

Original Article

Compassion in Health Care: An Empirical Model

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Abstract

Context. Compassion is frequently referenced as a hallmark of quality care by patients, health care providers, health care administrators, and policy makers. Despite its putative centrality, including its institution in recent health care reform, an empirical understanding based on the perspectives of patients, the recipients of compassion, is lacking—making compassion one of the most referenced yet poorly understood elements of quality care.

Objectives. The objective of this study was to investigate palliative cancer patients' understanding and experiences of compassion to provide a critical perspective on the nature and importance of compassion.

Methods. This grounded theory study used semi-structured interviews to investigate how patients understand and experience compassion in clinical care. Using convenience and theoretical sampling, 53 advanced cancer inpatients were recruited over a seven-month period from a specialized palliative care unit and hospital-wide palliative care service within a Canadian urban setting. Data were analyzed by four members of the research team through the three stages of Straussian grounded theory.

Results. Qualitative analysis yielded seven categories, each containing distinct themes and subthemes. Together, they constitute components of the compassion model—the first empirically based clinical model of compassion. The model defines compassion as a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action.

Conclusion. The components of the compassion model provide insight into how patients understand and experience compassion, providing the necessary empirical foundation to develop future research, measures, training, and clinical care based on this vital feature of quality care. *J Pain Symptom Manage* 2016;51:193–203. © 2016 The Authors. Published by Elsevier Inc. on behalf of American Academy of Hospice and Palliative Medicine. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

Key Words

Compassion, model, empirical, oncology, palliative care, qualitative research

Introduction

Patients, family members, health care providers, professional bodies, and leading health care organizations identify compassion as a hallmark of quality care. The role of compassion in health care is evident in its prominent position within codes of patients' rights,¹

best practice guidelines,² health care reform,^{1–3} and standards of quality care.^{1,3,4} Compassion is prominently featured in professional organizations' codes of ethics,^{5,6} including the first principle of the American Medical Association code of ethics which states, "A physician shall be dedicated to providing

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competent medical care, with compassion and respect for human dignity and rights.”⁶

Compassion has been defined as “suffering with” or a deep awareness of the suffering of another, coupled with a wish to relieve it.^{7,8} Although the importance of compassion is given credence across health care, the importance that patients and family members place on health care provider qualities associated with compassion cannot be easily dismissed,^{9–14} particularly when facing the end of life.^{15–17} Studies have reported that patients and family members consistently identify components of compassion, such as receiving care that is person-centered, responsive, and dialogic, as indicators of quality care,^{2,13,16} with health care providers and institutions characterized as compassionate being less likely to receive patient complaints and malpractice suits.^{18,19} Recently, the importance of compassion was highlighted in the Francis Inquiry report,³ which identified a lack of compassion as a leading cause of the failures at the Mid Staffordshire Health Trust and within the National Health Service in general. Recommendations included that all health professionals be trained in compassion, that compassion be considered and evaluated as a core competency of health care providers, and that system-wide standards of compassionate care be adopted and implemented. Although the relevance of compassionate care seems self-evident, studies have repeatedly identified the emergence of a gap between patients’ and clinicians’ perceptions of compassionate care.^{11,18–20}

Although there is an extensive body of literature within health care invoking compassion and its importance, these writings are largely theoretical, rhetorical, anecdotal, and fail to incorporate the conceptualizations of patients^{21,22}—the recipients of compassionate care. This represents a significant gap, as a comprehensive understanding of compassion requires consideration of the sufferer’s perspective.^{23–26} Although initial inquiries of patients’ perspectives of compassionate health care²² and associations of compassion²⁷ are emerging, we could only identify one small ($n = 10$) study that inquired about the meaning of compassion from patients directly.²⁸ As a result, although the clinical relevance of compassion is inferred and is one of the most liberally referenced aspects of quality health care, an empirical understanding of compassion, including key qualities, facilitators, and inhibitors in a clinical setting, is lacking.^{23,24,29}

To address these gaps, this qualitative, grounded theory³⁰ study investigated palliative cancer patients’ understanding and experiences of compassion—individuals

who are ideally positioned—based on their proximity to suffering and extensive interaction with the health care system—to provide a critical perspective on the nature and importance of compassion.

