



Dr. Sharron L. Spicer

Managing Compassion Fatigue is an Organizational Responsibility

Dr. Sharron Spicer

We're all familiar with imposter syndrome. You know, the sense that you know you're incompetent and very soon something will happen to make everyone else know, too. You'll be found out. It's your little secret and soon everyone will know you're a fraud!

There's another secret that I want to talk about. Compassion fatigue. That nagging feeling like, "How can I care for anyone else if I can't even keep myself together?" Maybe you think you're not legitimately cut out to be a caregiver. Maybe you feel like you signed the Oath of Hypocrites rather than Hippocrates.

Charles Figley, one of the first researchers of compassion fatigue, studied mental health in returning Viet Nam veterans, and himself suffered secondary trauma and burnout, even losing his marriage in the process. He was a mental health researcher who suffered a mental health breakdown. He has gone on to tend caregivers to prevent the same outcome for them.¹

What is compassion fatigue? It is profound emotional and physical exhaustion that helping people can develop over the course of their helping. Physicians, nurses, first responders, social workers, personal support workers, volunteers in animal rescue groups... any who care for other people (or animals) in physical or emotional pain can develop compassion fatigue.²

How frequently do you treat a patient who is in a place of suffering — weekly, daily, constantly? What are some of those circumstances? Likely disease, pain, grief, loss, abuse, assault, discrimination and poverty, to name a few. As human beings, we should feel compassion for people in those situations! Is compassion fatigue inevitable? Well, no. Bouts of it, perhaps, but not to the point of losing ourselves — our identities, our family lives, our careers or our lives. That's why we need to talk about it.

Now I ask you to consider this question: Is it the responsibility of the organization or the practitioner to manage compassion fatigue?

I am a pediatrician. I worked for most of the past 15 years in pediatric palliative care. I have had a rewarding career, but I always dread the airplane conversations. "What do you do?" "I work in health care." "Oh, are you a nurse?" "No, I'm a pediatrician," hoping the questions stop. If it gets to the detail of my work with fragile children, the common reply is, "Oh, I could never do that. I'm too sensitive." What does that make me? Calloused? I don't think so! As a society, we have an understanding that working with others in pain would naturally cause us sorrow, but we, as caregivers, have a sense of shame when we feel overwhelmed with the burdens of others.

Compassion fatigue is physical and emotional exhaustion, and erosion of the things we bring to our caregiver role: empathy, hope, compassion. We may become cynical, bitter, and disrespectful. We are more likely to become disruptive in the workplace; we are more prone to errors. We may violate boundaries with colleagues and patients. We become disconnected with our families and our social connections. And as this happens, what do we do? We tend to work more, work harder, as though if we could just do more, we could make things better (for our patients, for the system, for society). But we just make things worse for ourselves.

Compassion fatigue is an occupational hazard of being in a caring profession. But it is not inevitable that it will be debilitating. In fact,

there are personal and organizational strategies to manage it. And none of them involve stopping caring!

Charles Figley and Beth Hudnall Stamm are two of the early researchers in compassion fatigue, which really emerged in the literature around 1995. In the past decade, there has been a real rise in the amount of published data in this field. Stamm has developed a website with dedicated print and electronic resources where interested readers can find more details.³

Stamm proposes a model that the caregiver's "professional quality of life" is derived from two factors: compassion satisfaction (the positive aspects of helping) and compassion fatigue (the negative aspects of helping). Simplistically, you want the balance to rest on more of the good stuff and less of the bad stuff (Figure 1).

Compassion satisfaction is the pleasure derived from the work, from helping others. It may be related to providing care, working with colleagues, intellectual challenge, and altruism.

Compassion fatigue is the result of the factors that deplete our satisfaction. Stamm describes compassion fatigue as having two kinds of contributors: burnout and secondary trauma. Burnout, she says, is a feeling of being "worn out," ineffective, unable to advocate, overwhelmed. Trauma, on the other hand, is more like anxiety. It can be a primary trauma from witnessing a terrible event (past or present), or secondary, that is, having the event related by another person.

