

Compassion and self-compassion in medicine: Self-care for the caregiver

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EDITORIAL

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Introduction

Combining medicine and compassion means resolving to cultivate compassion—the will to ease suffering—in order to benefit your patients. Compassion and loving kindness are the basic factors that create harmony and wellbeing for ourselves and others.¹

In a *Lancet* article several years ago, physician wellness was highlighted globally as a missing quality indicator—in the context of widespread self-neglect and ill-health.² Now in our region the health and wellbeing of doctors are topics of growing interest. Both were discussed as essential to safe and effective medical practice at the recent Australasian Doctors' Health Conference.³ While the provision of staff support and doctors' health programs are imperative; so too, is effective self-care. By this, we mean actively taking care of oneself. It has now been a decade since the publication of *Keeping the Doctor Alive*,⁴ but there is a clear need for further work in this area.⁵ In this paper, we suggest such work could usefully explore doctors' self-care in relation to their feelings of compassion for themselves and for others. After all, how well can doctors care for patients or themselves, if they lack such compassion?

In the words of the 14th Dalai Lama, an esteemed scholar of compassion:

For someone to develop genuine compassion towards others, first he or she must have a basis upon which to cultivate compassion, and that basis is the ability to connect to one's own feelings and to care for one's own welfare. . . . Caring for others requires caring for oneself.⁶

The importance of self-care

Whilst not unique to medicine, doctors working in this profession appear at risk of stress and burnout. Apart from doctors' personal stressors, exposure to patients' pain and suffering is a normal feature of clinical practice.^{7,8} Traditionally, many doctors have worn the signs of 'burnout' as a badge of honour.⁹ But many argue the impact of stress can compromise the compassionate care provided to patients in addition to its effect on the doctor's well-being.⁸⁻¹⁰ Unfortunately there is evidence to suggest that anxiety and depression are common, and the suicide rate of doctors has been found to be higher than in the general population.⁵

Consideration must also be given to social factors influencing the therapeutic relationship between doctor and patient.¹¹ In the context of health professionals' role as exemplars for health promotion - patients may be less likely to take medical advice seriously, if it seems incongruent with their doctor's own actions. Medical advice about patients' self-care could be seen as hypocritical, if self-care isn't in some way modelled by doctors.¹² Negative role modelling from doctors' behaviour can also affect the training and well-being of medical students.¹³ Exposure to self-destructive behaviour (such as cynicism or poor self-care) through supervising doctors is a potential contributor to the high rates of stress, depression, and burnout among medical students.^{5,13,14} The practice of self-care, then, may be essential for medical practitioners and those around them such as patients and students. In theory, self-care is not complex; it's simply about looking after one's own health

and wellbeing. In practice however, this may prove challenging for some doctors-and demands congruence with self-care advice given to patients. Self-care involves various strategies that help promote or maintain ones' physical, mental, emotional, and spiritual health; as well as ensuring that personal or family needs are not neglected.⁴ Self-care also requires self-reflection and awareness to identify relevant stressors and supports in both personal and professional spheres. But to what extent can doctors effectively attend to self-care, if they lack self-compassion?

The importance of compassion and self-compassion

Self-compassion involves extending the same compassion to oneself as would be given to others. In this way self-compassion does not denote a narcissistic self-interest. As a construct, self-compassion has been conceptualised to comprise self-kindness, mindfulness, and a sense of common humanity.¹⁵ Importantly, self-compassion and its elements can be learned. A suite of resources (including a self-test version of the validated self-compassion scale) as well as self-compassion exercises are freely available from Dr Kristin Neff (<http://selfcompassion.org/>), co-author of the Mindful Self-Compassion Program. Results from a randomised controlled trial of this program indicate that mindfulness, self-compassion, and wellbeing can be enhanced in the general community.¹⁵

There is also a growing body of literature on self-compassion in health care professionals, highlighting its benefits to clinician's wellbeing and its potential to enhance compassionate care for patients.¹⁶⁻¹⁸ However, little is known about self-compassion in doctors, as there has been scant research into the medical workforce. While being self-critical and perfectionistic may be common amongst doctors, being kind to oneself is not a luxury; it is a necessity.¹⁹ Self-care is, in a sense, a *sine qua non* for giving care to others-and it may be that for doctors, as is the case in other populations, self-compassion relates to compassion for others.^{20,21} Further, investigations into possible correlations between doctors' self-compassion and self-care, or compassion for others are required and need to be based on an understanding of compassion itself.