Methods

Study Population

Using convenience and theoretical sampling,³⁰ data were collected from adult cancer inpatients on a palliative care unit and a hospital palliative care consult service at a large acute academic hospital in Calgary, Alberta, Canada. Patients meeting eligibility criteria were informed about the study by a member of the palliative care team. Eligibility criteria included being at least 18 years of age, able to speak and read English, an incurable cancer diagnosis, no demonstrable signs of confusion (as determined by the clinical team), and a life expectancy of less than six months. After obtaining written, informed consent from those patients expressing interest, a mutually agreeable interview time was arranged with the research nurse.

From May to December 2013, 151 eligible patients were referred to the study by palliative care staff. Of those, 25 were too sick to participate and were, thus, deemed ineligible. Of the remaining 126 patients, the following reasons for nonparticipation were cited: 48 (38%) were disinterested, five (4%) were discharged, and 18 (14%) died before the interview could be conducted. Two patients who consented to participate were excluded: one participant partially completed the interview before being transferred to hospice and the other was excluded because of technical difficulties with the audio recorder. We estimated that 50 patients would be needed to reach data saturation/redundancy in the data, but in actuality, a final sample of 53 patients was required to reach this threshold (Table 1).

Data Collection

Data were collected using face-to-face semi-structured interviews. An interview guide was developed (Table 2) based on a literature review and our research team’s previous experience conducting research with patients approaching end of life.^{12,31,32} Interviews averaged one hour and were administered in a private space by an experienced research nurse who also was responsible for recruitment and data management under the supervision of the principal investigator. Interviews were audio-recorded and transcribed verbatim, with emotional content being noted in the research nurses’ field notes that captured the

Table 1
Demographic Information for 53 Participants

Characteristic	%
Mean age (years)	61.44
Men	35.19
Women	64.81
Mean (range) time between interview and death (days) ^a	79.56 (8–261)
Marital status	
Never married	3.70
Married/common law/cohabiting	70.37
Divorced/separated	16.67
Widowed	7.41
Other	1.85
Person living with ^b	
Spouse/partner	70.37
Parent(s)	3.70
Sibling(s)	1.85
Child(ren)	31.48
Other relative(s)	5.56
Friend(s)	1.85
Other	5.56
Alone	18.52
Highest education level attained	
No formal education	0.00
Elementary—completed	1.85
Some high school	16.67
High school—completed	9.26
Some university/college/technical school	20.37
University/college/technical school—completed	38.89
Post-graduate university—completed	12.96
Employment status ^b	
Retired	59.26
On sick leave	5.56
On disability	31.48
Working full time	1.85
Working part-time	5.56
Household net income	
≤\$60,000/year	29.62
>\$60,000/year	70.38
Religious and spiritual status	
Spiritual and religious	53.70
Spiritual but not religious	37.04
Religious but not spiritual	3.70
None	5.56

Numbers expressed as percentages, unless otherwise stated.

^aBased on 45 patients who had died at the time of analysis.

^bThe total for these categories exceeds 100% because patients were permitted to provide more than one response.

contextual and nonverbal features of the interview. Data integrity between the audio files and the verbatim transcripts was assured by having both the transcriptionist and a research team member independently verify transcripts line-by-line. The research protocol was approved by the University of Calgary Conjoint Health Research Ethics Board.

Using Strauss and Corbin's approach to grounded theory, data analysis proceeded through three stages of coding.³⁰ The first stage of coding, open coding, involved the analysis team (S.S., S.McCl., S.R.B., T.H.) independently coding transcripts line-by-line using the constant comparative technique, whereby subsequent codes are compared with previous codes both within and across interviews to discover, name, and categorize phenomena.³⁰ Investigators met through videoconference each month to review transcripts,

comparing and contrasting individual codes until consensus was reached. The second stage of coding, axial coding, involved assigning codes to themes and categories by way of a coding schema illustrating the context in which the category occurs, the purpose it serves, the intervening constructs influencing the category, and the consequences of those categories. The coding schema was developed after analyzing the first 10 transcripts during a three-day face-to-face meeting. During this meeting, the analysis team grouped codes and categories from each transcript under initial concepts, identifying the interview in which the code occurred and the code's frequency across transcripts. The coding schema was used as a guide in subsequent interviews, with investigators independently recording the occurrence of a code within the coding schema, recording additional codes in the transcript margins, and informing and incorporating the tentative core variable and the modified coding schema through a process of consensus. The third stage of analysis, selective coding, occurred after all transcripts had been analyzed over the course of a three-day face-to-face meeting and involved the verification of the core variable and the development of the empirical model.