Symptoms of burnout include somatic symptoms, moodiness, conflict, social isolation, feelings of resentment, cynicism. One may try to self-medicate with over-the-counter or prescribed sleep agents. Often the symptoms are recognized by others before the person experiencing them. Often things mount until there is a crisis, and that crisis is the wake-up call. With secondary trauma, the symptoms are more like PTSD: anxiety, decreased concentration, loss of meaning or hope, thoughts of current or past trauma. The symptoms tend to emerge suddenly without warning. The person may use escape mechanisms such as drinking or drugs.

According to Stamm's model, to achieve the highest professional quality of life, we want to increase compassion satisfaction and decrease compassion fatigue. In a more detailed rendering of this model, she details factors within the personal environment, the work environment and the client environment that further impact professional quality of life.

I also like to use another model that represents professional fulfillment as an ecosystem with interactive parts.⁴ This model, From Stanford University Faculty of Medicine, show the interplay of multiple factors. Professional fulfillment has contributions from our workplace culture, the efficiency of our workplace, and personal resilience (Figure 2).

You will note that two-thirds of this wheel is related to organizational factors: culture and efficiency. I correlate these factors with leadership and management. According to management author Peter Drucker, management is doing things right, leadership is doing the right things.⁵

I look at this wheel and see culture — the Culture of Wellness — dependent upon leadership: are we doing the right things? Leaders create the culture by their actions. Our leaders need to understand and believe in the vision of the programs they run, to convey enthusiasm to the others in the group. They need to build skills in themselves and others to identify gaps, suggest methods of improvement and lead change. Effective leaders ensure that there is mentorship and succession planning happening in their group. They will advocate for change where it is needed. Leaders address conflict; if they do not, they are neglecting their responsibilities and the culture of wellness suffers. They create the environment for people to work hard and achieve results.

I look at Efficiency of Practice as management strategy. How is workflow managed? Factors such as on-call rosters, clinic or ward set-up, waitlist management, the use of electronic health records, how staff deal with patient phone calls, access to exam rooms... all of these make real impacts on the day-to-day experience of your work. Over time, those things that niggle at you become bigger and bigger. Good management (and I refer her to management in the generic sense, not someone's job description) addresses those issues so that people can do their jobs to their fullest. Workplace systems also affect quality, safety and effectiveness. They also contribute to positive patient and colleague interactions. People feel satisfied when their workplace supports them in being efficient in what they do.

The third component of the model is personal resilience: individual skills, behaviors, and attitudes that contribute to physical, emotional, and professional well-being. Resilience is exceedingly important — but regrettably, it is often portrayed or perceived as the sole factor in determining physician well-being. We do disservice if we look only at individual factors and fail to address the work environment. You can't eat enough celery or do enough yoga to come out unscathed from an ecosystem where culture and efficiency are overwhelmingly negative. Or, going back to Stamm's model, you can't just add up compassion satisfaction and compassion fatigue and hope you end up with a sum above zero. It is a dynamic, complex system with inputs at the individual, organizational and even societal levels that come together to create a sense of professional fulfillment.

We need to avoid burdening the person who is suffering compassion fatigue with further guilt and shame! They should not shoulder their suffering alone. We should support our colleagues to maximize their resilience while at the same time seeking to navigate the increasingly complex culture and improve the efficiency of the systems in which we work.⁶

In this way, management of compassion fatigue truly is a leadership responsibility. Good organizational leadership and management support caregivers to work hard and work efficiently, maximizing the carers' and the organizations' achievement and satisfaction.

This article is adapted from a plenary address delivered by Dr. Spicer at a recent CME event of the Society of Obstetricians and Gynaecologists of Canada.

CS-CF Model

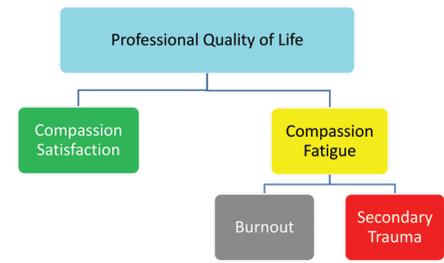


Figure 1. Stamm's Model of professional Quality of Life



Figure 2. Stanford Medicine WellMD Center Model of Professional Fulfillment.

Sharron Spicer, MD, FRCPC
Pediatrician, Physician Lead for Safety and Chair of the Alberta Children's Hospital Quality Assurance Committee; Past President, Calgary and Area Medical Staff Society

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