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Perceptions and implications of compassionate care in a specialized hospital institution in Medellín

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Abstract

Compassionate care has been implicated as a protective factor against burnout; it involves identifying the patient's needs and responding to them according to the resources available. To do this, it is necessary to consider the patient's perspective and identify his or her emotions, understand the context and establish a limit to the situation. The objective of this study was to evaluate and understand how compassionate treatment is understood by patients and health professionals, as well as the implications it has in a specialized hospital institution in Medellin. Therefore, a mixed approach with quantitative questionnaires and semi-structured interviews was used. The sample corresponds to health professionals and patients. Levels and perceptions of burnout, empathy and compassion were evaluated. The study found high levels of emotional exhaustion and depersonalization in 28.8% and 31.8%; low perspective taking in 30.3%,

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Article resulting from the research entitled: *Caracterización multidimensional de los adultos mayores de 60 años de la ciudad de San Juan de Pasto*, develop from February 1st 2023 to January 31st 2024, in Antioquia, Colombia.The article corresponds to the first phase of the project that runs until June 30, 2023

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and low empathic understanding in 39.4%. Personal and organizational resources are needed to provide compassionate care that is sustainable over time. Personalization of care, two-way communication, treatment follow-up, and identification of needs are highlighted as key aspects of compassionate care. Compassionate care is positively valued by patients and can be easily adapted in medical care; however, addressing emotional exhaustion and promoting cognitive empathy are needed to ensure quality of care and the well-being of health care professionals.

Keywords: empathy; compassion; burnout; quality of life; patient satisfaction

Percepciones e implicaciones del cuidado compasivo en una institución hospitalaria especializada de Medellín

Resumen

El cuidado compasivo ha sido asociado como un factor protector contra el burnout. Este cuidado implica identificar la necesidad del paciente y dar respuesta a este síndrome, de acuerdo con los recursos disponibles. Para ello, es necesario tener en cuenta la perspectiva del paciente e identificar sus emociones, la comprensión del contexto y el establecimiento de un límite frente a la situación. En este estudio, se planteó evaluar y comprender cómo es entendido el trato compasivo por pacientes y por profesionales de la salud, así como las implicaciones que tiene en una institución hospitalaria especializada en Medellín. Por lo tanto, se utilizó un enfoque mixto con cuestionarios cuantitativos y entrevistas semiestructuradas. La muestra corresponde a profesionales de la salud y pacientes. Se evaluaron niveles y percepciones de burnout, empatía y compasión. El estudio señaló niveles elevados de cansancio emocional y despersonalización en el 28,8 % y el 31,8 %; además de baja adopción de perspectivas en el 30,3 % y baja comprensión empática en el 39,4 %. Adicionalmente, se necesitan recursos personales y organizacionales para brindar un trato compasivo que sea sostenible en el tiempo. La personalización en la atención, la comunicación bidireccional, el seguimiento al tratamiento y la identificación de necesidades son resaltados como aspectos clave de la atención compasiva. El trato compasivo es valorado positivamente por los pacientes; además, se lo puede adaptar fácilmente en la atención médica; sin embargo, es necesario abordar el agotamiento emocional y promover la empatía cognitiva para asegurar la calidad de atención y el bienestar de los profesionales de la salud.

Palabras clave: empatía; compasión; burnout; calidad de vida; satisfacción del paciente

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Percepções e implicações do cuidado compassivo em uma instituição hospitalar especializada em Medellín