Results

The key elements of compassion emerging from the data generated seven categories, each containing several distinct themes and subthemes (Fig. 1). In addition to these core components (categories, themes and sub-themes), the relationship between the key categories and clinical processes are conceptualized within an empirical model of compassionate practice (Fig. 2). The verbatim quotes here serve as exemplars of their associated categories and themes and were selected based on their clarity and consistency in illustrating the collective views and diversity of the sample.

The core variable of compassion that emerged from the data, which traversed each component of the conceptual model, was a "virtuous response to suffering." The identification and verification of the core variable resulted in the following definition of compassion—"a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action."

Virtues

Study participants indicated that compassion was predicated on health care provider virtues, independent of patient behavior, relatedness, or deservedness. Virtues were described as "good or noble qualities embodied in the character of the health care provider." Specifically, patients felt compassion stemmed

Table 2
Interview Guiding Questions

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1. What are the things that you have found to be important to your well-being during your illness? Particularly as it relates to the care you have received?
 2. In terms of your own illness experience, what does compassion mean to you?
 3. Can you give me an example of when you experienced care that was compassionate?
 4. How do you know when a healthcare professional is being compassionate?
 5. Since you have had cancer, has compassionate care always been helpful? Have been there times when health providers' efforts to be compassionate missed the mark?
 6. What advice would you give health care providers on being compassionate? [Do you think we can train people to be compassionate? If so, how]?
 7. We have talked about compassion, another word that might be related to compassion is sympathy. In your experience are compassion and sympathy related? [Tell me how they are the same or different].
 8. We have talked about compassion and sympathy, another word that might be related to compassion is empathy. In your experience are compassion and empathy related? [Tell me how they are the same or different].
 9. How does what you have told me about compassion relate to your experience of spirituality?
 10. Is there anything that that we have not talked about day that we have missed or you were hoping to talk about?
-

from virtues of genuineness, love, honesty, openness, care, authenticity, understanding, tolerance, kindness, and acceptance. Patients felt that the dispositional nature of virtues was experienced largely through their health care providers' presence, with disingenuous or overly prescriptive approaches being easily distinguishable from their virtue-based counterpart. Virtues functioned as antecedents to health care provider compassion, whereas suffering was the corresponding patient antecedent in the compassion equation—with the former being explicitly identified as a core category of compassion while the latter functioned implicitly in the subtext of patient narratives. In identifying virtues as the internal motivator for compassion, several patients shared experiences where compassion was lacking, attributing these clinical encounters to either the absence of health care provider virtues or to competing vocational motivators that usurped health care provider virtues.

I think possibly that's one of the reasons why maybe they've gotten into the healthcare industry ... you still have to have that inner fire to sort of motivate you to want to do that ... if you just learn the outward actions it'll come across as being a sort of façade and really not as meaningful (Patient 51).

It is okay to become a professional and make a reasonable, genuine decent living but, at the same time, use those noble qualities to serve people with compassion (Patient 20).

It's the acceptance of allowing the person to be their worse (Patient 7).

