too little sleep, I actually have trouble focusing on the 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.' (F, 31 years, FP, YP-3)

Self-care and cultivating the capacity for compassion. Participants revealed activities and life choices they believed bolstered their capacity for providing compassion. These included spending time with friends and family, time alone, taking holidays, travelling, and exercise:

'I think it's important to understand your own physical and mental health and wellbeing. Take time for yourself. Try [to] take enough holiday time to recuperate, regenerate.' (M, 39 years, FP, YP-10)

They emphasised that having the self-awareness to understand what energised them was critical:

'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.' (M, 44 years, FP, YP-17)

Participants described how spiritual time for reflection through religious practices or other means was important for cultivating compassion. They also 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 to increasing physician capacity for 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.' (F, 31 years, FP, YP-4)

Connection

Participants identified the central role that connecting with patients played in compassion. They described three relevant aspects: skills, sustained patient-physician relationship, and time restraints.

The skill to connect — showing compassion. Participants believed compassion could be conveyed 'in words, in tone, and conversation', and also through actions and body language:

'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 maximised.' (M, 61 years, FP, YP-34)

They described how they demonstrated compassion to patients through verbal and non-verbal communication:

'I think I try to speak, if I can, on a patient's level, whether it be a child or an elderly person.' (F, 34 years, FP, YP-4)

'I'm making eye contact with the patient. I may smile, acknowledge the situation, or I may just nod.' (M, 31 years, FP, YP-4)

These skills for demonstrating compassion can be grouped as follows:

- demonstrating openness, for example validation and open body language;
- being present, for example taking time, and active listening;
- endeavouring to understand, for example exploring illness experience and nodding;
- being supportive, for example advocating and encouraging;
- relating as one human being to another, for example using humour and sitting at the same level as the patient.

Relationship, connection, and compassion.

Participants believed compassion enabled them to care for their patients, build trust, rapport, and, ultimately, connection:

'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 foundation which is the relationship, and they all go into the foundation which is underlying the entire interaction.' (F, 31 years, FP, YP-3)

Participants noted that the compassionate patient-doctor relationship grew over time, and patients often reciprocated kindness. They described how it was easier to connect with patients with whom they had rapport. However, patients who were threatening, demanding, critical, disrespectful, or unappreciative were more challenging. These 'difficult' patients, such as drug seekers and abusive patients, challenged physicians to seek out a 'kernel' of understanding to make a connection.

However, participants argued that having compassion allowed them to suppress their reflex emotions and look beyond these behaviours to their common link of humanity with the patient:

'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.' (F, 31 years, FP, YP-4)

Time, connection, and compassion.

Participants illustrated how duties unrelated to patient care and physician shortages resulted in them spending less time with their patients:

'Perhaps we can't be as compassionate as we would like to be because of time constraints.' (F, 30 years, FP, YP-1)

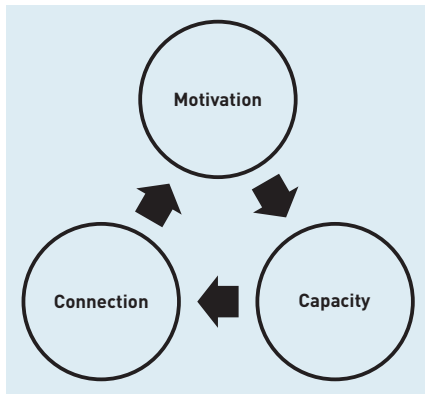


Figure 1. The Compassion Trichotomy.

They described how insufficient time and busy workplaces affected their ability to focus and be compassionate:

'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. 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.' (F, 30 years, FP, YP-1)

Participants believed physicians could connect with their patients during a brief visit by focusing, acknowledging their difficulties, motivating them, using humour, relating on social issues, and through physical gestures of comfort.

However, they considered listening, explaining, achieving understanding, and advocating as important parts of connecting and showing compassion that took time.

In addition, participants also noted that having compassion could save time overall as it could assist physicians in uncovering and resolving 'hidden agendas':

'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.' (M, 40 years, FP, YP-13)

The Compassion Trichotomy

Participants observed that when they were able to be compassionate, a virtuous cycle occurred:

'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.' (F, 38 years, FP, YP-10)

Participants articulated that the human connection they experienced through compassion motivated them to be compassionate.

This motivation energised them and fed their capacity for compassion. Finally, participants expressed how their capacity for compassion, built on experience and empathy, enhanced their skills to connect with their patients. The authors have labelled

this virtuous cycle between motivation, capacity, and connection the Compassion Trichotomy (Figure 1).

DISCUSSION

Summary

The objective of this study was to explore family physicians' capacity for and experiences of compassion in practice. The findings of this study identify three key areas that impact compassion in family physicians: motivation (personal reflection and values), capacity (awareness and regulation of energy, emotion, and cognition), and connection (sustained patient-physician relationship). These results mirror many aspects of the broader research on compassion, but they also provide insight specific to family physicians' experiences of compassion in practice. Finally, the Compassion Trichotomy illustrates how interrelated the areas of motivation, capacity, and connection are in the evolution of compassion.