Resumo

O atendimento compassivo tem sido apontado como um fator de proteção contra o esgotamento; ele envolve a identificação das necessidades do paciente e a resposta a elas de acordo com os recursos disponíveis. Para isso, é necessário considerar a perspectiva do paciente e identificar suas emoções, entender o contexto e estabelecer um limite para a situação. O objetivo deste estudo foi avaliar e compreender como o tratamento compassivo é entendido pelos pacientes e profissionais de saúde, bem como as implicações que ele tem em uma instituição hospitalar especializada em Medellín. Portanto, foi utilizada uma abordagem mista com questionários quantitativos e entrevistas semiestruturadas. A amostra corresponde a profissionais de saúde e pacientes. Foram avaliados os níveis e as percepções de esgotamento, empatia e compaixão. O estudo constatou altos níveis de exaustão emocional e despersonalização em 28,8% e 31,8%, baixa tomada de perspectiva em 30,3% e baixa compreensão empática em 39,4%. São necessários recursos pessoais e organizacionais para oferecer um atendimento compassivo que seja sustentável ao longo do tempo. A personalização do atendimento, a comunicação bidirecional, o acompanhamento do tratamento e a identificação das necessidades são destacados como aspectos fundamentais do atendimento compassivo. O atendimento compassivo é valorizado positivamente pelos pacientes e pode ser facilmente adaptado ao atendimento médico; entretanto, é imprescindível abordar a exaustão emocional e promover a empatia cognitiva para garantir a qualidade do atendimento e o bem-estar dos profissionais de saúde.

Palavras-chave: empatia; compaixão; esgotamento; qualidade de vida; satisfação do paciente

Introduction

Healthcare professionals who are responsible for the well-being of their patients are constantly exposed to situations of high emotional involvement and are victims of high work pressure (Conversano et al., 2020). Moreover, the interaction with patients, in addition to the other duties of the position, is faced with situations that require not only time, but also technical and practical skills, emotional regulation, and assertive communication (Wacker and Dziobek, 2018; Kamal et al., 2020).

«Although job strain exists in different occupations, its chronicity [...] has been shown to be more prevalent in occupations with low levels of personal control, poor support networks, and high expectations» (Kroll et al., 2016, p. 690). In the case of health professionals, the lack of tools to cope with the demands of the environment increases the risk of emotional exhaustion, distancing from the people they work with, and feelings of incompetence, that is, burnout (Maslach and Jackson, 1981).

Burnout is a prolonged response to the emotional and interpersonal stressors of work life; it consists of three dimensions: exhaustion (feelings of emotional exhaustion), depersonalization (distancing from the people with whom one works), and reduced self-actualization (feelings of incompetence) (Kroll et al., 2016). In the study of burnout,

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a multidirectional relationship has been found with empathy and compassion in the interaction with the patient (Yuguero et al., 2018). In this regard, three hypotheses have been proposed to explain this relationship: first, burnout reduces the ability to be empathetic; second, being empathetic leads to the development of burnout, which has been called compassion fatigue; and third, empathy may protect against burnout by increasing job satisfaction (Reynolds et al., 2021).

Empathy is defined as the cognitive and affective recognition of one person's mood and current situation by another (López-Pérez et al., 2008); in practical terms, it bridges the gap between one's own experiences and those of others (Reynolds et al., 2021). It is conceptualized in terms of its affective dimensions (referring to the ability to feel what the other feels and the degree of personal affect generated by the adverse situations of others) and cognitive dimensions (the ability to understand emotions and have a perspective) dimensions (Hernández-Ayala, 2020; Dulay et al., 2018).

Burnout has been shown to affect between 10% and 70% of health professionals (Arian et al., 2023; Fucuta-de-Moraes and Ruths, 2023; Ge et al., 2023; Rotenstein et al., 2018). In the Colombian context, a study of physicians, residents, and medical students found a prevalence of emotional exhaustion of 41.9%, depersonalization of 21%, and low personal accomplishment of 19.5%. In addition, only 21.2% of the respondents had optimal levels of perspective taking and 38% of empathic understanding, dimensions of cognitive empathy (Suárez et al., 2022).

