Maintaining compassion and preventing compassion fatigue: a practical guide

Anna Charlotte Baverstock,1 Fiona Olwen Finlay2

ABSTRACT
Compassion is innate in us as human beings. Compassion can be defined as a deep awareness of the suffering of another individual, coupled with the wish to relieve it. It has been increasingly topical, recently, in situations where an apparent breathtaking absence of compassion has allowed great harm to come to patients. So, how do we sustain compassion and prevent this loss? Central to our ability to maintain compassion is how we look after ourselves and those in our teams.

INTRODUCTION
Compassion can be defined as a deep awareness of the suffering of another individual, coupled with the wish to relieve it.1 Recent examples of breathtaking lack of compassion2 have allowed great harm to come to patients. So, how do we sustain compassion and prevent its loss? Central to our ability to maintain compassion is how we look after ourselves and those in our teams.

There is much written in the medical literature and general press about compassion. General practitioner Dr Kieran Sweeney—as many readers will know—died from mesothelioma in 2009. From the time of diagnosis he was, in his words, ‘a man devoid of hope’. He powerfully and at times very movingly communicates his reflections and thoughts on compassionate care. He recorded many honest interviews that make humbling viewing. Most memorably, he talks about how situations may be commonplace and almost mundane for professionals, but for a patient experiencing things for the first time they are anything but that. Henry Marsh in his book3 talks about his ‘attempts and occasional failures, to find a balance between the necessary detachment and compassion that a surgical career requires’ illustrating in his words, and anecdotes the difficulties achieving the ‘balance between hope and realism’.

So, in an ever-challenging healthcare environment, how do we ensure we maintain our own compassion? In this article, we would like to use the analogy of the charge in a mobile phone battery. On some days, you do not use it much, so your battery strength is good. On other days, there is a bigger drain on those reserves, and the battery needs recharging. Compassion fatigue is on a similar continuum—at times, we are more resilient; our reserves are not used up that quickly, whereas at other times our reserves do not last so long.

We hope that by the end of this article, you have a wider knowledge on compassion and awareness of compassion drainers and chargers. In particular, you will have, learned to recognise when you are low in reserve, have some strategies for maintaining, protecting and improving compassion and understand, we all have compassion ‘lapses’.

DIAGNOSTICS AND SELF-AWARENESS
Drains on your reserves may be at the level of the individual, the team or the organisation.

Individual drainers
The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to walk through water without getting wet—Rachel Remen, 1996

We all have days, when there is a greater drain on our reserves, and our compassion is low. Left unaddressed this may lead to compassion fatigue which in turn,
Implement restorative strategies before things get worse, and our batteries go flat as we head towards burnout. Stamm has developed a compassion fatigue self-test call the ProQOL. This is a very detailed test, but worth the time invested especially, if you recognise in yourself some of the features of compassion fatigue. An individual’s ability to recognise when his or her attitudes are deteriorating, and then do something about it, may be a key difference between those with a healthy engagement in the practice of medicine, and those suffering from burnout.

Improved self-care is the cornerstone of compassion fatigue prevention. We need to carefully and honestly assess our life situation, and review the balance. We often hear about work life balance, but in order to nurture our compassion, we need to recognise that compassion drainers can come from work and home. Many professionals have other life stresses to deal with, many are in the ‘sandwich generation’ with children and ageing parents to look after. Do we have enough to give when we get home or have we shut down by then?

If left unaddressed burnout may occur. It is characterised by feelings of, unhappiness, hopelessness, disconnectedness, being overwhelmed, exhaustion, being out of touch with whom you want to be and insensitivity to the work environment. The negative feelings leading to compassion fatigue and eventual burnout may have a gradual onset implying that if recognised the situation can be improved.

We are not immune to pain in our lives, and studies show that we are more vulnerable to life changes, such as divorce and problems with addictions than those who do less stressful work. Many professionals with compassion fatigue enjoy the patient related work ‘I don’t have problems with my patients, in fact I love my patient work, it is everything around it at work that is grinding me down’.

Box 1 includes a list of symptoms, including how you may feel, what you may experience and what you or others may see. A few symptoms are very common, but the cumulative effect and the number of symptoms are what we need to be aware of in having some personal insight that you are perhaps drifting towards compassion fatigue.

**Team drainers**

Most of us work in a team, and clearly within the team environment, it is important to recognise the relationships and dynamics. Within any team, there is potential for the team structure and environment to act as a drainer rather than charger.

At this point, it is helpful to look at the two aspects of care that are often described—transactional (what patient is cared for) and relational (how patient cared about). Kieran Sweeney talks about how most aspects of his transactional care were outstanding. Appointments were on time, and staff were efficient.
However, many aspects of his relational care were lacking. Those more human aspects of care: a hand to hold, spending time with patients and enabling empathy to develop. As a team, where would you fit in table 1?

