Advancing Understanding of Compassion and Compassion Training

Compassion is the awareness of the suffering of others and the motivation to alleviate their distress. Not merely an emotional state, compassion is a complex experience of sensitivity and attunement to the interior state of another person and to the commonality of suffering, as well as the recognition of one's own response. Compassion involves a capacity to remain openhearted and withstand discomfort and disquiet in the presence of pain. Compassion entails the wish or yearning to lessen suffering as well as the intention to help another person bear her burdens.

Compassion differs from empathy, which is the ability to identify with another person, and from sympathy, which reflects sincere concern but sometimes can convey a sense of one person being superior to another. Instead, the experience of compassion is a connection of greater depth and symmetry, linking 2 people to one another and tying them both to humanity as a whole and the shared hardships of life. Compassion is thus integral to the therapeutic alliance in medicine and to fostering fluency in the relationship between a clinician and patient. As noted by Pellegrino and Thomasma, "the good physician cosuffers with the patient."

Deepening and preserving compassion are aims within medical education’s purview. A review and a report related to compassion education appear in this issue of Academic Medicine. In their review, Sinclair et al1 explore the state of compassion education in the health professions, identifying 103 compassion training interventions published in the English language literature. The authors found only 1 randomized clinical trial and very few interventions with comparator/control group designs or longitudinal follow-up. The majority of the studies relied on self-report rather than evaluation by standardized or actual patients, and the authors noted the lack of a standardized validated measure of compassion as a barrier to assessing the effectiveness of training interventions. Sinclair et al eloquently state that "compassionate encounters are cocreated through relationships and require action." In summarizing their findings, the authors concluded that much work is needed to develop both a shared definition of compassion and also evidence-driven methodologies for implementation and assessment of compassion training in the health professions.

With the expansion and growing influence of technology in medicine, new questions arise regarding the experience of compassion in patient care and how best to approach compassion training across the health professions. To explore whether technology-enhanced learning might represent an opportunity to refine and increase the uptake of compassion training, in their report in this issue of the journal, Sukhera and Poleksic interviewed clinicians, researchers, and education specialists from several disciplines who had experience with the design and evaluation of compassion education. The authors’ findings suggest that barriers to technology-enhanced compassion training exist, such as ambivalence toward technology, inherent costs, certain learning and communication styles, and diminished trust in interactions occurring via technology. The interviews also suggested that technology can promote deeper reflection, allow for greater reach, and create psychological safety, advantages that, taken together, could facilitate compassion training. The interviews also underscored the need for innovation and creativity to ensure that technology serves to strengthen, not diminish, human connection.

The need to better understand and advance compassion training is well documented in the review and the report discussed above. Compassion itself is an elusive and unexpectedly controversial topic in need of greater attention in the health professions. Thoughtful people hold differing views on its moral standing, its behavioral dimensions, its evolutionary roots, its differentiation from fleeting affective states, its erosion and relationship with cynicism, its teachability, and its overlap and ambiguities with related ideas, such as self-compassion. Whether compassion is a necessary component of clinical competence, how to measure compassion, and the ways in which compassion may contribute to clinical quality are among many questions that remain unsettled. Moreover, evidence-based strategies in the design of systems for health care delivery and training interventions that enhance the likelihood of compassionate interactions with patients have not been established.

An important critique in the discussion of compassion is a concern that the focus is too much on the clinician’s experience rather than on the patient’s well-being. Indeed, relatively little is known about the positive impact of compassion training on health outcomes, as noted by Sinclair et al. A review by Patel et al documented 5 behaviors that improved patient perception of physician empathy and/or compassion. These 5 behaviors are sitting (rather than standing) during an interview; detecting nonverbal emotional cues expressed by patients; recognizing and responding to opportunities to express compassion; expressing care to patients nonverbally, such as through eye contact; and making verbal statements of acknowledgment, validation, and support. Whether these behaviors lead to better health outcomes of patients or even to key aspects of physicians’ experience, such as personal fulfillment in their professional roles, is unknown. Similarly, the hypothesized negative effects of the erosion of compassion in medicine and medical education, while widely described, remain understudied, given their potential significance.

The capacity to experience compassion is an extraordinary gift in our work as clinicians and as teachers. Like many
gifts, compassion has “strings attached.” The strings of compassion tie our hearts to our patients and to humanity as a whole. The strings of compassion also tie us to our trainees who, we know, will “cosuffer” with their patients on the path ahead.

Compassion, for these reasons alone, is worthy of our attention and study—and, yet, there is a larger context for our consideration. The experience of compassion and efforts to advance compassion training, taken together, represent a means to the larger aims of academic medicine in advancing health, addressing disability, and alleviating suffering, now and in the future. Our work should focus on rigorous studies of the relationship of compassion and health outcomes, the impact of compassion education on trainees and their patients, and the broader challenge of building and evaluating systems that enable and enhance cocreated compassionate encounters.

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References