On the other hand, compassion is a virtue in the doctor-patient relationship that begins with the recognition of the patient's suffering and is accompanied by an internal and emotional response to it; it then implies an expression that denotes awareness of the patient's suffering, materialized in words and actions that seek to benefit the other. Unlike empathy, compassion seeks to motivate the individual to 'feel with the other' and reduce their suffering (Cameron et al., 2015; Dávalos et al., 2020; López et al., 2018). Regarding this relationship, the study by Suárez et al. (2022), conducted in Colombia, pointed out that burnout is negatively associated with the perception of balance between social, work, and personal life, compassion towards others and the age of the individual; in contrast, compassion and self-compassion favor personal fulfillment and feelings of competence. Concerning empathy, the same study found a negative relationship between burnout and emotional understanding, a cognitive component of empathy.

In addition, a qualitative study conducted with residents between the ages of 20 and 35 revealed that high levels of empathy and compassion may increase burnout due to compassion fatigue or even perceived high workload when the emotional demands of the environment exceed their coping capacity (Picard et al., 2016). «Similarly, other studies have demonstrated that the process of imagining oneself in the other's situation produces higher levels of negative affect than imagining the emotional impact of the situation from the patient's perspective» (Suárez et al., 2022, p. 69). In other words, theoretically, high levels of empathy or compassion in the absence of coping strategies or tools can lead to burnout, which in turn would imply emotional exhaustion, depersonalization, lower quality of care, and consequently a decrease in therapeutic effectiveness, which could lead to lower levels of personal fulfillment.

Despite these approaches, there is no consensus on the causal relationship between levels of involvement in patients' problems, as measured by empathy and compassion, and their association with burnout, either as a consequence or an antecedent. However, given the demands of the environment, healthcare can be a significant stressor for professionals (Altmann and Roth, 2021; Pavlova et al., 2022).

Being compassionate in the patient care, that is to say, practicing compassionate care, means recognizing and responding to needs within the limits of available resources. To ensure that identification and action do not become an additional burden on the practitioner, it is necessary to take the patient's perspective, understand his/her context, identify his/her emotions, and set boundaries for the situation.

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Compassionate care has been associated with greater satisfaction with care, better adherence to treatment, better self-care after discharge, more successful recovery, less pain for patients, and even better quality of life (Cameron et al., 2015; Dávalos et al., 2020; Malenfant et al., 2022). It has also been observed to result in benefits for professionals, such as time and cost savings, a sense of satisfaction and efficiency, and personal fulfillment (Dalvandi et al., 2019).

For these reasons, compassionate health care becomes a necessity and a critical component that contributes to improving the quality of life of both users and providers, while promoting the sustainability of the health care system in general.

The importance of compassion has led some healthcare organizations to focus on compassionate care as part of their humanization strategies. This involves adopting an empathic stance, focusing on the patient's needs, and providing treatment that is consistent with those needs. However, humanized treatment could be a consequence of high levels of affective empathy in the absence of cognitive empathy. Given these implications for professionals, it is important to understand how compassionate care is perceived by patients and health care professionals, as well as the implications of providing it. For this humanized approach to be sustainable over time, both the quality of care and the well-being of professionals must be ensured.

Consequently, the objective of this study was to assess the levels of burnout, empathy, and compassion among health professionals and to understand the relationship between these factors in a high complexity hospital institution in the city of Medellin.

Methodology

Design

Mixed methods with multiple data collection strategies to obtain robust and integrated information, exploring the perspectives of different health system stakeholders.

Context

The hospital is a fourth-level center specializing in cardiovascular, thoracic, pulmonary, and neurovascular services. It has approximately 800 employees, including 150 physicians. The majority of patients and their families come from low socioeconomic backgrounds with lower levels of education, corresponding to the adult or elderly population. The institution has a culture of humanized care, in which patient care and compassion during hospitalization are paramount, as well as its high-quality standards.

Participants

The target population was the employees of a hospital institution and their patients, including their relatives, who were in the inpatient service at the time of the study. A convenience sample was used with those employees and patients who agreed to participate in the study.