Relational Space

The interpersonal nature of compassion engendered and was subsequently delivered within a relational space, which was defined as “the context and content of a compassionate encounter where the person suffering is aware of and is engaged by, the virtues

of the health care provider.” The intent and depth of the health care provider-patient relationship was a defining feature of compassion, extending beyond simply acknowledging and understanding the needs of the patient to relating to them as a fellow human being and actively engaging their suffering. The category of relational space comprised two themes. The theme of “patient awareness” describes the extent to which patients intuitively knew or initially sensed health care provider capacity for compassion. The second theme, “engaged caregiving,” refers to tangible indicators of health care provider compassion in the clinical encounter that established and continued to define the health care provider-patient relationship over time. Although categories of “virtuous response, seeking to understand, relational communicating, and attending to needs” were distinct categories (Fig. 1), they were subsumed in the broader category of relational space (Fig. 2) and describe, in greater detail, the specific attitudes, behaviors and actions related to compassion that occurred there.

Theme: Patient Awareness.

I would have to say I know it intuitively. You feel it coming off them (Patient 47).

I can feel people's compassion. Somebody can come by and I do not even know or see or nothing and I can tell that they're giving me compassion (Patient 27).

Theme: Engaged Caregiving.

They stop and listen, they establish a relationship and get to know who you are, they get to know me as a person and vice versa (Patient 10).

You could feel she was being compassionate ... just by their body language, the way they're talking to you, when they come in you can just tell by the feeling you get off them, their reactions (Patient 33).

Categories	Themes	Sub-themes
Virtues	Genuineness	
	Love	
	Openness	
	Honest	
	Authenticity	
	Care	
	Understanding	
	Tolerance	
	Kindness	
	Acceptance	
Relational Space	Patient awareness	
	Engaged caregiving	
Virtuous Response	Knowing the person	
	Person as priority	
	Beneficence	
Seeking to Understand	Seeking to understand the person	
	Seeking to understand the person's needs	
Relational Communicating	Demeanor	Non-verbal
		Tone
		Outlook
		Intent
	Affect	Expressed Affect
		Attentive stance
	Behaviors	Physical displays of caring
		Listening and supportive words
		Showing respect
	Engagement	Acknowledgment of the Person and Situation
Attentive		
Dialogue		
Attending to Needs	Compassion related needs	Physical Comfort
		Spiritual
		Emotional
		Disease and Treatment
		Family
		Financial
		Timely
Action		
Patient Reported Outcomes	Alleviates Suffering	
	Enhances Wellbeing	
	Enhances Care	

Fig. 1. Elements of compassion: categories, themes, and subthemes.

Virtuous Response

Virtuous response, “the enactment of a virtue toward a person in suffering,” emerged as both a distinct category and an overarching principle of care that functioned as a catalyst to the three core categories of compassionate caregiving: “seeking to understand, relational communicating, and attending to needs” (Fig. 2). The category of virtuous response contained three broad themes within it: knowing the person, person as priority, and beneficence. Health care providers’ latent virtues were considered insufficient for a clinical encounter to be deemed compassionate, as virtues

needed to generate an externalized response to patient suffering within the relational space. The first theme within the category of virtuous response, “knowing the person,” refers to the extent to which health care providers approached their patients as persons and viewed their health issues and suffering from this vantage point. The theme “person as priority” involved health care providers’ ability to prioritize patient needs, setting aside their own assumptions and health care system priorities in the process. “Beneficence” refers to health care providers desiring the best for the patient, informing the three more targeted core categories of

