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NCPD

WORLDVIEWS ON EVIDENCE-BASED NURSING

ORIGINAL ARTICLE

The impact of organizational compassion in health care on clinicians: A scoping review

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Abstract

Background: The unprecedented exodus of workers from the healthcare system is a patient safety crisis. Organizational compassion in health care is the proactive, systematic, and continuous identification, alleviation, and prevention of all sources of suffering.

Aims: This scoping review aimed to describe the evidence regarding the impact of organizational compassion on clinicians, identify gaps, and provide recommendations for future research.

Methods: A comprehensive librarian-assisted database search was conducted. Databases searched were PubMed, SCOPUS, EMBASE, Web of Science, PsychInfo, and Business Source Complete. Combinations of search terms regarding health care, compassion, organizational compassion, and workplace suffering were used. The search strategy was limited to English language articles and those published between 2000 and 2021.

Results: Database search yielded 781 articles. After removing duplicates, 468 were screened by title and abstract, and 313 were excluded. One-hundred and fifty-five underwent full-text screening, and 137 were removed, leaving 18 eligible articles, two of which were set in the United States. Ten articles evaluated barriers or facilitators to organizational compassion, four evaluated elements of compassionate leadership, and four evaluated the Schwartz Center Rounds intervention. Several described the need to create systems that are compassionate to clinicians. Lack of time, support staff, and resources impeded the delivery of such interventions.

Linking evidence to action: Little research has been done to understand and evaluate the impact of compassion on US clinicians. Given the workforce crisis in American health care and the potential positive impact of increasing compassion for clinicians, there is an urgent need for researchers and healthcare administrators to fill this gap.

KEYWORDS
burnout, clinician, compassion, health care, organizational compassion, suffering, well-being

Details regarding NCPD can be found following the References section.

INTRODUCTION

Rationale for scoping review

We are in the midst of an unprecedented exodus of workers from the American healthcare system. Healthcare workforce shortages have long been predicted due to the large population of aging Baby Boomers (Stevenson, 2018). Unfortunately, the COVID-19 pandemic rapidly accelerated the rate of worker departures (Lopez et al., 2022). Consequently, a US shortage of more than one million nurses is anticipated by 2030 (US Bureau of Labor Statistics, 2022). These shortages are unsurprising because while health care aspires to provide compassionate and healing patient care, it has long been a harmful work environment for clinicians (Thienprayoon et al., 2022). Working in health care exposes workers to intrinsic sources of suffering (Dempsey & Mylod, 2016), namely the distress engendered by caring for the sick and dying. Regrettably, healthcare workers also face avoidable sources of suffering, such as workplace bullying (Lamberth, 2015), violence (Liu et al., 2019), low psychological safety (O'Donovan & Mcauliffe, 2020), and moral distress — knowing the morally correct action, but being rendered powerless to act differently (Lamiani et al., 2017). Clinicians enter health care driven by an innate motivation to alleviate suffering for patients. However, the burden of unnecessary tasks, inefficient documentation and workflow (Ashton, 2018), and a sense of not being valued engender high levels of disengagement and a desire to leave the workforce (Berg, 2022). Nurses are at high risk for mental health disorders such as anxiety, depression, including severe depressive episodes, with the prevalence of each increasing from 2017 to 2021 (Cuccia et al., 2022). Nurses and physicians are also at higher risk of suicide than the general population, with nurses at higher risk than physicians (Davidson et al., 2020; Davis et al., 2021; Fink-Miller & Nestler, 2018). While these problems persist, there remains a culture of silence and stigma around openly acknowledging the mental health challenges, trauma, and distress associated with healthcare work (Lehmann et al., 2018). This contributes to a cycle of shame, guilt, and further suffering (Bento, 1994; Hazen, 2008; Hill, 2017).

Published reports of clinician distress and suffering frequently confound these experiences with burnout, a syndrome characterized by emotional exhaustion, depersonalization, and low professional accomplishment (Maslach et al., 1996). Though burnout is widespread among healthcare workers (Harrison et al., 2017; Kamal et al., 2016; Shanafelt et al., 2010, 2012; West et al., 2016), the tendency to regard the trauma and distress clinicians face only in terms of burnout is woefully inadequate. In the business of health care, the emphasis on burnout contributes to a view of workers as merely overused organizational resources. It falls short of considering healthcare workers as whole human beings who deserve not to suffer. Shifting the focus from clinician burnout to clinician *suffering* enables a broader understanding of the nature and implications of clinicians' challenging and painful experiences. Suffering underlies burnout but is phenomenologically closer to clinicians' immediate experiences. Changing this focus allows for the consideration of episodes of distress that have immediate consequences for clinician well-being but may take years to engender burnout (e.g., serious safety events and unexpected patient death), as well as those not necessarily classically associated with burnout (e.g., traumatic experiences in one's personal life). Attention to suffering also opens a vital door to compassion, an empathic behavioral response to suffering. Many scholars, spiritual leaders, and healthcare professionals recognize compassion as an ameliorator of suffering that transcends cultures, specialties, and healthcare sectors (Thienprayoon et al., 2022).