Materials

Quantitative and qualitative information was collected on behaviors and beliefs about compassion in health care and its possible relationship to burnout, as well as perceptions of treatment received in the institution. To this end, a protocol consisting of several questionnaires was administered to the administrative and nursing staff of the institution, and semi-structured interviews were conducted with both patients and professionals.

Questionnaires

- **Maslach Burnout Inventory -MBI-**. This instrument consists of 22 items with responses on a seven-point Likert scale, where 0 is 'Never' and 6 is 'Daily', regarding the frequency with which certain work-related feelings are experienced (Maslach and Jackson, 1981). The questionnaire has three dimensions: Emotional Exhaustion (EA) with nine items, reflecting the feeling of being emotionally exhausted by work and less able to give to others; Depersonalization (DP) with five items, describing an impersonal and cold response to patients;

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Personal Accomplishment (PR) with eight items, expressing feelings of competence and success. Unlike the previous two components, low scores on this last dimension indicate burnout.

The scale has adequate internal consistency (Cronbach's alpha = 0.76), and when comparing the factor structure of the adapted scale with the original version, it was found that the three dimensions are consistent.

- **Cognitive and Affective Empathy Test -CAET-.** Questionnaire for the assessment of empathy, consisting of 33 items to be answered on a Likert-type scale from 1 (Strongly disagree) to 5 (Strongly agree). It has a four-factor structure: Perspective taking, which refers to the intellectual or imaginative ability to put oneself in another person's place; Emotional understanding, as the ability to recognize and understand other people's emotional states, intentions, and impressions; Empathic Distress, as the ability to share another person's negative emotions; and Empathic Joy, as the ability to share another person's positive emotions (López-Pérez et al., 2008). The scale has adequate internal consistency (Cronbach's alpha = 0.89). The factor structure of the scale presents two factors, each with two dimensions: cognitive empathy, which includes the scales perspective taking (PA) and emotional understanding (EQ); and affective empathy, which includes empathic stress (ES) and empathic joy (EA).
- **Santa Clara Compassion Scale -SCCS-**. This compassion scale is a short instrument originally developed in English (Hwang et al., 2008), whose validation in Spanish was carried out by Caycho-Rodríguez et al. (2020), with high reliability (Cronbach's alpha = 0.9). The scale consists of five Likert-type questions, where 1 indicates 'Strongly disagree' and 7, 'Strongly agree'. The scale is directly scored: the higher the score, the higher the level of compassion, with a minimum score of 7 and a maximum score of 35.
- **SF12 Health Questionnaire**: uses 12 items to assess the level of well-being, quality of life, and functioning related to perceived health in people aged 14 and over. It has eight dimensions and two components: physical and mental. It is written to answer how you have felt over the past four weeks. Responses are recorded on a five-point Likert scale ranging from always (1) to never (5) (Ware et al., 1996). In the Colombian context, previous research has concluded that it is a valid and reliable instrument (Cronbach's α = > 0.7) for all subscales (Ramírez-Vélez et al., 2010).

Semi-structured interviews

These are instruments that use a guide of questions or categories, where the interviewer has the power to introduce additional questions to specify elements and obtain more information. This type of interview provides flexibility and depth when a phenomenon is difficult to observe (Hernández et al., 2014).

Semi-structured interviews were conducted with two different groups; in the first, health professionals of the institution were interrogated to collect information about the work environment, what indicators of performance each participant perceives, what are the main stressors and resources they encounter in their daily life, how is the relationship with patients, what happens in adverse events with them and, in addition, how their health and work are affected and influenced by elements external to the work environment such as family, personal, and social life. In the second group, patients were interviewed.

These interviews were designed to gather information about the patient's experience in each of the phases of hospitalization and care described by the patient. We also inquired about the patient's general information, adherence to treatment, relationship with health care personnel, and overall experience in the hospital.