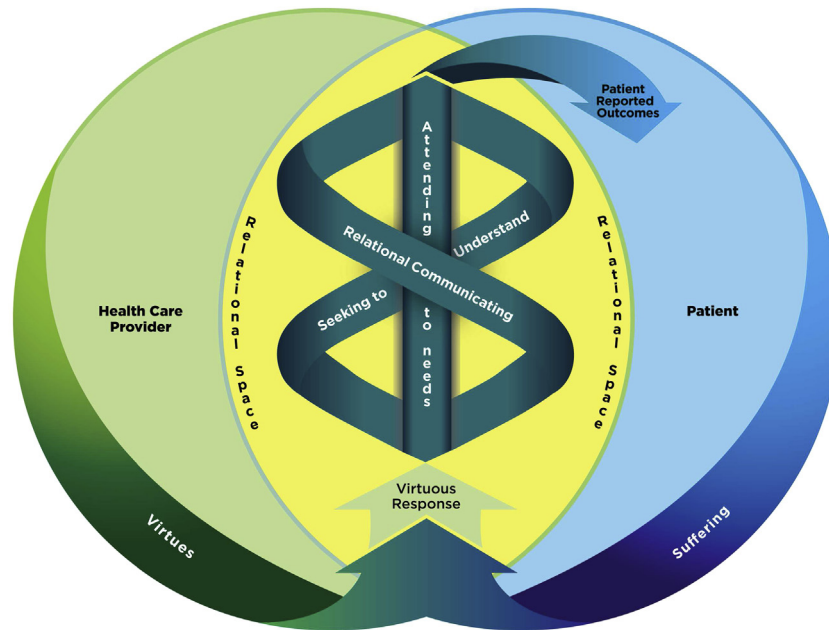


Fig. 2. Compassion model: compassion in clinical practice.

compassionate caregiving: seeking to understand, relational communicating, and attending to needs.

Theme: Knowing the Person.

Compassion is caring enough to see what you're going through, let me see how I can make this experience better for you (Patient 53).

Take the time to reflect back and think about what the patient's going through (Patient 4).

Theme: Person as Priority.

They're [healthcare providers] going all according to the law, the legalities of the system but the patient might have needs that have to override that (Patient 11).

Compassion is not about you, its about the other person (Patient 23).

Theme: Beneficence.

Not only do they mean well, they also do well (Patient 40).

Compassion is just a general feeling on a person's behalf that he wants only good ... he feels only good things should happen for this person (Patient 9).

Seeking to Understand

Seeking to understand was defined as "the extent to which health care providers attempt to understand the

patient as a person and to understand the person's unique needs to optimize the effect of compassion." Seeking to understand extended health care providers' initial desire to know and prioritize the patient as a person by pursuing a deeper understanding of the person and their unique illness experience—to understand the person behind the disease. Being seen as a disease, rather than a person living with a disease, was experienced subtly and infrequently. However, when this did occur it often had an enduring and detrimental effect on the caregiving relationship and participants' sense of well-being. The necessity of attempting to understand a person's needs and then tailoring care accordingly was identified by most patients as a fundamental feature of compassion.

Theme: Seeking to Understand the Person.

We've got to give space to people to be human, so just like I want to be treated human, I want to treat them humanly too, with compassion (Patient 7).

The day I [a male patient] was diagnosed I was seen by a person from the counseling team ... I told her that I need to get my kids to talk to someone and she said "Well I'm busy doing programming next week and if you want to talk to someone sooner, I'll get someone from one of the other cancer groups to contact you." And I said "What do you mean other cancer groups?" and she said "Well we divide our counseling up by the kind of cancer you have" ... It seems a little odd to me that it is based on the kind of cancer I have because it's not the kind of cancer that's concerning me, it's

the fact that cancer is killing me. When I was finally contacted I said “So which cancer group are you from?” and she said “I’m from the breast and ovarian cancer group.” What I wanted to say was “You know what, when my ovaries need cancer counseling, I’ll give you a call” (Patient 53).

Theme: Seeking to Understand the Person’s Needs.

They’ve invested in me, emotionally, to understand me and my needs (Patient 53).

When someone is trying to be helpful on their terms, that’s just not going to cut it . . . to be compassionate is to listen to see what the other person needs (Patient 17).

Relational Communicating

The category of relational communicating was a prominent element of compassion identified by patients consisting of “verbal and nonverbal displays of compassion conveyed through health care provider demeanor, affect, behavior, and engagement with the person in suffering.” A defining characteristic of relational communicating was that it is mediated through verbal and nonverbal communication, affecting the health care provider-patient relationship and patient well-being in the process. Participants identified four specific themes and associated subthemes that conveyed compassion within clinical communication: demeanor (“being”), affect (“feeling for”), behavior (“doing for”), and engagement (“being with”).

Theme: Demeanor. “Demeanor” was the expression of health care provider disposition, conveyed by way of nonverbal communication such as body language, eye contact, tone of voice, posturing, and countenance—functioning as the initial indicators of compassion-based communication. Demeanor was closely related to the theme of “patient awareness” within the category of “relational space” but differed in being more sensory-based, developed, and contextual to clinical communication in comparison with the extrasensory character of patient awareness.