Many of us work in teams where aspects of transactional care are documented and rewarded. The challenge for us is to seek to improve relational care alongside this. There are ways; we can look to measure this, for example, with exit questionnaires and patient feedback looking at how the patient felt they were cared for. Other team drainers often overlap with those described below as organisational factors. A team acceptance of poor behaviours can be very pervasive, if left unchallenged.

Organisational drainers
We all work for organisations of a variety of sizes. The organisation, we work for also affects our ability to maintain compassion. Organisational factors that drain compassion may include bullying, understaffing, poor engagement between staff and management and poor morale. Many of us are working in an increasingly target-driven culture, which can also turn focus away from compassionate care, if targets focus on transactional care alone rather than in combination with relational care.

STRATEGIES TO HELP WITH COMPASSION FATIGUE

If you want others to be happy, practice compassion.
If you want to be happy, practice compassion—HH
The Dalai Lama XIV

Maintaining compassion as an individual—‘individual chargers’
Strategies to help cope with compassion fatigue are outlined in table 2. We have divided these into individual internal and external chargers. This is not an exhaustive list, but we hope this illustrates some of the options you may consider.

Closely linked to compassion is our own resilience. Resilience is a dynamic capability, which enables people to thrive on challenges. Inherent skills contributing to resiliency include self-efficacy, self-control, ability to engage support, learning from difficulties and persistence.8 What we do in our jobs is often hard—Daniel Cabrera9 writes in his blog that we need to teach and prepare for failure and learn from it. ‘Failure is not always negative, failing is acceptable as long as there is a framework for detecting failure, learning about the complex systems and factors leading to it, and creating a solution to overcome it’. He says that he did not realise the importance of resiliency until late in medical school, when he began to realise that the people who actually make it are those who have the mental toughness, emotional skills and the physical ability to conquer daily adversity. Personal resilience is the ability to bounce back from adversity. Highly resilient people are found to have five key elements that contribute to their resilience.10

To maintain compassion, we must develop personal skills in self-reflection. Many of us recognise that reflection is an inherent part of appraisal and ongoing continued professional development. However, for some, only the most superficial reflection can be evident in portfolios. Many have had little training in reflective practice, and therefore, it is often a missed opportunity. We have undertaken local and regional training on reflective practice with good feedback. In particular, introducing the concept of shared reflection can be very insightful. This can be done in pairs

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Some suggestions for compassion chargers</th>
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<tbody>
<tr>
<td><strong>Internal chargers</strong></td>
<td><strong>External chargers</strong></td>
</tr>
<tr>
<td>Mindfulness is becoming very popular in its various forms. Even when very busy, we can switch off autopilot and take stock</td>
<td>Coaching, mentoring and supervision</td>
</tr>
<tr>
<td>Training in what to look out for in ourselves. Could also review any 360 feedback</td>
<td>Role models</td>
</tr>
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<table>
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<tr>
<th>Reflection</th>
<th>Supportive team reflection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set limits between home and work</td>
<td>Activities—team or individual</td>
</tr>
<tr>
<td>Avoid being doctor or therapist in personal relationships</td>
<td>Exercise</td>
</tr>
<tr>
<td>Medical humanities</td>
<td>Theatre</td>
</tr>
<tr>
<td>Medicine at its core is a human practice looking at human health and illness. Wide study of humanities (literature, philosophy, ethics, history and religion), social science and the arts (literature, theatre, film and art) gains us insights into medicine and medical practice. Enabling us to broaden our view by incorporating how others may view human life and death in a creative and broad way</td>
<td>Cinema</td>
</tr>
<tr>
<td>Important in a team to have shared fun and lighter moments</td>
<td>Join groups knitting and orchestra</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Table 1</th>
<th>Transactional and relational care</th>
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<tr>
<td><strong>Care</strong></td>
<td><strong>High relational</strong></td>
</tr>
<tr>
<td>High transactional</td>
<td>Efficient and warm</td>
</tr>
<tr>
<td>Low transactional</td>
<td>Chaotic and warm</td>
</tr>
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</table>
Best practice

or within teams to help gain a wider perspective. Reflecting on situations where things have gone well can also be very helpful. Much reflection is often focused around situations that have perhaps not gone to plan, and focusing on lessons learnt.

Feedback is also essential as part of personal and professional development. Motivational feedback is important to nurture in our teams. If, we see something done well, it is important to say so. It is important to teach and incorporate a culture of feedback. Many teams have developed very creative ways of widening this, for example, use of wow boards and a Paed Heros email, which is then circulated to the department. Alongside motivational feedback, it is clearly important to give and receive developmental feedback. This is different, and therefore, more care is often needed to ensure the recipient is ready, and able to receive it. When thinking about feedback, you also need to consider how resilient the recipient is at that time.