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Procedure

Participants were invited by direct invitation to participate in the hospitalization services during the months of March to June 2023. In addition, an infographic was distributed in the WhatsApp groups of the primary groups and through institutional mail, including a QR code for those who wished to participate. Regarding patient recruitment, those who did not want to be disturbed were asked at the nursing stations, and those who did not have this restriction were invited to participate by completing a short interview. The collected data were then analyzed. The research was approved by the research ethics committee of the hospital.

Data Analysis

The questionnaire data were downloaded from Microsoft Forms in an Excel file for export and subsequent analysis in SPSS version 29. Descriptive statistics were obtained, generating frequency tables that allowed us to observe the frequencies and prevalence of each dimension.

Regarding the qualitative analyses, in the interviews each participant was identified according to his or her role, age, and gender. The analyses were based on the descriptive categories of each dimension of compassionate care and its barriers, namely: Information external to the work environment; Work environment; Dealing with the patient and compassion; Indicators of performance; Stressors; Resources, and Adverse events during patient care, which, according to what was found in each group, derived analytical categories.

Content Relational Analysis with Cognitive Mapping was also used to evaluate the qualitative information. This included: (1) Type of analysis: selection of the type of relational content analysis; (2) Level of analysis, selection of sentences as the main element of analysis; (3) Coding, generation of initial codes, and adaptation of new codes as needed according to the content; (4) Construction of networks, identification of relationships, and association between codes based on their coexistence in the quotations; (5) Synthesis of the information from the networks, writing the synthesis of the network analysis. This process was carried out in Atlas.ti version 8. Finally, the data were integrated and the concordance between the results of the questionnaire and the results of the semi-structured interviews of each group were evaluated.

Results

Characterization of the sample

The participants in this study were physicians, representing 22.7%, and nursing assistants, representing 28.8%. A total of 80.3% were in a care role; 81.8% of those evaluated were female. The mean age was 38.2 years and the mean years of experience was 13.25 years. Table 1 shows the sociodemographic characteristics.

Table 1

Sociodemographic characteristics of the questionnaire

Characterization		M (D.E)	N (%)
Gender	Male	-	12 (18,2)
	Female	-	54 (81,8)

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Characterization		M (D.E)	N (%)
Occupation	Research	-	4 (6,1)
	Administrative	-	4 (6,1)
	Physician	-	15 (22,7)
	Nurse	-	17 (25,8)
	Auxiliary nurse	-	19 (28,8)
	Others	-	7 (10,6)
Type of participant	Assistance	-	53 (80,3)
	Non-assistance	-	13 (19,7)
Age		38.02 (10.16)	-
Experience		13.25 (8.67)	-

Note. M: mean; S.D.: standard deviation; N: absolute frequency.

The interviews were conducted with ten professionals and nine patients of the institution. The description of the socio-demographic characteristics of the participants can be found in Table 2.

Table 2

Sociodemographic characteristics of the interviewed participants

Code	Participant	Position	Age	Gender
1	Health professional	Auxiliary nurse	-	Female
2	Health professional	Admissions	-	Female
3	Health professional	Psychologist	-	Female
4	Health professional	Subspecialist	-	Male
5	Health professional	Security guard	-	Male
6	Health professional	Head nurse	-	Female
7	Health professional	Administrative physician	-	Female
8	Health professional	Subspecialist	-	Male
9	Health professional	Specialist	-	Female
10	Health professional	User service	-	Female
11	Patient	-	79	Female
12	Patient	-	37	Male
13	Patient	-	33	Male

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Code	Participant	Position	Age	Gender
14	Patient	-	43	Male
15	Patient	-	42	Female
16	Patient	-	60	Male
17	Patient	-	74	Male
18	Patient	-	39	Female
19	Patient	-	63	Female

Quantitative outcomes: Levels of burnout, empathy, and compassion

Regarding burnout, 28.8% of the participants had clinically significant levels of emotional exhaustion, 31.8% had high levels of depersonalization, and 15.2% had low levels of personal accomplishment. Regarding empathy, most of the professionals were within the optimal profile in the affective empathy dimensions (ES and EJ dimensions); however, 30% of the staff presented low levels of cognitive empathy (PA and EC dimensions). Finally, the mean level of empathy was high (29.47), considering that the maximum possible score on the scale is 35 (see Table 3).