You can hear it in their voice and you can see it in their tone. They actually care how you are feeling (Patient 45).

Their demeanor, their body language, how they speak to you, their tone of voice, the eye contact that they make with you. I think those are the primary indicators (Patient 51).

Something in their eyes, in their face. Something in the way they act toward you. All of these things enter in the picture (Patient 18).

Theme: Affect. “Affect” described the extent to which health care providers could actively resonate with their patients’ emotions and the influence that their virtues had in this process. In relation to compassion, affect was characterized by vulnerability and action, requiring health care providers to enter the relational space and position themselves in the “patient’s shoes” as clinical information was being shared.

They [patient’s health care team] are all good but there are just some exceptional ones. That’s the compassion part. Just really loving their patients and I guess putting themselves out there you know, it could be their brother or their sister. So just I guess putting themselves, you know to see what it could be like if it was me or one of my family (Patient 21).

Compassion involves feeling with, someone trying to put themselves in your shoes first, feeling for you not just as an outsider, by trying to understand and accordingly act (Patient 26).

Theme: Behaviors. “Behaviors” associated with relational communicating refer to interpersonal skills used in clinical communication that conveyed compassion. Compassion-related behaviors varied in expression; however, each shared an important commonality that distinguished them from generalized caring—they required health care providers to give not only of themselves as a professional but as a person. The primary behaviors associated with relational communicating were described by patients as showing respect, physical displays of caring, and listening and supportive words.

There’s the ones that really want to help and then there’s the ones that will put the gloves on just to touch me and you know, that can be offensive, it takes away from compassion as soon as they walk in, it’s the gloves . . . I feel like I am contagious (Patient 11).

Compassion means to me someone listening. Really listening and hearing what I am saying rather than what they think I am saying. It’s important that you hear what I’m saying so that we can address this correctly for me (Patient 32).

Theme: Engagement. “Engagement” involved the degree to which patients felt that health care providers

were actively present in the clinical encounter. The first facet of engagement was attentiveness, evident through nonverbal (e.g., sitting versus standing at the patient's bedside) and temporal indicators (e.g., communicating regularly with patients about their needs or communicating potential health issues to other members of the patient's care team). Acknowledgment, the second essential facet of engagement, involved recognizing the personal impact of suffering, mirroring this back to the patient, and integrating this information into subsequent interactions. The final facet of engagement that participants identified was dialogue, consisting of health care providers communicating clinical information accurately and sensitively, including the effective use of silence and allowing patients to participate in the clinical conversation.

They're actually there, you can see that they're there in mind and body, that they're not off somewhere else (Patient 25).

Just sitting there is all the compassion that they can give, because you know they cannot do anything for the person, but they can be there (Patient 15).

Attending to Needs

Attending to needs refers to "a timely and attuned desire to actively engage in and address a person's multifactorial suffering"—the quintessential category and outcome of compassion. Although other categories and themes are essential components of compassion, they culminated into one singular aim—to actively and tangibly address the needs of a person in suffering. Attending to needs had three interrelated themes: "compassion-related needs, timely, and action."

Theme: Compassion-Related Needs. "Compassion-related needs" refer to the dimensions of suffering that participants felt compassion ameliorated: physical, emotional, spiritual, familial, and financial. Participants identified compassionate health care providers as those who, regardless of their scope of practice, were willing to actively attend to a patient's immediate needs.

Doctors who are more compassionate that way, they care about your whole being and not just about the cancer you are living with. It's just some doctors are so busy and entrenched in their specialty that they became maybe a bit hardened (Patient 26).

I started crying [at diagnosis] and the nurse came and sat beside me and put her arms around me and held me and I cried enough to soak her uniform (Patient 15).

Theme: Timely. A second distinguishing characteristic of compassion in relation to attending to needs was addressing suffering in a "timely" manner. A dual understanding of time emerged from the data, referring to both the desire of health care providers to address suffering in a responsive manner and at an opportune moment. The responsive dimension of time was frequently referenced to acute suffering (e.g., a pain crisis), whereas exemplars related to the opportune aspect of time were associated with situations where health care providers sought to sensitively address protracted suffering. These included addressing existential distress or sharing prognostic information at a time when patients were most receptive and supported to receive it (e.g., such as breaking bad news when family was present or titrating prognostic information over time).