Maintaining compassion as a team—‘team chargers’

Teams need to discuss and recognise compassion fatigue in the workplace. If, it is recognised early, then larger costs and drains on the service can be prevented later on. Professionals need to develop a supportive working environment that encourages proper time for reflection. This may include debriefing, regular breaks, peer support and regular review of workloads. Improving access to further development and regular times for staff to safely discuss and reflect on the impact of the work on their personal and professional lives also need facilitating. Environment is also important. Are our work areas designed to enable time away from patients and rest breaks in comfortable surroundings? These are all a challenge to professionals working in modern healthcare.

Teams need to discuss and decide what works for them. We have been incorporating teaching sessions on ‘compassion what is it and how do we maintain it?’ into our local and regional teaching sessions. Medical staff, from medical students to consultants have been involved, and to date feedback and discussion have been very positive. We are planning a study to evaluate the impact of these sessions and widening the sessions to include nurses and wider staff groups. Alongside this, we are interested in practical ways of encouraging a greater awareness of the medical humanities. In Taunton, we have also started to include sessions on ‘Medicine and Art’ and ‘Medicine and Literature’ into our teaching programme. A broader understanding of the complexities of human nature in all its expressive forms can be very enlightening. In Bath, we have established a ‘health and wellbeing’ group in the department, with staff members contributing suggestions for team chargers.

There has been much written about debrief, and it is beyond the scope of this article, but needs to be considered as a part of this wider topic. Alongside this, many trusts are now running Schwartz rounds. These are meetings, which provide an opportunity for staff from all disciplines across organisations to reflect on the emotional aspects of their work. They were first developed by the Schwartz Center for Compassionate Healthcare in Boston, USA, and research into their effectiveness shows the positive impact they have on individuals, teams, patient outcomes and organisational culture. For more information take a look at the Schwartz website,11 which has a rich source of information, and has links to some of Kieran Sweeney’s podcasts and some very thought provoking articles, including some by Jocelyn Cornwell, the chief executive and founder.

Maintaining compassion in an organisation—organisational chargers

It is clearly important for an organisation to articulate what good care is in their values and structures. Acknowledgement of successes is important alongside a willingness to challenge individuals, and teams failing to deliver compassionate care. In the UK, the National Health Service (NHS) constitution is very clear; staff must be treated with respect at work and have tools, training and support to deliver compassionate care. The UK Government’s preliminary response to the Mid-Staffordshire Public Enquiry contains the word compassion or compassionate 59 times in <70 pages of text.13 Organisations need to act to ensure this is not just another list of unmet recommendations.

DEVELOPING A COMPASSION TOOLKIT FOR YOURSELF

Need to practice and refine, can’t just have good intentions—Aristotle

The challenge now is to think about how you are going to take this forward. You need to spend some time thinking and designing what will work for you. This is a very individual process. See table 3 for some key questions to get you started, and examples to help you.

Developing compassion fatigue is a gradual cumulative process. Maintaining compassion is a process that is unique as we are. Each of us will need a different mix in our toolkit. It is important to schedule a regular check-in, perhaps weekly. It is interesting to note that, although Anna would see herself as an extrovert, when feeling drained of compassion, her intensive rechargers do not involve others. It is important to be self-aware when building your toolkit.

Team or organisational toolkit

There has been much interest and debate, since the public enquiry as to how organisations can promote and prioritise compassionate care. We are aware that
this is a constantly evolving field, and are conscious
that initiatives are being developed by many trusts. The NHS England website has details of comprehension in practice—our culture of compassionate care, including information on the 6Cs and the Culture of Care Barometer.

<table>
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<tr>
<th>Anna’s signs</th>
<th>Rechargers</th>
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<tr>
<td>Irritable at home and work</td>
<td>Individual</td>
</tr>
<tr>
<td>Playing flute</td>
<td>Running</td>
</tr>
<tr>
<td>Coffee with friends</td>
<td>Reflection</td>
</tr>
<tr>
<td>Team</td>
<td>Department teaching</td>
</tr>
<tr>
<td>Schwartz rounds</td>
<td>Individual</td>
</tr>
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If left unaddressed, could lead to...

| Worrying about patients outside of work | Formal mindfulness |
| Reduced empathy | Formal reflection—written |
| Reduced interest in seeing friends | Plan a few hours at home on own for ’time out’ |
| | Team |
| | Termly meet up with Fiona |
| | Team discussion around workloads and debrief |

Organisational Discussion with managers about workflow/targets

SUMMARY AND CONCLUSION

Maintaining compassion is a dynamic process, which rather like any exercise or diet programme involves input ‘little and often’ for best results. Most of us enjoy and are motivated to provide compassionate care—those ‘small acts of kindness’ and the ‘human touch that makes the unbearable bearable’ (Schwartz).

We hope this article may help inspire a personal change or motivate you to make some changes in your team or organisation. We recognise that there is no one-size-fits-all remedy, and are really interested to hear from you. In particular, what you find helps individually, as a team, or wider within your organisation.

Competing interests None declared.

Provenance and peer review Commissioned; externally peer reviewed.

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