Compassion has been identified as a crucial dimension of excellence in work organizations (Worline et al., 2017). Management scholars conceptualize organizational compassion as a four-part "NEAR" process: (1) **N**oticing a person's suffering, (2) **E**mpathizing with the individual's distress, (3) rationally **A**ssessing the circumstances, and (4) **R**esponding with actions aimed at lessening or alleviating that suffering (Dutton et al., 2014; Simpson & Farr-Wharton, 2017). This definition includes key qualities that distinguish compassion from seemingly similar concepts such as kindness, empathy, or sympathy. Namely, compassion arises specifically in response to suffering. It encompasses both feeling and action taken to relieve suffering (Strauss et al., 2016). This definition can be applied at different organizational levels, including dyadic (i.e., person-to-person) compassion, group- or team-level compassion, and system-level compassion within organizations (Simpson et al., 2020). Efforts to address organizational members' suffering through compassion were found to significantly benefit both employees and organizations. These benefits included accelerating post-traumatic healing, strengthening trust, and enhancing employee motivation, pride, and organizational commitment (Dutton et al., 2002, 2007; Lilius et al., 2008, 2011; Powley & Cameron, 2008; Simpson et al., 2015).

Although compassion research in health care has typically focused on the clinician–patient dyad and the alleviation of patient suffering (Sinclair, McClement et al., 2016, Sinclair, Norris et al., 2016, Sinclair et al., 2017, 2018, 2020), interest in understanding compassion for and among healthcare workers has grown. This trend is concurrent with the management literature's attention to compassion for and among organizational members (Simpson et al., 2019, 2020; Simpson & Simpson, 2021). Considering the unique realities of working in health care, the organizational definition of compassion has been adapted as follows: "the proactive, systematic, and continuous identification, alleviation, and prevention of all sources of workplace suffering" (Thienprayoon et al., 2022, p.2) This definition accounts for the fact that the work of health care is more likely to cause suffering than work in other industries (Thienprayoon et al., 2022). Indeed, when causes of suffering are recurrent and foreseeable, a retroactive response is insufficiently compassionate. Anticipation and prevention of predictable sources of distress is crucial (Gilbert, 2014). Considering clinician suffering through the lens of organizational compassion rather than individual

burnout shifts the responsibility for response onto the organization (Simpson et al., 2020). It fosters a new paradigm of developing individual, team, and organizational capabilities to create positive clinician experiences (Dutton & Workman, 2011). A compassionate approach to improving clinician experiences orients us to a broader set of clinician outcomes beyond burnout. These outcomes include resilience, engagement, job satisfaction, and a sense of purpose. This compassionate approach is also applicable to patient experiences and outcomes (Sinclair, McClement et al., 2016, Sinclair, Norris et al., 2016, Sinclair et al., 2017, 2020).

Objectives

Because the field of organizational compassion in health care is in its infancy, scoping review methods were chosen to conduct a preliminary assessment of the size and scope of the existing body of literature (Munn et al., 2018). A scoping review consists of a systematic approach to investigating and understanding bodies of literature with little or no synthesis or emerging topics, helping to identify gaps in the literature and clarifying concepts (Arksey & O'Malley, 2005; Levac et al., 2010). A systematic review was not employed because exploratory literature searches during study planning revealed a paucity of data that would indicate the need for a systematic review (Munn et al., 2018). We employed the methodologic framework developed by Arksey and O'Malley (2005). The primary research question was: "What is the evidence (human subjects research) regarding the impact of organizational compassion in healthcare on clinicians?"

METHODS

Protocol and registration

The process and search criteria for this scoping review comply with the Preferred Reporting Items for Systematic reviews and Meta-analyses (PRISMA; Page, McKenzie, Bossuyt, Boutron, Hoffmann, Mulrow, Shamseer, Tetzlaff & Moher, 2021) and the PRISMA extension for scoping reviews (PRISMA-ScR; McGowan et al., 2020). A scoping review protocol was developed and followed throughout the study, but not registered.

Search strategy

To ensure rigor and consistency throughout the process, the review team included content and methodological experts in organizational compassion in health care, and the study team members remained consistent throughout the process. The search strategy was developed in consultation with a medical librarian. Following a preliminary literature search of applicable databases, search criteria were iteratively revised and focused on understanding terms commonly and uncommonly used in the literature.

Eligibility criteria and information sources

The search strategy was limited to English language articles and those published between January 1, 2000 and December 31, 2020. This range was chosen because seminal papers on organizational compassion (Kanov et al., 2004; Lilius et al., 2003) were published in the early 2000s, and a PubMed search revealed no references to organizational compassion published before 2002. To reduce the risk of publication bias, R.T. and T.P. conducted searches of multiple electronic databases between January 1, 2021 and April 30, 2021: PubMed, SCOPUS, EMBASE, Web of Science, PsychInfo, and Business Source Complete. These databases were chosen because of their combined ability to generate evidence that was specific to the research topic. Combinations of the following search terms were used: "compassionate leadership" OR "organizational compassion" OR "organizational behavior" OR "organizational culture" OR "organizational design" OR "organizational values" OR "organizational strategy" OR "workplace suffering" OR "healthcare culture" AND "compassion*" OR "empathy" OR "empath*" AND "healthcare" OR "health care" OR "hospital." MeSH terms were used for searching "empathy." Search strategies are summarized in Table A1. Gray literature searches were not included. Reference lists from included articles were screened to identify additional articles not captured by the search criteria. Covidence software was used to import and screen references and organize the study procedures.

Selection of sources of evidence

Our primary interest was in the evidence (human subjects research) regarding the impact of organizational compassion in health care on clinicians. Therefore, inclusion criteria for full-text review were articles that focused on healthcare worker experiences of compassion; displays of compassion for clinicians or employees at the system, hospital, or team level; systems to improve clinician experiences of compassion; elements of compassionate leadership in health care; and systems or systems-level interventions to alleviate clinician suffering. The definition of "health care" was purposefully broad for the purposes of this study and inclusive of all contexts (e.g., ambulatory, inpatient, long-term care, and nursing home settings). Studies evaluating compassionate leadership behaviors were included because clinician perceptions or experiences of organizational compassion may be directly impacted by the behaviors of organizational leaders. Exclusion criteria were articles focused exclusively on patient experiences of compassionate or noncompassionate care; articles focused solely on reporting the prevalence of burnout in specific cohorts (e.g., anesthesiologists) unless they also focused on compassion as

a systems-level response; articles focused on student experiences, theoretical articles, letters, commentaries, or editorials. Gray literature searches were not completed as the focus was exclusively on peer-reviewed evidence and human subjects' research.