Table 3

Burnout, empathy, and compassion factors

		Low N (%)	Medium/ Optimum N (%)	High N (%)	M (S.D.)	Total N (%)	Lost N (%)
MBI-burnout	Emotional fatigue	41 (62,1)	12 (18,2)	7 (10,6)		60 (91)	6 (9,1)
	Depersonalization	39 (59,1)	14 (21,2)	7 (10,6)		60 (91)	6 (9,1)
	Personal fulfilment	10 (15,2)	11 (16,7)	39 (59,1)		60 (91)	6 (9,1)
CAET-empathy	Perspective adoption	20 (30,3)	25 (37,9)	21 (31,8)		66 (100)	
	Emotional comprehension	26 (39,4)	9 (13,6)	31 (47)		66 (100)	
	Empathic stress	1 (1,5)	52 (78,8)	13 (19,7)		66 (100)	
	Empathic joy	2 (3)	33 (50)	31 (47)		66 (100)	
SCCS-compassion	Total score				29.5 (6.5)		

Note. M: mean; S.D.: standard deviation; N: absolute frequency.

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Qualitative findings: facilitators of compassionate care

During the development of the qualitative analysis interviews, some of the most relevant codes were identified and are presented below.

Resources for compassionate care

For professionals, providing compassionate care means spending more time with the patient and their family, which requires a greater investment of resources:

> I leave late for two reasons. Either because I have a lot of remote work and I leave the system last, or because I think my patients need a lot of nursing support and I sit down to talk to them one day. And obviously I think I have to waste time, I am not wasting time, I am spending time with someone who does not have a family member next to them [...]. So, it is something that I consider to be timely care and it is like global (Participant 6, personal communication).

[For quality care, we need to] have time to listen to the patient, to listen to all their complaints, both physical and emotional, and also to talk to the family and the caregiver, because a lot of times we forget the caregiver. (Participant 9, personal communication).

> It is emphasized that quality care, compassionate care, and satisfaction with care are made possible by sufficient environmental resources (equipment, time, colleagues, teamwork, support from the work environment) and personal resources (information, cognitive development, emotional regulation, and interpersonal communication skills).

[For quality care, you need...] I think that having enough time to talk to the patient, enough time to examine the patient, that there are adequate clinical tools, also to complement the clinical assessment, and that you also have ... the possibility of long-term follow-up of the patient, ... teamwork and, with the integration of that, with what the patient has outside, it will depend a lot on the Health Provider Institute. (Participant 4, personal communication)

The lack of resources was highlighted as an obstacle to compassionate treatment, with participants highlighting the following aspects: time, personal and emotional skills. In addition, the lack of balance between personal and professional life leads to exhaustion and has a direct impact on the conditions of the professional. Similarly, the perception of a lack of support from colleagues or the organization and an unbalanced workload were cited as common barriers to compassionate care.

Understanding the patient (environment, reactions, and needs) enables more compassionate care.

> On the one hand, understanding the patient from a biopsychosocial approach (understanding the environment and determinants of health) facilitates a better comprehension and consequently a more needs-based treatment, i.e. compassionate treatment. This is facilitated by aspects related to cognitive empathy, which involves taking the patient's perspective, understanding his or her emotional reactions and environment, without becoming emotionally involved in the situation.

For us, from an internal medicine perspective, if I do not consider the whole context and what the patient is experiencing and how the disease is making them feel, it is very likely that they will not adhere to the treatment. (Participant 9, personal communication).

On the other hand, if the professional has experienced a situation similar to that of the patient, it is easier for him/her to adopt the patient's perspective and provide compassionate treatment.