Don't numb them [patients] over the head with the bald truth, be compassionate about the way you talk to them ... the professionals here have been very compassionate in terms of how they're relaying news to me (Patient 6).

I really feel the most important thing is for people to try to understand that with the pain we have, how bad it can be. And that you know when we when we're in pain, just to understand that if we ask for a breakthrough in medication in the hospital and it takes 45 minutes to get it, that's very, very, painful, that's not compassionate (Patient 25).

Theme: Action. The prevalence of "action" throughout the various components of compassion was particularly pronounced in the category of attending to needs. Action referred to the initiation and engagement of a dynamic and tangible process aimed at alleviating suffering. Although participants acknowledged action as a general attribute of caregiving, it was the quintessential feature of compassion. In particular, participants identified supererogatory acts, whereby health care providers went "beyond the call of duty" or "going the extra mile," as exemplars of compassionate action.

Compassion is more action. (Patient 47).

They put themselves out there, they're doing the extra little bit that you do not normally get ... They're going above and beyond and doing other things that they've been taught, [things they] do not necessarily have to do because it's not their job but they're doing it anyways (Patient 9).

The girls [nurses] come in [and say] "would you like a warm blanket"? They know you are going to

be uncovered. Like taking that extra step. Taking that extra step is compassion (Patient 50).

Patient-Reported Outcomes

The impact of compassion on patients who were suffering was profound. Patient-reported outcomes refers to “the effect of compassion on suffering, patient well-being, and care.” Patients did not regard compassion as a panacea to suffering; rather, compassion had an ameliorating affect on suffering, while concurrently protecting patient well-being. Although some patients felt that compassion directly improved health outcomes, most felt it primarily enhanced their well-being and the quality of their relationship with their health care providers. In describing the impact of compassion, a number of patients noted negative outcomes resulting from the absence of compassion. These experiences had an equally enduring, albeit detrimental, effect on their well-being and the caregiving relationship, often exacerbating suffering in the process.

There was absolutely zero compassion that night [when the emergency room physician communicated the diagnosis] ... I would tell her the way you handled this situation, if I would have been weak of mind in any stretch of the imagination, I would not have been surprised and maybe I would have tried to commit suicide, that’s where it pushed me (Patient 5).

If you’re not receiving compassionate care, you get frustrated, your spirit drops. I become overwhelmed, I become completely frustrated by the situation to the point where little things that should be relatively manageable become unmanageable, so I think it has a huge impact on the recipient (Patient 10).

It’s a very, very strong feeling, it’s a solidifying building quality that makes a person feel whole, it make them feel valued and loved, that brings dignity ... it’s such a powerful thing (Patient 7).

Discussion

Despite being espoused as a hallmark of quality care,^{1–4,14} a health care priority,^{1,2,9,15,16} and emerging research that suggests it has a positive effect on patients’ health,^{9,13,15} an evidence-based framework on the nature and key domains of compassion in health care remains nascent. This study addresses this theory-practice gap and a significant conceptual issue: the lack of patient perspectives of compassion. Although theoretical conceptualizations and initial studies directly involving patients are beginning to emerge,^{28,33} they largely use a priori definitions of compassion

conceptualized by scholars, describing the responder’s perspective, often with disregard to the recipients perspective—in this case, patients.^{21,24} We could locate only one exploratory study investigating patients’ perceptions of compassionate nursing, which inquired about the meaning of compassionate nursing care from patients directly.²⁸ The present study addresses these fundamental conceptual and methodologic issues by generating the first clinically informed empirical model of compassion that defines and codifies the core elements of compassion from the perspective of patients at the end of life. The various components of compassion provide an empirical foundation for the development of a compassion inventory to measure patients’ experiences of compassion. In addition to its clinical utility, a measure would provide the means to conduct future randomized controlled trials and to evaluate education interventions.