Study selection

R.T. and T.P. conducted all stages of the scoping review. To help identify and deter reporting bias, our review adhered to the protocol, developed prior to beginning our search. All relevant records were screened by title and abstract by both authors independently to determine whether they met the inclusion or exclusion criteria to reduce possible detection bias. Disagreements were resolved through iterative discussion until an agreement was reached. Initial inter-rater reliability for Level 1 screening was moderate (Cohen's kappa = 0.57) as the team clarified their criteria for study eligibility, and for Level 2 screening was excellent (Cohen's kappa = 1.0).

Data charting process, including data items, critical appraisal, and data synthesis

All references were uploaded to Covidence software, and duplicates were removed. Articles were then screened by R.T. and T.P. by title and abstract using inclusion and exclusion criteria. R.T. and T.P. then read full-text articles and extracted standardized data into a shared Excel sheet, including authors, title, journal, publication year, country of origin, study design, study setting, healthcare professionals included as participants, and study findings. The spreadsheet was developed specifically for this study, and extracted data were populated independently by T.P and verified independently by R.T., and any disagreements resolved through iterative discussion. Articles were grouped into three themes: (1) barriers and facilitators of organizational compassion, (2) compassionate leadership in health care, and (3) Schwartz Center Rounds™ (SCR). The quality of evidence was evaluated for each eligible article according to Fineout-Overholt and Melnyk (2015).

RESULTS

Selection of sources of evidence

The search strategy returned 781 possible articles for screening. After removing the duplicates ($N = 313$), 468 articles were screened by title and abstract using inclusion and exclusion criteria; 313 were removed. Full-text screening of the remaining 155 removed an additional 137 articles, leaving 18 evaluable for our purposes (Figure 1). Reasons for full-text exclusion were not focused on compassion ($N = 50$), not human subjects research (i.e., editorials, theoretical pieces, commentaries, $N = 45$), wrong setting (i.e., not health care, $N = 32$), and wrong population (i.e., studies involving patients and not healthcare workers, $N = 10$).

Characteristics of sources of evidence

Of the 18 evaluable articles, the majority ($N = 12$, 67%) were from the United Kingdom or Canada (Adamson, Searl et al., 2018, Adamson, Sengsavang et al., 2018; Ali & Terry, 2017; Bridges et al., 2017; Clyne et al., 2018; Farr & Barker, 2017; Goodrich, 2012; Henshall et al., 2018; Hewison et al., 2018, 2019; Ledoux et al., 2018; McSherry & Pearce, 2018). Only two (11%) were exclusively from the United States (Lown et al., 2019, 2020). Eight (44%) utilized mixed-methods methodology (Clyne et al., 2018; Farr & Barker, 2017; Goodrich, 2012; Henshall et al., 2018; Lown et al., 2020; McSherry & Pearce, 2018; Papadopoulos et al., 2020, 2021), six (33%) employed qualitative methodology (Adamson, Sengsavang et al., 2018; Ali & Terry, 2017; Bridges et al., 2017; Hewison et al., 2018, 2019; Vanstone et al., 2020), and four (22%) were cross-sectional surveys (Adamson, Searl et al., 2018; Ledoux et al., 2018; Lown et al., 2019; McClelland & Vogus, 2014). Ten studies (56%) evaluated perceptions of organizational/workplace compassion, obstacles to organizational compassion, or interventions to increase workplace compassion (Bridges et al., 2017; Clyne et al., 2018; Henshall et al., 2018; Ledoux et al., 2018; Lown et al., 2019, 2020; McClelland & Vogus, 2014; McSherry & Pearce, 2018; Papadopoulos et al., 2020; Vanstone et al., 2020). Four (22%) focused specifically on the impact of the SCR intervention (Adamson, Searl, et al., 2018, Adamson, Sengsavang, et al., 2018; Farr & Barker, 2017; Goodrich, 2012). Four (22%) described or evaluated elements of compassionate leadership in health care. Article details, including level of evidence, are summarized in Table 1 (Ali & Terry, 2017; Hewison et al., 2018; Hewison et al., 2019; Papadopoulos et al., 2021; 22%). Table 2 provides an outcomes synthesis table including compassion interventions and associated outcomes.

Synthesis of results

Barriers and facilitators of organizational and workplace compassion

Several articles highlighted the need to create systems and cultures that are compassionate to clinicians (Clyne et al., 2018; Lown et al., 2020; McSherry & Pearce, 2018; Papadopoulos et al., 2020). Barriers to experiencing compassion in the workplace and perceiving high levels of organizational compassion include a high frequency of staff turnover, sickness, and absence (Lown et al., 2020; McSherry & Pearce, 2018), low organizational support (Lown et al., 2019), and perceived organizational threat (e.g., the stressors and challenges faced by individuals working in an organization; Henshall et al., 2018). Barriers to managerial compassion behaviors included personal characteristics and experiences, issues with the system such as rigid and archaic administrative structures and rules, and stress and burnout (Papadopoulos et al., 2020); emotional exhaustion and depersonalization, which are elements of burnout, also predicted lower compassion-related behaviors among clinicians (Lown