According to Cassell,²² compassion as a positive emotion is vital to the practice of medicine. But compassion is more than just kindness. It involves cognition, affect, intention, and motivation; that in a context of suffering, relate to the alleviation of that suffering.²³ A recent study of patient perspectives has defined compassion as 'a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action'.²⁴ In clinicians,

some might argue a preference for competence over compassion, but these are increasingly seen as inseparable qualities.^{1,22-26} Expressing compassion in clinical practice is, however, a complex endeavour which may either influence or be influenced by a variety of intrinsic, extrinsic, and organisational factors during any given interaction.²⁶ An appraisal process is also involved in compassionate responding, and might be evident in patient care when a doctor either consciously or otherwise gauges whether they consider a patient to be deserving of compassion.²² In the same way, compassion for oneself can be absent if this appraisal results in judgement or self-disparagement. Yet, compassion is necessary. Even for unappreciative or 'difficult' patients, and doctors who, of course, are only human.

Distinguishing between compassion and empathy

For compassion to be expressed more freely, greater clarity of what compassion *is* and a deeper understanding of *how to educate for* compassion will be required.²² A frequent issue complicating the understanding of compassion is its conflation with empathy. These terms are often used interchangeably and while both represent other-focussed concern and are important for medical practice, there are important distinctions. Empathy relates to an awareness of another's experience be that pleasant or otherwise; whereas compassion relates specifically to contexts of suffering and the alleviation of it. Moreover, one's empathy in response to others' suffering could be a source of distress and inaction, if this empathy is not accompanied by a compassionate wish to act. This has been supported by research into functional neural plasticity through the use of functional magnetic resonance imaging (fMRI), where findings from multiple studies suggest that increasing compassion may reflect a new coping strategy to overcome empathic distress and strengthen resilience.²⁷⁻²⁹

This highlights the misunderstanding of these two capacities in the common use of the phrase *compassion fatigue*, which as a construct is now widely measured in health professional populations. It is seemingly empathy that fatigues, and distances clinicians from their patients and the best care that they can provide. Compassion is better understood as a potential therapeutic intervention for such fatigue. To overcome conflation with empathy, and to enhance both patient care and the wellbeing of doctors, a greater understanding of compassion is required in medical education and practice. This could be achieved through an explicit curriculum that educates

medical students about compassion, and prepares them experientially for compassionate practice.

Educating for compassion and self-compassion

The Healer's Art is an innovative course taught at the Australian National University to help restore the humanity in medical education.³⁰ Importantly, educational initiatives such as this emphasise the 'art' of compassion, but we argue that understanding the science of compassion is equally important. A scientific basis for understanding compassion can help to clarify misconceptions, inform education, and enhance its application to clinical practice. It may be important, for instance, to understand whether compassion levels in students are enhanced throughout medical training—or if compassion decreases over time, as with the so-called *erosion of empathy*.³¹ Establishing an empirical evidence base will be necessary to address questions like these. The use of validated measures in longitudinal research designs will be required to inform medical education and practice. Sir David Haslam,³² Chair of the UK's National Institute for Health and Care Excellence (NICE), argues 'compassion needs to be nurtured and retained, or it will very soon wither on the vine.' Indeed, public expectation might be that medical students should become more compassionate as they progress through training. Whilst this is yet to be established empirically, there is growing evidence to suggest that compassion can be cultivated.^{33,34}

