Special Article

Beyond Compassion Fatigue: The Transactional Model of Physician Compassion

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Abstract

Physician compassion is expected by both patients and the medical profession and is central to effective clinical practice. Yet, despite the centrality of compassion to medical practice, most compassion-related research has focused on compassion fatigue, a specific type of burnout among health providers. Although such research has highlighted the phenomenon among clinicians, the focus on compassion fatigue has neglected the study of compassion itself. In this article, we present the Transactional Model of Physician Compassion. After briefly critiquing the utility of the compassion fatigue concept, we offer a view in which physician compassion stems from the dynamic but interrelated influences of physician, patient and family, clinical situation, and environmental factors. Illuminating the specific aspects of physicians' intrapersonal, interpersonal, clinical, and professional functioning that may interfere with or enhance compassion allows for targeted interventions to promote compassion in both education and practice as well as to reduce the barriers that impede it. J Pain Symptom Manage 2014;48:289–298. © *2014 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.*

Key Words

Empathy, compassion, compassion fatigue, physician, doctor, barriers, transactional model

Introduction

Physicians are expected to practice medicine compassionately. Indeed, as part of their professional practice statements, professional and medical regulatory bodies in most Western countries stipulate that physicians must practice medicine compassionately.[1,2] Equally, patients and consumers anticipate compassionate caring from their medical professionals.[3–7] Compassionate caring is associated with greater patient satisfaction, better doctor-patient relationships, and improved psychological states among patients.[5] Although compassion is central to the professional practice of medicine, it remains understudied; there are a considerably larger number of studies on empathy[8,9] and compassion fatigue[10–21] than there are on compassion itself. This article briefly reviews and critiques existing conceptualizations of compassion among physicians before outlining the Transactional Model of Physician Compassion in which physician, patient and family, clinical situation, and environmental factors interact to influence physician compassion.

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In explicating this position more fully, it is worth noting that compassion is distinct from empathy.[22,23] By definition, the term "empathy" is generally used to refer to the cognitive and/or emotional processes in which the perspective of the other (a patient) is taken.[24] In contrast, compassion involves or necessitates empathy, but includes the additional step of wanting to help and/or desiring to relieve the suffering of others.[25,26] Linguistically, the term "compassion" is derived from the Latin roots *com*, which means "together with," and *pati*, which is "to bear or suffer."[27] Recent empirical studies indicate that the neural substrates of empathy and compassion are distinct;[22] conceptual reviews likewise support the distinction.[28]

More than just a duty and requirement for medical practice, the capacity for compassion appears to be hardwired among humans and higher mammals. Compassion-like and altruistic behaviors have been observed in several species[29,30] and caregiving toward the vulnerable and wounded is evident among chimpanzees and bonobos.[31] In controlled settings, young chimpanzees and human toddlers tend to help humans who "accidentally" dropped objects in the absence of no obvious benefit or reward.[32] Anecdotally, media are replete with stories of spontaneous assistance from strangers who risk their lives to save unrelated people and animals. Taken together, such data imply that, rather than being a phenomenon that is specific to medical settings, compassion in medical contexts is more likely a specific instantiation of a complex adaptive system that evolved to motivate recognition and assistance when others are suffering.

Compassion Fatigue—A Compassionate Critique

Paradoxically, despite being central to the practice of good medicine, the bulk of studies across the past two decades have been focused not on compassion, but on compassion fatigue.[10–21] The term was coined by Joinson in 1992[33] while studying nurses in emergency rooms (ERs) who were burned out. Compassion fatigue is thus a specific type of burnout that follows exposure to patient trauma and suffering[11] and manifests in marked emotional, behavioral, and cognitive changes in the clinician.[12] Although initially described in ER nurses,[33] compassion fatigue has since been studied in many clinical groups.[10–13,15,17,21] Oddly, and despite being mentioned together with burnout as a common phenomenon among health workers, there are few prevalence studies on compassion fatigue,[19,21] with only two studies among doctors.[18,34]

Although compassion per se is notably absent from such research, the study of compassion fatigue has been important in that it has highlighted burnout and emotional exhaustion among doctors and some of the outcomes that may accompany them—reduction in empathy and compassion, reduced satisfaction in clinical work, poorer clinical judgment, apathy in care, a lack of energy, and even emotional breakdown;[12,13] poorer quality of care, higher patient dissatisfaction, and increased medical errors are thought to accompany compassion fatigue.[35–37] At an institutional level, organizations also bear the costs of physician fatigue via the negative effects on manpower and lost productivity.[38]

As noted, however, and despite being an important and very real phenomenon, the focus on compassion fatigue appears to have led to a paradoxical neglect of compassion itself. Furthermore, the term and concept have several limitations, tending to guide research in particular directions. In the following sections, we briefly consider some of the issues confronting compassion fatigue research more fully before offering a supplementary conceptualization of the origins and barriers to compassion in medical practice.

Other writers have noted that the term compassion fatigue is problematic[14] and is often confused with burnout, secondary trauma, and vicarious traumatization.[12–14,19] According to some, the definition requires secondary traumatization,[11] which limits its relevance to physicians who may struggle to remain compassionate but are not normatively exposed to trauma. Compounding these problems are additional issues with the term itself. To remark that physicians are compassion fatigued tends to imply that doctors have a finite reservoir of compassion that dries up or becomes depleted with use or overuse. Such an approach implies that compassion fatigue (and related outcomes) should be more common with age. Perplexingly then,