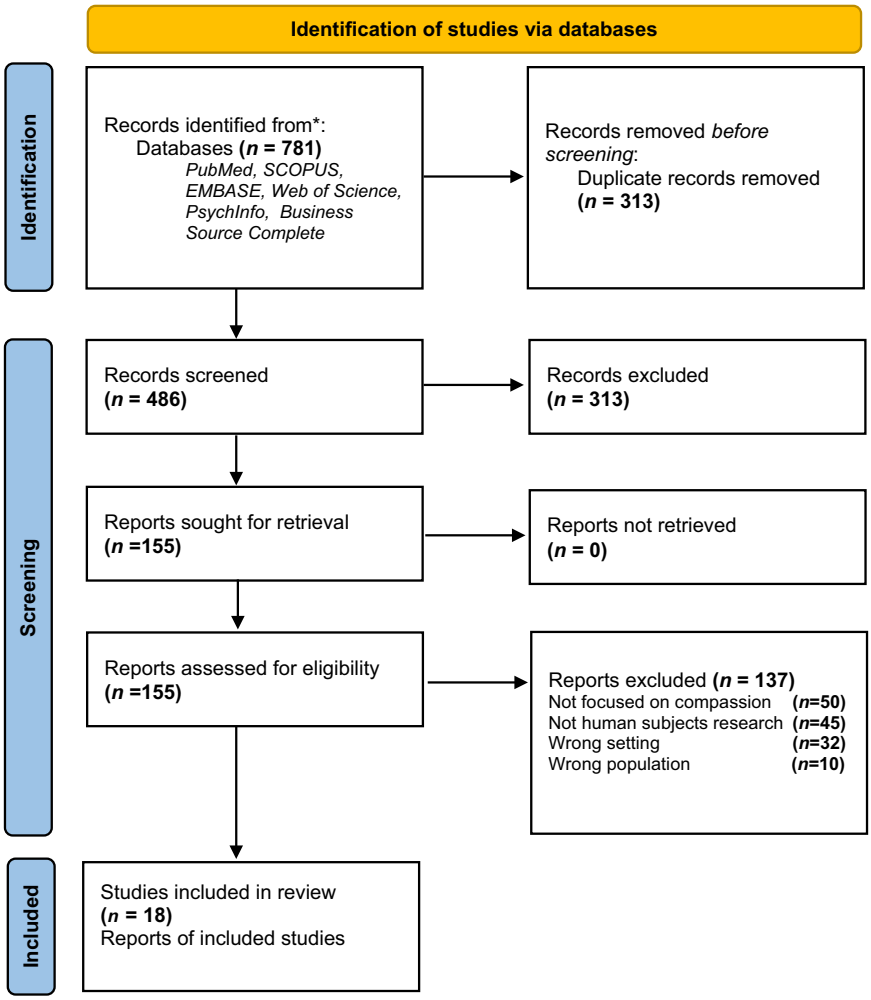

FIGURE 1 PRISMA diagram of study procedures. Adapted from Page, McKenzie, Bossuyt, Boutron, Hoffmann, Mulrow, Shamseer, Tetzlaff, Akl et al. 2021.

et al., 2019). Finally, Bridges et al. (2017) found that a "Creating Learning Environments for Compassionate Care" intervention was valuable for clinician well-being and patient care, but a significant barrier to implementation was that the "organizational culture, focused on tasks and targets, constrained opportunities for staff mutual support and learning" (p.971).

Conversely, small acts of kindness, an embedded organizational culture of caring for one another, and recognition of healthcare work's emotional and physical impact are facilitators of workplace compassion in health care (Clyne et al., 2018). Similarly, a high perception of team caring facilitates higher perceived organizational compassion, and higher perceived organizational compassion predicts higher worker engagement in the healthcare organization (Lown et al., 2020). Regarding facilitators of compassionate patient care, organizational variables found to impact clinicians' ability to practice with compassion include structural empowerment, psychological empowerment, interprofessional collaboration (Ledoux et al., 2018), and both rewarding compassionate acts and compassionately supporting employees (McClelland & Vogus, 2014). Finally, the "3 Wishes Project," an intervention focused on eliciting and implementing wishes for the dying, was found to facilitate the collective capacity of a unit to notice, feel, and respond to suffering, both in patients and in one another (Vanstone et al., 2020).

Compassionate leadership in health care

Several articles found that compassionate leadership is an important facilitator of clinician experiences of compassion in the workplace (Ali & Terry, 2017; Bridges et al., 2017; Hewison et al., 2018, 2019; Papadopoulos et al., 2021). Elements of compassionate leadership in health care include empowering, nurturing, and challenging clinicians, giving clinicians permission to be human, modeling and maintaining professional boundaries with patients, and providing resources to manage work stress (Hewison et al., 2019). Similarly, Ali and Terry (2017) found that in health care, compassionate leadership is about leading with the "head and the heart" or balancing kindness with honesty, consistency, and courage to challenge noncompassionate behaviors toward patients. A "Leading with Compassion" program designed to develop compassionate leadership in health care was found to be helpful for frontline clinicians to identify how compassion is viewed, enacted, and appreciated as part of the organizational culture (Hewison et al., 2018).

TABLE 1 Articles that met criteria for review with authors and year, methodology, country of origin, setting, study purpose, participants, and findings.

