JOURNAL OF WELLNESS

EDITORIAL

Organizational Compassion: Ameliorating Healthcare Worker's Suffering and Burnout

Rachel Thienprayoon MD, MSCS[1*], Shane Sinclair PhD[2], Beth A. Lown MD[3], Teresa Pestian MS[4], Eli Awtrey PhD[5], Naomi Winick MD[6], Jason Kanov PhD[7]

https://doi.org/10.55504/2578-9333.1122
Website: https://ir.library.louisville.edu/jwellness/
Affiliations: [1]Cincinnati Children's Hospital Medical Center, [2]University of Calgary, [3]The Schwartz Center for Compassionate Healthcare, [4]University of Cincinnati, [5]University of Cincinnati Lindner College of Business, [6]University of Texas Southwestern Medical Center, [7]Western Washington University
Recommended Citation: Thienprayoon, Rachel; Sinclair, Shane; Lown, Beth A.; Pestian, Teresa; Awtrey, Eli; Winick, Naomi; and Kanov, Jason (2022) "Organizational Compassion: Ameliorating Healthcare Worker's Suffering and Burnout," Journal of Wellness: Vol. 3 : Iss. 4, Article 1.

Received Date: Jan 24, 2022
Accepted Date: March 19, 2022
Publication Date: June 15, 2022

Compassion is recognized by scholars, spiritual leaders, healthcare researchers and patients as a salient ameliorator of suffering that transcends cultures, patient populations, specialties, and healthcare sectors. Healthcare worker (HCW) suffering is frequently equated with burnout in the literature, but burnout is a narrow lens through which to view the full range of challenging and painful HCW experiences; HCW suffering is inclusive of but more broadly focused than burnout. Further, the response to burnout and HCW suffering has largely placed the onus of change on the individual person, but it has become clear that HCW suffering must be approached and tackled as a systems issue, at the level of the organization and the individual healthcare unit [1, 2]. Only when we approach HCW suffering as a systems problem—which means that organizational leaders begin to systematically acknowledge and mitigate the myriad factors that contribute to suffering in HCWs—will we create the safest and healthiest environments for our patients, and prevent suffering and burnout in the HCWs. This approach defines organizational compassion for HCWs.

HCWs habitually encounter deep human suffering

Suffering is distress experienced when physical, spiritual or existential pain or injury disrupts one's basic personhood [3, 4]. Suffering is part of being human—and since organizations are collective entities populated by humans, suffering is ubiquitous in any workplace. Yet while healthcare aspires to provide care that is compassionate to patients, it has long been known as a particularly harmful context for healthcare workers (HCWs). For instance, HCWs are at risk of workplace violence [5], workplace bullying [6] and moral distress—the belief that they are doing something ethically wrong but are powerless to act differently [7]. The very nature of healthcare is that HCWs habitually encounter deep human suffering which is in itself traumatizing—and further traumatizing is that this suffering is embedded in social structures that worsen inequities in healthcare access and health outcomes. Critically, part of the "hidden curriculum" of medicine is the culture of silence and stigma in acknowledging the distress engendered by healthcare work. As Dr. Adam Hill wrote, "A system of hoops and barriers detours suffering [HCWs] away from the help they desperately need...[And] when mental health conditions come too close to us, we tend to look away—or to look with pity, exclusion or shame" [8].

HCW burnout during the COVID-19 pandemic

For these reasons and others, burnout was an epidemic in healthcare prior to the COVID-19 pandemic [9], and the pandemic has only illuminated at scale the manifold difficulties and suffering experienced by the healthcare workforce. Burnout causes harm to HCWs (depression and substance use disorder [10, 11]), to patients (higher medical errors, poor quality care lower satisfaction [12, 13]) and to healthcare systems (greater patient harm, lower HCW productivity, higher HCW turnover, financial losses [13-15]).

Two years into the COVID-19 pandemic, the US is experiencing an exodus of burned-out HCWs. In fact, HCWs were so harmed during the COVID-19 pandemic that the $1.9 trillion national COVID-19 American Rescue Plan included $120 million to support HCW mental health and to help decrease burnout. This is why HCWs during COVID-19 have been compared to those first responders who died on September 11, 2001, in which the "enduring narrative of fearless heroes" continues to overshadow the lack of organizational consequences for systemic factors that contributed to their deaths [16].