Another notable and related finding of this study was the identification of health care provider virtues as antecedents to compassion, affirming theory within the field of virtue ethics,²⁶ which may distinguish compassion from related constructs of empathy and sympathy. Study participants identified compassion primarily as a disposition, requiring action, constituting another important demarcation from empathy, which has been identified as an attitude, emotion, or state that is situational and contingent on health care providers’ ability to “feel for” the patient, the degree to which they can personally relate to the patient, and the perceived deservedness of suffering.^{34–36} The distinguishing virtue-based antecedents and action-based outcomes of compassion affirm studies within the social neuroscience investigating empathic brain responses.³⁵ The authors concluded that empathy is an affective state that is isomorphic with the affective state of an “other,” that is not necessarily linked with prosocial motivation or behavior, which was postulated to be a defining feature of compassion.³⁵

Numerous studies have identified the central role of nonverbal communication in effective bedside clinical communication within health care delivery, including listening, presence, human relatedness, and creativity.^{10,12,13,25,32,37,38} These often subtle, yet powerful elements of human communication have been found to be teachable skills that positively impact patient-trainee interactions.³⁹ Translating “clinical communication skills” into “skilled clinical communication,” however, remains a challenge as clinicians afford minimal time to active listening,^{20,38} despite evidence indicating that family satisfaction with physician communication is significantly predicted by the proportion of time that physicians listen.¹³ The present study provides some guidance as compassionate clinical communication involves not only emotional resonance

on the part of the health care provider but a willingness to actively “suffer with”⁷ patients coupled with action aimed at amelioration.⁸ As such, compassion implores vulnerability on the part of health care providers to engage and relate to patient suffering from a place of shared humanity.

Although the plausibility of compassion training is contested,^{1,36,40} recent research has demonstrated that aptitude in these areas can and needs to be cultivated within health care education.⁴¹ This study adds to this debate, suggesting that although compassion can be cultivated, it may in part be contingent on the innate human qualities that learners possess at baseline. Therefore, it may be beneficial to evaluate students’ compassion aptitude at an early stage to determine teachability and to develop individualized learning plans to enhance these inherent qualities over time or at the very least buffer against the erosion of these qualities over the course of health care training.^{36,41} Further research is needed, including interventional studies, to explore these pedagogical issues and their impact on clinical communication scores^{3,11,15} and patient experience,^{10,18,19} including longitudinal studies measuring the retention and effect of training over time.

Although this study addresses many fundamental questions on the nature of compassion within clinical practice, it raises a number of other questions, requiring further research. Although patients’ perspectives are foundational to an empirical understanding of compassion,²⁶ the inherently relational nature of compassion requires the inclusion of health care provider perspectives to validate and further inform the compassion model (Fig. 2). Extending the scope of inquiry to health care providers could help identify: health care provider outcomes within the compassion model; patient facilitators, barriers indicators, and outcomes; contextual variants of compassion, such as personality, health care discipline, and specialty; and the relationship between virtues and compassion from the perspective of the individuals who possess these qualities.

There are several limitations to be disclosed that affect the generalizability of our findings. The sample comprised cancer inpatients being cared for by an interdisciplinary palliative care team. Their perspectives may not be indicative of noncancer populations or patients at other points along the disease trajectory. Despite using an open-ended interview guide allowing participants to reflect on their experience of compassion throughout their illness, the retrospective nature of these questions and the palliative care team’s awareness of the study may have caused recall bias or shaped participant responses. A further limitation of this study, and the literature in general, is the lack of

clinical research on the nature of suffering in a health care context⁴²—an important antecedent and the underlying condition that compassion aims to ameliorate.

The findings suggest that compassion, as experienced by patients, is both situational and dispositional—requiring health care providers to invoke their personhood along with their clinical proficiencies to have an optimal effect in alleviating patient suffering. Although compassion is seemingly intuitive, a gap persists between what patients consider a pillar of quality care and health care providers’ ability to deliver this essential component of care from an evidence-based perspective. Although the compassion model codifies the key elements of compassion, providing a foundation for clinical practice and research, the nature and diversity of compassion will be as unique and particular as the players who enter the clinical encounter.

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