References	Methodology (level of evidence)	Country	Setting	Study purpose	Participants	Findings
Barriers and facilitators to organizational or workplace compassion						
McClelland and Vogus (2014)	Cross-sectional survey (Level 6)	US	US nonfederal acute care hospitals	To examine benefits of compassion practices on two indicators of patient perceptions of quality	269 C-suite executives	Compassion practices were significantly and positively associated with hospital ratings and likelihood of recommendation by patients
Bridges et al. (2017)	Qualitative (Level 6)	UK	Two general hospitals in the NHS	To identify and explain the extent to which CLECC was implemented into existing work practices by nursing staff and to inform conclusions about how such interventions can be optimized to support compassionate care	25 inpatient clinicians	Creating Learning Environments for Compassionate Care (CLECC) focused on developing sustainable leadership team practices to support team relational capacity and compassionate care. CLECC had high staff engagement, staff valued benefits to their well-being and patient care. Organizational culture focused on tasks and targets was a barrier to implementation
Clyne et al. (2018)	Qualitative (Level 6)	UK	Twitter/Tweets focused on NHS communications	To use social media for the generation and collection of primary data to gain understanding of the concept of workplace compassion in the NHS	260 tweets using hashtag #showsworkplacecompassion	Tweets concerned leadership and management, values and culture, personalized policies, activities, and action. Most frequently mentioned characteristics of workplace compassion: small acts of kindness, caring for one another and recognition of work
Henshall et al. (2018)	Cross-sectional survey (Level 6)	UK	3 NHS trusts	To investigate whether perceived organizational threat impacted compassion for others and whether self-compassion and/or perceived organizational compassion might moderate this relationship	276 healthcare workers	Perceived organizational threat was negatively correlated with compassion for others. Self-compassion and perceived organizational compassion were strong predictors of compassion for others
Ledoux et al. (2018)	Cross-sectional survey (Level 6)	Canada	College of Nurses of Ontario registry	To examine personal and organizational variables that might impact nurses' ability to practice with compassion	191 registered nurses	Predictors for compassion in nursing were structural empowerment, psychological empowerment, and interprofessional collaboration
McSherry and Pearce (2018)	Mixed-methods (Level 6)	UK	Two NHS Hospitals	To develop and test a cultural health check toolkit to support health care workers, patients, and organizations in the provision of safe, compassionate, and dignified care	98 healthcare workers	The cultural health check rating scale could be used to gauge the level of compassion with a health care organization culture and working environment. As the scale was developed and validated in small feasibility sample in 2 NHS, authors state that it is not otherwise generalizable

(Continues)

TABLE 1 (Continued)

References	Methodology (level of evidence)	Country	Setting	Study purpose	Participants	Findings
Lown et al. (2019)	Cross-sectional survey (Level 6)	US	Hospital-based physicians and nurses from across the US	To evaluate perceptions of the status of compassionate health care in the US in 2017 compared to 2010 and whether burnout correlated with perceptions of compassionate care	250 nurses and 380 physicians in the US	More participants responded negatively regarding the state of compassion in the US healthcare system in 2017 than in 2010. Compassion-related behaviors among clinicians correlated significantly and inversely with their responses to questions related to emotional exhaustion and depersonalization and with lack of perceived organizational support
Vanstone et al. (2020)	Qualitative (Level 6)	US Canada	4 North American ICUs	To examine how the "3 Wishes Project" enables collective patterns of compassion between patients, families, clinicians, and managerial leaders	72 clinicians, 74 family members, and 20 managerial leaders	"3 Wishes Project" elicits and implements wishes for patients dying in ICU. The intervention was found to support ICU staff to collectively notice, feel, and respond to suffering – promoting compassion between patients, family members, and clinicians
Lown et al. (2020)	Cross-sectional survey (Level 6)	US	One US Academic Health System/ Hospital	To examine factors that influence nurses' perceptions of organizational compassion and their engagement with the organization	686 nurses	Higher individual and team compassion were associated with higher perceived organizational compassion. Higher organizational compassion was associated with greater engagement. Adequate staffing, resource allocation, support help build capacity and for organizational compassion
Papadopoulos et al. (2020)	Cross-sectional survey (Level 6)	International	International research	To explore nursing and midwifery manager' views regarding obstacles to compassion-giving across country cultures	217 nursing and midwifery managers	Obstacles to compassion-giving among managers: managers' personal characteristics, experiences (e.g., fear of losing authority, compassion-related stress), staff-related (e.g., perceived risk staff may abuse compassion received), system-related (e.g., the system itself, workload, stress, burnout)
Compassionate leadership in health care						
Ali and Terry (2017)	Qualitative (Level 6)	UK	One community NHS trust	To understand how leaders and senior staff within a community NHS trust perceive compassionate leadership and its importance	11 nursing leaders	Themes of compassionate leadership: leading with head and heart (e.g., balancing kindness with honesty, consistency, courage), being cared for – not just treated (e.g., leading with emotions, feelings while not losing sight of patients being cared for)

TABLE 1 (Continued)