*Correspondence To: Rachel Thienprayoon
Email: Rachel.thienprayoon@cchmc.org

Organizational compassion in healthcare

Compassion and burnout exist at opposite ends of the spectrum of human experience: whereas burnout includes emotional exhaustion, depersonalization, and low professional accomplishment, compassion means emotional engagement, connecting with another's humanity, and a neuronally-mediated sense of reward from helping [1]. Compassion consists of recognizing suffering, emotionally connecting with the distress of the person suffering, and acting to lessen or alleviate the suffering [17]. The key feature of compassion that distinguishes it from similar states (e.g., kindness, empathy, or sympathy) is that it arises specifically in response to suffering and requires not simply a desire to act but action aimed at relieving suffering [17]. Compassion is, by its very definition, ideally suited to directly prevent and alleviate individual and collective suffering. Organizational compassion in healthcare is demonstrating leadership behaviors (e.g., rewarding compassionate acts by employees) that help to result in a climate in which compassionate responses arise when suffering happens [18, 19]. More compassionate workplace relationships lead to individual and organizational benefits, including enhanced employee trust and commitment to the organization, better perceptions of leadership effectiveness, and improved organizational performance [19].

Hospitals that embody these "compassion practices" are more likely to have higher ratings and higher likelihood of patients recommending them to others [20]. Still, our understanding of the positive potential of compassion in healthcare is limited by conceptualizing compassion only in response to suffering. Given the rampant and predictably recurring suffering in healthcare, an expanded view of compassion for HCWs that includes consideration of the prevention of suffering—particularly avoidable suffering that workplaces themselves cause or exacerbate—is necessary [3]. Therefore, we propose this definition for organizational compassion for HCWs: the proactive, systematic and continuous identification, alleviation, and prevention of all sources of workplace suffering. The difference between this and previous definitions of organizational compassion is nuanced, but critical.

Compassionate healthcare systems for prevention of HCW suffering

While some researchers have described interventions to mitigate burnout, these efforts don't always directly and compassionately prevent HCW suffering. Sources of avoidable suffering must be targeted at the systems level, whereas the harm caused by sources of inherent or unavoidable suffering must be minimized [21]. Tools to measure both HCW suffering and HCW experiences of compassion must be developed, tested, validated, and disseminated. While there are tools to measure organizational compassion [22] and compassionate climate [23] at work, these tools were developed for use in the general population—not in HCWs. Yet the research behind these tools provides some insight into how organizational compassion may relate to other outcomes, such as post-traumatic healing [24] and employee well-being [22].

Once HCW experiences of compassion at work can be measured, we can then evaluate how those experiences relate to other HCW outcomes such as post-traumatic healing, engagement, burnout, resilience, and mental health issues, and thereby develop responsive interventions to improve those outcomes at scale. Leaders and unit managers must be taught about the impact of suffering in their teams, educated in how to evaluate unit-specific sources of distress, and be provided the resources to continuously and meaningfully intervene.

Financial models must be created to understand how the cost of these interventions compare to that of the status quo. A 2019 analysis published in the Annals of Internal Medicine found that in the US, physician burnout had been estimated to cost $4.6 billion per year [14]. This figure does not include the cost of burnout in other healthcare workers and does not include the increase in burnout due to COVID-19.

HCW suffering must be confronted as the safety emergency it is. Preventing HCW suffering—and the burnout it engenders—is a far better strategy than waiting to treat it after it becomes a problem [1]. Patients also need and deserve the most compassionate care that we can provide. In order to develop systems that reliably enable clinicians to deliver this compassionate care to each patient, we must first focus our attention and resources on the wellbeing of those working in healthcare. Only when organizational leaders systematically acknowledge, prevent, and mitigate the myriad factors that contribute to HCW suffering, will we build the truly sustainable healthcare workforce that the US desires and deserves.

REFERENCES

1. Lown BA, Shin A, Jones RN. Can organizational leaders sustain compassionate, patient-centered care and mitigate burnout? J Healthc Manag. 2019 Nov-Dec;64(6):398–412. https://doi.org/10.1097/JHM-D-18-00023 PMID:31725567
2. Montgomery A, Panagopoulou E, Esmail A, Richards T, Maslach C. Burnout in healthcare: the case for organisational change. BMJ. 2019 Jul;366:l4774. https://doi.org/10.1136/bmj.l4774 PMID:31362957
3. Kanov J. Why Suffering Matters! J Manage Inq. 2021;30(1):85-90. https://doi.org/10.1177/1056492620929766.
4. Cassell EJ. The nature of suffering and the goals of medicine. Loss Grief Care. 1998;8(1-2):129–42. https://doi.org/10.1300/J132v08n01_18.
5. Liu J, Gan Y, Jiang H, Li L, Dwyer R, Lu K, et al. Prevalence of workplace violence against healthcare workers: a systematic review and meta-analysis. Occup Environ Med. 2019 Dec;76(12):927–37. https://doi.org/10.1136/oemed-2019-105849 PMID:31611310
6. Lamberth BB. "Workplace Bullying in Healthcare: Part 3," Radiol Manage, vol. 37, no. 3, pp. 18-22; quiz 24-5, May-Jun 2015. [Online]. Available: https://www.ncbi.nlm.nih.gov/pubmed/26314175
7. Lamiani G, Borghi L, Argentero P. When healthcare professionals cannot do the right thing: A systematic review of moral distress and its correlates. J Health Psychol. 2017 Jan;22(1):51–67. https://doi.org/10.1177/1359105315595120 PMID:26220460
8. Hill AB. Breaking the Stigma - A Physician's Perspective on Self-Care and Recovery. N Engl J Med. 2017

