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Identifying the risk of compassion fatigue, improving compassion satisfaction and building resilience in emergency medicine

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Introduction

Compassion fatigue (CF) is a risk for health professionals working in emergency medicine (EM) because of the pace, expectations, patient load and acuity that confront staff daily.[1, 2] CF can be conceptualised as the emotional, moral and physical distress, which occurs as a consequence of caring and bearing witness to the suffering of others.[3-5] It is the cost of being a caring health professional, as a result of exposure to trauma, distress, frustrations, violence, resuscitations and death of patients in their care.[4, 6, 7] EM staff impacted by CF may still be able to deliver compassion to those they work with, even though the personal toll of this care may be felt physically and emotionally with a reduced ability for self-protection.

Compassion fatigue relates to the way an individual feels they are able to interact and engage with patients in a caring nature. Importantly, CF is an inherently different construct to burnout. Burnout is strongly associated with organisational environment, disillusionment, emotional exhaustion, personal accomplishment and depersonalisation.[2, 8, 9] CF has more features in common with vicarious or secondary trauma than burnout.[4] A significant feature distinguishing CF from burnout is that burnout usually has a slow and gradual onset, whereas CF may be cumulative in the grief absorbed from caring for patients. Despite this insidious development, onset of CF may be felt suddenly by the individual health professional.[10]

Risks for compassion fatigue

There is a growing body of literature on the risk of CF in EM, although ambiguity and diverse understandings of the term persist.[2, 8, 11-14] Research exploring CF in emergency staff has identified a number of risk factors as well as protective factors.[2, 8, 12, 14] It may be difficult to predict which individuals are at risk, as no specific health professional demographic has been shown to be associated.[3] It is suggested that those with a high standard of care may be at greater risk of CF.[15]

Hamilton *et al*. summarise risk factors in EM in their accompanying article.[16] CF in EM is also contributed to by ecological factors. Within the ED, staff are constantly exposed to patients who present for minor ailments, chronic pain, addictions and mental health issues. Many of these have no clear or definitive resolution, thereby increasing the risk of CF. EM staff also have increased pressures from shift work

covering the departments 24/7. Administrative pressures such as achieving key performance indicators and time-based targets may also contribute.2, 8 There is a recurring theme in CF literature of staff disempowerment and lack of control in decision-making, as organisational leadership moves towards a business model based around economic constraints.15

A significant and self-amplifying risk factor is that increasing CF may decrease self-care ability and diminish protective factors. This highlights that when staff are suffering from CF, they may be unable to activate previous resources and coping strategies, hence may require assistance and direction from colleagues.17 Unsupportive, disinterested or detached leadership has been repeatedly highlighted as a risk factor for CF for staff across a number of healthcare settings.2, 10, 17

Compassion satisfaction

The balancing factor of CF for emergency physicians is compassion satisfaction (CS).2, 4, 7, 17CS is the positivity and growth resulting from caring for others and the ability to receive gratification and reward from the care-giving role.5 This occurs when healthcare workers have a sense of connection with their patients.8 The promotion of CS is integral to the prevention of CF. Emergency staff are fortunate to balance a high risk of CF with high levels of CS.4 There are clear strategies for promotion of CS and prevention of CF in the emergency setting as well as within other areas of medicine.2

Interested, engaged and appreciative leadership is one such organisational factor that has been shown to improve staff well-being, reduce CF and increase CS.2, 8, 10 Dasan *et al*. suggest a number of individual protective factors that were useful in prevention of CF for emergency physicians, including physical exercise, time for reflection and ensuring appropriate downtime after traumatic events or intense periods of work.2 CS has been noted to increase with a longer career in EM.2 A focus on building coherent and supportive teams is recommended as a means to longevity in staff, reduced risk of CF and increased CS.5, 17Individual self-awareness is imperative to recognising signs of CF and being able to tap into the resources and activities that facilitate CS; however, these are likely to be very individualised responses.

A holistic approach to well-being is strongly advocated. This includes addressing social, emotional, physical, cognitive and vocational needs of individual staff members, and creating a culture of well-being within the organisation.5, 17 It is proposed that EDs provide psychoeducational opportunities for staff on CF and CS as a means of building resilience, understanding and resourcing staff to manage the realities of the day-to-day work.5, 17

Davies *et al*. propose that organisations provide creative outlets for patients and their families to express gratitude to emergency staff as a means of increasing CS.17 Building an EM culture where opportunities exist for individuals and teams to openly discuss ethical and moral issues, emotions associated with work and their learning on CF and CS will improve staff well-being.

Building resilience

Resilience is often misunderstood as a concept within health environments.18 There are three significant misconceptions associated with resilience: resilience is not a personality characteristic, it does not refer to an absence of psychopathology nor is it associated with above average psychological adjustment.18 Resilience is the process of experiencing an adversity and managing to maintain a relatively stable trajectory of healthy functioning and adaptation.18, 19 Resilient individuals may still experience stress and distress during adversity; however, these symptoms are mild and transient and will not interfere with long-term functioning.18, 19 Psychoeducation of EM physicians

requires normalisation of a range of emotions to adversity, promoting recovery as expectant functioning. Resiliency training requires painful self-awareness of the components that build CS and utilising them daily, not just when we are weary of the symptoms of CF.

Individually, there is a need for EM staff to consciously build their resilience. Resilient individuals recover quickly after challenging situations, while also growing stronger. Paradoxically, these challenges may contribute to CS.[20] An individual's coping style may be a predictor of burnout and CF.[21] Identification of dysfunctional coping styles may allow guidance in improving responses to stress, to build resilience. There is evidence that self-compassion may be an essential starting point and protective factor.[22] Self-compassion includes an empathic response and curiosity to one's own mistakes and faults, perceiving the event as part of the larger human experience rather than individual failing. Self-compassion allows examination and sitting comfortably with painful thoughts and feelings in balanced awareness.[3] Teaching EM staff that a range of emotions is normal, encouraging team cohesion and having leaders who offer genuine support and appreciation are all strong predictors of high levels of CS and low risk of CF. There is a need for teaching and role modelling on how to engage with patients and others without being at risk for CF.[23]

Conclusion

Human beings are wired for empathy and connection.[24] Connecting with and understanding the challenges of others is an ongoing responsibility in EM, which subjects emergency staff to an ongoing risk of CF. Preventing CF is the responsibility of everyone within the ED and requires a disciplined and reflective daily response, not merely an afterthought following a difficult event. In caring for others, it is an inherent risk that emergency staff may feel burdened by CF at some point. CF should not be feared; awareness and heightened vigilance should be instilled instead to allow early recognition and rapid triggering of preventative measures and intervention. Staff resilience coupled with early recognition of CF, a willingness to seek help and leaders who are proactive for their staff welfare, are fundamental to maintain well-being and tip the balance of compassion satisfaction over fatigue.

Competing interests

None declared.