References	Methodology (level of evidence)	Country	Setting	Study purpose	Participants	Findings
Hewison et al. (2018)	Qualitative (Level 6)	UK	10 healthcare organizations	To report an evaluation of the "leading with compassion" recognition scheme and present a framework for compassion derived from the data (1500 nomination statements)	Eight clinicians (semi-structured interviews) in 1 focus group of 3 clinicians	The purpose of the "Leading with Compassion" program in UK was to "embed, recognize and research compassionate leadership" and "to engage staff in recognizing and celebrating compassion." Participants noted importance of modeling compassion at all organizational levels and felt the program was an appropriate step in working to develop a compassionate culture for clinicians
Hewison et al. (2019)	Qualitative (Level 6)	UK	Network of professionals acting as leaders in palliative and end-of-life care in West Midlands, England	To explore compassionate leadership with clinicians involved in leading system-wide end-of-life care	14 participants in 4 focus groups	The nature of leadership in palliative and end-of-life care is challenging and overlaps with common features of good leaders such as servant leadership, resonant leadership, and authentic leadership. Sensitivity to the needs of staff is heightened, and management of boundaries are uniquely important
Papadopoulos et al. (2021)	Cross-sectional survey (Level 6)	International	International research	To explore views of nursing and midwifery managers from different countries in relation to the definition, advantages, and importance of compassion	1210 nursing and midwifery managers	Participants felt that compassion is a virtuous quality and associated with humanness, that compassion is an important quality for managers, and that it benefits managers directly in terms of feeling valued and respected. Manager–staff relationships informed by a compassionate approach become more open, closer, and more positive, establishing a nurturing, positive environment with better teamwork
Schwartz Center Rounds™						
Goodrich (2012)	Qualitative (Level 6)	UK	Two NHS hospitals	To assess whether the Schwartz Center Rounds could transfer from the US to a UK setting and whether the rounds would achieve a similar positive impact on individuals, teams, and hospital culture	41 hospital staff	Schwartz Center Rounds were perceived as having personal benefit by leading staff to provide patients with more compassionate care, positively impacting relationships with colleagues and teams, and positively impacting organizational culture by providing a forum where people could meet and discuss as equals

(Continues)

TABLE 1 (Continued)

References	Methodology (level of evidence)	Country	Setting	Study purpose	Participants	Findings
Farr and Barker (2017)	Mixed-methods (Level 6)	UK	Three NHS community and mental health services	To study staff experiences of Schwartz Rounds in mental health and community settings and the mechanisms within them that support compassionate care, study enablers and obstacles to implementing rounds, and study perceived effects of rounds within community services and mental health services	85 staff observed 22 staff interviewed 206 completed evaluation sheets	Schwartz Center Round implementation provided space for staff to share emotional impact of their work. Perceived positive impact on working with patients, colleagues, and wider organizational culture. Perceived benefits: Improved communications, trust, openness with colleagues, and compassionate care with patients
Adamson, Searl et al. (2018)	Cross-sectional survey (Level 6)	Canada	One academic pediatric rehabilitation hospital	To describe how a hospital implemented Schwartz Rounds to support the socio-emotional impact of providing care	571 rehab staff	Attendees of Schwartz Center Rounds reported positive impact, greater communication with coworkers, and more personal communications with supervisors after events, compared to nonattendees. Rounds increased perspective-taking in attendees
Adamson, Sengsavang et al. (2018)	Qualitative (Level 6)	Canada	One academic pediatric rehabilitation hospital	To assess the perceived impact of Schwartz Rounds in the health care context of pediatric rehabilitation and provide comparative analysis of how rounds affected clinical versus nonclinical staff	29 hospital staff	Thematic analysis revealed personal and social impact (e.g., reduced stress, increased approaching behaviors, normalizing/validating emotional experiences, building bridges) and impact on personal knowledge and skills (e.g., interprofessional practice, reflective practice, and clinical imagination). Clinicians gained insight into roles of nonclinical staff. Nonclinicians developed appreciation of frontline staff, challenges/stress of clinical work

Abbreviations: NHS, National Health Services; UK, United Kingdom; US, United States.

TABLE 2 Outcomes synthesis table with articles describing compassion interventions and associated outcomes.

Author	Compassion intervention	Associated outcome
McClelland and Vogus (2014)	Compassion practices, including 1. Rewarding employees for acts of caring to patients/families 2. Rewarding/recognizing employees for caring acts to one another 3. Having a compassionate caregiver/employee reward program 4. Offering pastoral care to employees 5. 5. Facilitating support sessions for units dealing with crises, conflict, trauma, or workplace stress	↑ Hospital ratings on Hospital Consumer Assessment of Healthcare Providers and Systems ↑ Likelihood of patient likelihood of recommending hospital to others
Bridges et al. (2017)	Creating Learning Environments for Compassionate Care, an educational intervention focused on developing sustainable leadership and work-team practices designed to support team relational capacity and compassionate care delivery	↑ Staff well-being, morale, and capacity to care ↑ Conscious, deliberate engagement with patients and colleagues ↑ Opportunities to value compassion and increase commitment to compassion
Vanstone et al. (2020)	Three Wishes Project	↑ Collective noticing, feeling, and responding to suffering
Hewison et al. (2018)	Leading with compassion recognition program which acknowledged and rewarded compassionate acts witnessed "in the moment." Nominations were made by completing cards and posting in central locations; nominees received the card explaining who nominated them, reasons for nomination, and a badge recognizing them for compassion	↑ Helpfulness in identifying how compassion is viewed, enacted, and appreciated
Goodrich (2012)	Schwartz Center Rounds	↑ Provision of compassionate care to patients ↑ Respect, empathy, and understanding between staff ↑ Potential for multidisciplinary work, promotion of collaboration between individuals and teams ↑ Potential to support an organization's strategic vision and build and support shared values ↓ Stress in working with patients ↓ Hierarchy in hospital environment
Farr and Barker (2017)	Schwartz Center Rounds	↑ Awareness of patients, improved communications with patients, mindfulness of emotional impact of work, empathy, and compassion ↑ Trust with colleagues, relating to colleagues on a more human level
Adamson, Searl et al. (2018)	Schwartz Center Rounds	↑ Communication with coworkers ↑ Personal conversations with supervisors ↑ Perspective-taking capacity
Adamson, Sengsavang et al. (2018)	Schwartz Center Rounds	↑ Renewed passion for work, empowerment, and internal motivation to do more in work ↑ Knowledge of other attendees' roles, which added to "resource pool" of people to reach out to assist patients and families ↑ Improved practices in engaging with patients and families (e.g., confidence in admitting when they do not know something, listening to patients, and patience) ↑ Perspective-taking ↑ Approaching behaviors to other colleagues for assistance ↓ Work-related stress