Mar;376(12):1103–5. https://doi.org/10.1056/NEJMp1615974 PMID:28328327
9. Reith TP. Burnout in United States Healthcare Professionals: A Narrative Review. Cureus. 2018 Dec;10(12):e3681–3681. https://doi.org/10.7759/cureus.3681 PMID:30761233
10. Jackson ER, Shanafelt TD, Hasan O, Satele DV, Dyrbye LN. Burnout and Alcohol Abuse/Dependence Among U.S. Medical Students. Acad Med. 2016 Sep;91(9):1251–6. https://doi.org/10.1097/ACM.0000000000001138 PMID:26934693
11. Bianchi R, Schonfeld IS, Laurent E. Is burnout a depressive disorder? A reexamination with special focus on atypical depression. Int J Stress Manag. 2014;21(4):307-24. https://doi.org/10.1037/a0037906.
12. Shanafelt TD, Balch CM, Bechamps G, Russell T, Dyrbye L, Satele D, et al. Burnout and medical errors among American surgeons. Ann Surg. 2010 Jun;251(6):995–1000. https://doi.org/10.1097/SLA.0b013e3181bfdab3 PMID:19934755
13. Halbesleben JR, Rathert C. Linking physician burnout and patient outcomes: exploring the dyadic relationship between physicians and patients. Health Care Manage Rev. 2008 Jan-Mar;33(1):29–39. https://doi.org/10.1097/01.HMR.0000304493.87898.72 PMID:18091442
14. S. Han et al., "Estimating the Attributable Cost of Physician Burnout in the United States," Annals of Internal Medicine, vol. 170, no. 11, pp. 784-790, 2019/06/04 2019, https://doi.org/10.7326/M18-1422..
15. Leiter MP, Maslach C. Nurse turnover: the mediating role of burnout. J Nurs Manag. 2009 Apr;17(3):331–9. https://doi.org/10.1111/j.1365-2834.2009.01004.x PMID:19426369
16. Lewis M, Willette Z, Park B. "Calling health care workers 'heroes' harms all of us," Statnews. com, 2020. [Online]. Available: https://www.statnews.com/2020/05/21/calling-health-care-workers-heroes-harms-all-of-us/
17. Strauss C, Lever Taylor B, Gu J, Kuyken W, Baer R, Jones F, et al. What is compassion and how can we measure it? A review of definitions and measures. Clin Psychol Rev. 2016 Jul;47:15–27. https://doi.org/10.1016/j.cpr.2016.05.004 PMID:27267346
18. Lilius JM, Worline MC, Maitlis S, Kanov J, Dutton JE, Frost P. The contours and consequences of compassion at work. J Organ Behav. 2008;29(2):193–218. https://doi.org/10.1002/job.508.
19. Simpson AV, Farr-Wharton B, Reddy P. Cultivating organizational compassion in healthcare. J Manage Organ. 2020;26(3):340–54. https://doi.org/10.1017/jmo.2019.54.
20. McClelland LE, Vogus TJ. Compassion practices and HCAHPS: does rewarding and supporting workplace compassion influence patient perceptions? Health Serv Res. 2014 Oct;49(5):1670–83. https://doi.org/10.1111/1475-6773.12186 PMID:24837713
21. Card AJ. Physician burnout: resilience training is only part of the solution. Ann Fam Med. 2018 May;16(3):267–70. https://doi.org/10.1370/afm.2223 PMID:29760034
22. Simpson A, Farr-Wharton B. The NEAR Organizational Compassion Scale: validity, reliability and correlations. Australian and New Zealand Academy of Management; 2017.
23. Nolan MT, Diefendorff J, Erickson RJ, Lee MT. Psychological compassion climate: examining the nomological network of perceptions of work group compassion. J Vocat Behav. 2022;133:103688. https://doi.org/10.1016/j.jvb.2021.103688.
24. J. E. Dutton, P. J. Frost, M. C. Worline, J. M. Lilius, and J. M. Kanov, "Leading in times of trauma," Harvard business review, vol. 80, no. 1, pp. 54-61, 125, 2002.