Strengths and limitations

This study is the first to explore family physicians' experiences of compassion. The use of semi-structured interviews for data collection allowed participants to share personal experiences that might not have emerged through focus groups or questionnaires. Sampling of participants in both urban and rural locations, at different stages of their careers, and with different interests provided a maximum variation sample in the recruited group.

Despite these efforts, sampling strategies like snowballing can result in viewpoints that are not entirely diverse. Given the nature of qualitative methodology, the limited numbers of participants from one Canadian province, and the fact that there was a single interviewer, these findings may not apply to all family physicians.

Comparison with existing literature

In the Compassion Trichotomy, connection promotes motivation. As expected, based on the literature,²³⁻²⁶ participants valued compassion, and their descriptions of developing values of compassion through teaching and the use of role models resonate with the literature on empathy development.⁴⁴⁻⁴⁷ However, it is notable that they described value development as being personal, and unrelated to medical education or culture. When describing compassion in the medical environment, participants focused more on challenges to compassionate values. This indicates that medical environments may be hindering

compassionate values, and provides one possible explanation for the studies showing decline of empathy in medical training.^{48–52} That leads to the question of how family physicians sustain compassionate values. The other source of their motivation for compassion was centred on their experiences with patients. Participants' impressions that compassionate care is desired, effective, and satisfying for patients is well described in the literature.^{9–15} However, what this study highlights is that experiencing compassionate patient–doctor interactions, and having the opportunity to reflect on them, may be important for sustaining the compassionate values that family physicians bring to medicine.

Motivation promotes capacity, but how do family physicians experience compassion satisfaction and compassion fatigue? This study illustrates that family physicians experience compassion satisfaction, as described by Stamm.¹⁶ Participants described deriving pleasure from helping others and developing meaning and purpose in their work, based on compassionate values. However, participants believed several other factors impacted the capacity for compassion. The literature concurs with participants' views that their capacity for compassion was both innate^{53–55} and learned.^{44–47,55–59} The capacity for compassion was seen as developing in three ways, and these are supported in the literature: through parental emotion role models,^{44–47} care giving experiences,^{56,57} and personal experiences of birth, illness, and death.^{58–60} These findings highlight once more that participants viewed development in this area as being personal. Medical training and practice, however, were described as presenting many challenges to the capacity for compassion. To maintain the capacity for compassion in medicine, participants described activities related to cognitive empathy that cultivate an understanding of others' perspectives, and a need for self-awareness and self-regulation to maintain energy levels. These findings provide new insights into how family physicians combat compassion fatigue, and are supported by the literature on compassion fatigue in other helping professions^{27–29} and the humanities in medical education.^{61–64}

Capacity promotes connection. As their capacity for compassion increased, participants believed they were better able to connect with their patients. The skills to show compassion illustrated by participants align with other studies.^{65–68} Empathic or compassionate communication skills described in these studies included getting

information, clarifying, understanding, supporting, and being non-judgemental and self-reflective.^{65–68} In addition, these findings illuminate how the capacity for compassion impacts the development of the patient–doctor relationship. Participants believed this capacity helped them to develop rapport and gain patient trust. Trust opened communication, improving visit outcomes, which participants then felt encouraged the return of the patient. This, in turn, provided the physician with both the opportunity and the motivation to learn more about their patient, which increased their understanding of and their connection with them. Finally, these findings illustrate that, although compassion can be demonstrated in short visits, it evolves over time because of and through the patient–doctor relationship.

Implications for research and practice

Some educational interventions have been developed to impact compassion. For example, Kalish *et al* videotaped 4th year medical students performing a medical history on a patient volunteer, and highlighted missed compassionate care opportunities using a schema of compassionate care skills they had developed.⁶⁷ However, the Compassion Trichotomy highlights that nurturing compassion requires a multifaceted approach; for example, reflective exercises for reviewing clinical encounters, relationships with patients, and personal values; exposure to the humanities and narratives to understand others' perspectives; learning around emotional intelligence and self-care; role modelling by compassionate physician mentors; and compassionate communication skills.

Continuing professional development programmes for family physicians in practice will find the Compassion Trichotomy model useful for preventing burnout and increasing job satisfaction through compassionate care. Medical educators will find the Compassion Trichotomy model useful to inform curricular change in their programmes to reinforce personal values, promote trainee compassion, and investigate environmental aspects that impede the development of compassion.

The theoretical framework that has been derived from these findings lends itself to further testing in diverse settings, and with other primary healthcare providers. To further validate this framework, a study aimed at patient perspectives on compassion in family medicine is necessary.

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Ethical approval

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Competing interests

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