Schwartz center rounds

Schwartz center rounds, developed by the Schwartz Center for Compassionate Healthcare, is an interdisciplinary forum in which attendees can discuss psychosocial and emotional aspects of patient care, to improve relationships, enhance clinicians' sense of support, and ultimately increase compassion for oneself, one another, and patients (Lown & Manning, 2010). By providing a forum in which people can meet as equals and share vulnerably, SCR have been found to positively impact compassionate patient care, relationships between colleagues and teams, and overall organizational culture (Goodrich, 2012). Adamson, Searl et al. (2018) surveyed

staff who attended SCR and found that attendees perceived it was relevant, had a positive impact, resulted in more communication with coworkers, more personal conversations with their supervisors, and increased perspective-taking. Qualitative interviews with 29 pediatric rehabilitation staff (15 clinical and 14 nonclinical) who attended SCR indicated reduced stress, increased normalizing and validating of emotional experiences, building bridges in the hospital, and a positive impact on knowledge and skills were perceived as relevant (Adamson, Sengsavang et al., 2018). SCR discussions were also found to enable emotional resonance across interdisciplinary colleagues and enable recognition of common humanity, resulting in improved communication, trust, and openness with colleagues (Farr & Barker, 2017).

DISCUSSION

Summary of evidence

In this scoping literature review of the evidence for the impact of organizational compassion on clinicians in health care, 18 articles met the criteria for evaluation, with two studies exclusively based in the US Beyond the Schwartz Center for Compassionate Care, little research has been conducted to understand and evaluate the impact of compassion on clinicians in the United States. Yet, there is evidence that organizations can improve clinician experiences by openly recognizing the emotional toll of healthcare work and creating cultures that promote caring behaviors among staff (Adamson, Sengsavang, et al., 2018; Clyne et al., 2018; Vanstone et al., 2020). Perceptions of caring within healthcare teams predict perceptions of organizational compassion, which itself predicts staff engagement (Lown et al., 2020). Strong connections between workers are crucial to organizational compassion (Lilius et al., 2011). Delivering high-quality health care requires high-functioning teams (Sevin et al., 2009). When managers exhibit compassionate leadership qualities, relationships with their staff are perceived to be closer and more nurturing, leading to better teamwork (Papadopoulos et al., 2021). Clinician staffing shortages are now the nation's top patient safety concern (Johnson, 2022), and systems-level changes focused on increasing compassion for clinicians may improve clinician engagement and retention in the short and long term. By cultivating compassionate organizational cultures, leaders can create environments to optimize clinician experiences and satisfaction over decades-long careers.

Patients, clinicians, family members, and professional healthcare organizations have all identified compassion as a cornerstone of high-quality patient care (Cherlin et al., 2004; Flocke et al., 2002; Francis, 2013; Heyland et al., 2006, 2010; Lown et al., 2011; Sinclair, McClement et al., 2016), and compassionate care has been named as a domain of high-quality pediatric hospice and palliative care (Thienprayoon et al., 2020). Therefore, there is an expectation that clinicians are compassionate in patient interactions, but less attention has been paid to creating systems that will support clinicians in continuously providing that care. Research outside of health care has found that efforts to alleviate workers' suffering through compassion can quicken post-traumatic healing, strengthen trust, and enhance employee motivation, pride, and commitment to the organization (Dutton et al., 2002, 2007; Lilius et al., 2008, 2011; Powley & Cameron, 2008; Simpson et al., 2015). Compassion is at the heart of employee engagement (Dutton et al., 2014), and higher healthcare worker engagement levels are predictive of better patient outcomes and decreased costs of care (Bell et al., 2022). The availability of compassionate social support also significantly impacts resilience to distress and mental health outcomes (Gilbert et al., 2017; Ozbay et al., 2007). It follows, then, that targeting compassion interventions to create more caring environments for clinicians may impact clinician experiences in a way that may also positively impact patient experiences and outcomes and improve the financial health of organizations. The juxtaposition of the clear benefits of compassion in the workplace with so little empirical research on this subject within the healthcare literature is particularly striking.

Several studies described research regarding the SCR intervention. While SCR events have been demonstrated to improve psychosocial support and increase connections between colleagues (Adamson, Searl et al., 2018), these events offer a single intervention to improve clinician experiences and to help staff manage the psychosocial stresses of caring for sick and dying people. However, other articles revealed evidence of alternative interventions which may also increase compassion at the unit or system level, including the 3 Wishes Project (Vanstone et al., 2020), Creating Learning Environments for Compassionate Care (Bridges et al., 2017), and the Leading with Compassion program (Hewison et al., 2018). Just as lack of time, support, staffing, and resources impede the delivery of compassionate care (Brown et al., 2014; Crawford et al., 2013; Curtis et al., 2012; Lown et al., 2011), similar barriers can impede the delivery of these interventions (Bridges et al., 2017). The implication is that although medicine espouses compassion as a core value, in reality, those practicing medicine are held accountable to metrics that interfere with creating compassionate cultures for clinicians and patients. Such competing priorities also drive burnout in medicine and contribute to an individual's intention to leave medicine (Ashton, 2018). To improve clinician experiences and decrease turnover, managers and leaders must confront this tension directly by focusing on improving work conditions for frontline healthcare workers alongside efforts to improve patient experiences and outcomes (Bodenheimer & Sinsky, 2014; Rotenstein et al., 2022).