The Stanford University School of Medicine's *Compassion Cultivation Training* (CCT) protocol is one example. In a randomised controlled trial involving community participants, CCT resulted in significant improvements in self-compassion and compassion for others.³³ Further analyses indicated that CCT also increased mindfulness and happiness, whilst decreasing worry and emotional suppression.²³ It has been argued that compassion contributes to the wellbeing of self and others, and there is now growing evidence to suggest the cultivation of compassion and self-compassion might have important implications for health and wellbeing. Previously, in an undergraduate sample, compassion-specific meditation was found to be associated with innate immune responses to a psychosocial stressor.³⁵ A more recent study has suggested that self-compassion may serve as a protective factor against stress-induced inflammation and inflammation-related disease—even when controlling for self-esteem, depressive symptoms, demographic factors, and distress.³⁶ However, there has been scant research into this area involving either medical students or practitioners. Although the benefits of mindfulness have been highlighted, including its links to compassion and self-compassion, a significant barrier to mindful practice has been its absence from medical training.¹⁹

Integration of mindfulness practices within some medical curricula has produced positive outcomes for student wellbeing,³⁷ although direct assessment of self-care and self-compassion have been limited to date. CCT has recently been introduced to medical students at the University of Melbourne,³⁸ but in the absence of reported outcomes, research is required to investigate its utility and evaluate the effectiveness of cultivating compassion in a medical student population.

An agenda for education, practice and research

Caring for others whilst neglecting oneself is neither safe, nor sustainable for the practice of medicine. To this end it is only logical that doctors' self-care supports patient care. As Kearney and colleagues³⁹ state: 'Self-care enables physicians to care for their patients in a sustainable way with greater compassion, sensitivity, effectiveness, and empathy.' Similarly, it has been argued that genuine compassion for others requires compassion for oneself.⁶ Compassion is not an 'optional extra'—and it needs to be valued more in health care.³² Medical education, it seems, does not yet adequately prepare doctors for the ongoing challenge to discern and achieve a balance between these. For medical students—and the profession itself—to flourish in Australia, a 'culture of compassion' is sorely needed, in place of a traditional culture that has been punctuated by mistreatment of medical students and teaching by humiliation.⁴⁰

As highlighted by Haslam at NICE,³² it is compassionate leadership that creates compassionate organisations and culture change. However, the medical profession is not alone in facing this challenge. Other health professions, including nurses, have identified and already begun to take up this research agenda to support clinical practice and enhance patient care.¹⁷ This common ground provides an opportunity for collaboration towards shared goals and, through this, advances can be made in interprofessional education. Scientific study of the balance between compassion and care for self and others presents a new perspective for research into clinicians' self-care. From this perspective, there is opportunity to gain an empirical understanding of the relationship between these variables in clinical practice, and how they might enhance the health and wellbeing of clinicians and benefit patient care.

Whilst essential to the practice of medicine, discussion of compassion, self-compassion and self-care is extremely limited; where discussion does exist it relies largely upon polemics as its basis, rather than empirical evidence. To benefit both clinicians and patients, systematic

research is needed to guide medical education and clinical practice. Both quantitative and qualitative research designs will be necessary in answering the important questions facing doctors; in how they might better care for themselves, each other, and ultimately, their patients. Future research might usefully focus on biomarkers and use of neuroimaging such as fMRI to overcome the limitations of previous studies that have relied solely on self-report measures of compassion; and were therefore potentially influenced by social desirability bias. Whilst compassionate care is a shared goal, it may be important to gain a nuanced understanding of self-care practices and the expression of compassion in the context of individual health professions. To this end, the development of a Transactional Model of Physician Compassion²⁶ addresses compassion from the medical perspective, but it remains unclear whether the expression of compassion or self-compassion in other professions can be understood in the same way. That there has been scant research into these areas limits clinical practice, medical education, and potentially compromises the preparedness of future doctors. A robust and stepwise research agenda is therefore needed: First, to examine any relationship between doctors' self-care, self-compassion, and compassion for others; second, to determine how these can best be cultivated; and finally, to investigate ways in which they might enhance clinical outcomes and the care recipients' experience of patient care. In this way, medical education can draw upon empirical evidence to prepare tomorrow's doctors to better care for themselves and their patients, with genuine compassion.

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