Suffering is a salient clinician experience, and organizations must shift their focus from crisis intervention to prevention of negative clinician outcomes (Melnyk, 2020). Focusing on compassion for clinicians, which seeks to prevent and alleviate clinician suffering, offers a philosophical and operational approach to necessary culture change in medicine. This scoping review identified a gap between research regarding the benefits of compassionate environments for clinicians and evidence-based interventions to improve workplace experiences. Specifically, there is a paucity of research regarding tools to understand and measure clinician experiences of compassion and

caring in the workplace, particularly in the United States. Priority areas for future research should include the exploration of sources of suffering and compassion for clinicians and the development and testing, validation, and dissemination of tools to measure clinician experiences of compassion (Thienprayoon et al., 2022). How clinician experiences relate to outcomes such as engagement, burnout, resilience, and mental health issues can then be evaluated, and responsive interventions to improve those outcomes developed (Thienprayoon et al., 2022). The relationship between specific clinician experiences and outcomes and patient experiences and outcomes must also ultimately be rigorously evaluated and understood. Ultimately, such research should enable the development and dissemination of systems-level interventions to improve these experiences (Thienprayoon et al., 2022). While new funding streams for research to improve clinician experiences have become available since COVID-19 (American Rescue Plan Act, 2021), overall research funding dedicated to the healthcare workforce remains inadequate. As physician burnout in the United States is estimated to cost $4.6 billion annually (Han et al., 2019), future research must also focus on the development of financial models to understand how the cost of such compassion interventions may decrease this financial burden of burnout (Thienprayoon et al., 2022).

Limitations

First, unlike systematic reviews, scoping reviews are not designed to answer clinical questions or provide evidence to inform practice; there are significant limitations inherent in these methods (Munn et al., 2018). Second, the level of evidence (Melnyk & Fineout-Overholt, 2022) of the included studies was consistently low (level 6 for all included), limiting the generalizability and impact of these results. Third, despite a robust search strategy, relevant studies may have been missed. Fourth, the exclusion of non-English language studies limits the generalizability of the findings beyond a Western setting. Fifth, as the field of organizational compassion in health care is expanding rapidly, this review may not include newer, relevant studies published since the search was completed. Finally, studies that were focused on related but distinct topics such as burnout or compassion fatigue were excluded, unless they included a focus on the impact organizational compassion as a response or solution; the rationale was to ensure feasibility and focus on the question, but this approach may have resulted in the inadvertent exclusion of potentially relevant works.

Linking evidence to action

- This review found a paucity of studies regarding tools to understand and measure clinician experiences of compassion and caring in the workplace, particularly in the United States.
- There is an urgent need for research regarding the impact of increasing experiences of compassion for clinicians.
- Organizations may improve clinician experiences by openly recognizing the emotional toll of healthcare work and creating cultures that reward caring behaviors between staff.
- By cultivating compassionate organizational cultures, leaders can create environments to optimize clinician experiences and satisfaction over decades-long careers.

CONCLUSION

This scoping review of the literature on the evidence for the impact of organizational compassion on clinicians in health care revealed few relevant publications, with only two studies exclusively based in the United States. Outside of the Schwartz Center for Compassionate Care, little work has been done to understand and evaluate the impact of compassion for clinicians in the United States. Organizations may improve clinician experiences by openly recognizing the emotional toll of healthcare work and creating cultures that reward caring behaviors between staff. Yet lack of time, support, staffing, and resources impede the delivery of interventions designed to improve clinician experiences of compassion. Given that the nature of health care is to care compassionately for the sick and dying, the salience of clinician suffering, the workforce crisis in American health care, and the potential positive impact of increasing experiences of compassion for clinicians demonstrated in this review, there is an urgent need for researchers and healthcare administrators to fill this gap.

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APPENDIX 1

TABLE A1 Examples of search strings used for pubmed search with numbers of results and duplicates.

Database	Search terms	Result *N*	*N* removed	Result running Total *N*
PubMed	((“Compassionate leadership”[Text word] OR “Organizational compassion”[Text word] AND (english[Filter])) OR ((“Organizational behavior”[Text Word] OR “Organizational culture”[Text Word] OR “Organizational design”[Text Word] OR “Organizational values”[Text Word] OR “Organizational strategy”[Text Word] OR “Workplace suffering”[Text Word] OR “healthcare culture”[Text Word]) AND (“compassion*”[Text Word] OR “empathy”[MeSH Terms] OR “empath*”[Text Word]) AND (english[Filter])) AND (english[Filter])) AND ((“healthcare”[Text Word] OR “health care”[Text Word] OR “hospital”[Text Word]) AND (english[Filter]) AND (english[Filter]))	252	0	252
PubMed	((“Compassionate leadership”[Text word] OR “Organizational compassion”[Text word] AND (english[Filter])) OR ((“Organizational behavior”[Text Word] OR “Organizational culture”[Text Word] OR “Organizational design”[Text Word] OR “Organizational values”[Text Word] OR “Organizational strategy”[Text Word] OR “Workplace suffering”[Text Word] OR “healthcare culture”[Text Word] OR Leadership[Majr]) AND (“compassion*”[Text Word] OR “empathy”[MeSH Terms] OR “empath*”[Text Word]) AND (english[Filter])) AND (english[Filter])) AND ((“healthcare”[Text Word] OR “health care”[Text Word] OR “hospital”[Text Word]) AND (english[Filter]) AND (english[Filter])) AND (english[Filter]) AND (english[Filter])	357	252	357