Self-care as part of patient care

> Currently, there is a prevailing attitude of over-commitment and involvement on the part of some professionals, which increases physical and emotional fatigue, limits the ability to respond to patients and their families, and depletes professional resources. In contrast, self-care behaviors such as maintaining hobbies, seeking

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social support, establishing rest periods, maintaining work-life balance, and setting boundaries facilitate compassionate care.

Heal first. If this person is not well, if one is not well, it is very difficult to help the other. Then, even within the institution, promote healthy habits, exercise, meditation, time outside of work spaces, for example, in the mobile clinical records (MCR) there are lectures, topics like health or wellness or meditation. That can make you a little better person, and when you are a better person, you can give more. (Participant 7, personal communication)

Managing demanding situations and emotions

On the one hand, the perception that a patient is demanding increases stress, creates more exhaustion, and causes tension. Taking the demands or questions of patients and their families personally, as well as their emotional reactions, contributes to this burden and emotional exhaustion. On the other hand, feeling in control, or knowing that you have the resources to handle situations and respond to patients' needs, reduces the burden.

[Compassionate treatment has an effect on the patient] because sometimes, especially in the emergency room, people come in and they want everything to be done right away; or they say 'my dad is in bad shape, I want you to take care of him quickly'. So, if you start like that, they come armed, let's say, and you say no, 'let's go back to the emergency room, look, we'll help him, you have to calm down'. So, if you start like that, the person is disarmed, the person understands that you want to help them, so I think that's important. (Participant 1, personal communication)

Service role

The service role is emphasized as a characteristic of the professional who provides compassionate treatment, since the perception of the patient's demands as valid and as part of the professional's work reduces the perception of burden and exhaustion, while facilitating the management of service users and allowing the adoption of a collaborative and decisive position towards patients and their families. In this way, listening, receptiveness, sensitivity, and a service attitude become characteristics of a health professional who provides quality care and compassionate treatment.

The other thing is the service attitude. The nurse must have a service attitude. I cannot give a service unwillingly. This is okay. I can't be angry when they say, 'Bring me a glass of water, bring me a napkin, clean me up here, please', because that's my service, I'm there to serve. (Participant 6, personal communication)

Recognition

Perceived recognition from patients, colleagues, and the organization contributes to a lower perceived workload. This recognition is perceived at a lower level by nurses.

And nursing is one of the best professions because it fills you up [...]. But we also think that it is one of the worst professions in terms of recognition, right? The patient is happy, relieved, the family is happy, they go home and they only thank the medical staff that took care of them, but not you for the day that you were there 24/7, all the time with them. (Participant 6, personal communication)

Two-way communication

Similarly, two-way communication and the perception of being treated as an equal are part of what facilitates the patient's comfort with the hospital environment, the identification of other needs, and the timely resolution of problems related to the hospital environment. In addition, cooperation and willingness to help with post-hospital administrative procedures 'motivates', facilitates adherence to treatment, and provides a sense of security. The patients surveyed understood the procedures performed, why they were performed, and the post-discharge care required.

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We had planned this surgery. Because of the risks and because she could not stand the pain in her leg, not even to touch it, so they talked to her to find out if she was willing to have the surgery; now she told us the risks and left the sheet for us to think about. I told her: 'You are conscious, in your five senses, and you are the one in pain, you are the one who has to decide'. They explained everything to us, because as doctors we have to explain to the patient and the family what is going to be done, how it is going to be done; she drew us a picture. They explained a lot to us, but they did not expect what happened, that her heart would not respond; they had to put her on the ECMO machine; she almost died, but they got her out of there and here we are. (Participant 15, personal communication).

Perceived impact of compassionate care

Satisfaction with care. Patients emphasize their appreciation of the kindness and warmth, the emotional support provided, the willingness to meet their needs, the speed of care, the clarity of communication, emphasizing the time of diagnosis, the procedure, and the individualized treatment, which refers to being treated by name and considered as a human being in its entirety.

> The attention here is very good, everyone is very friendly. One of the things I liked is that I am always treated by name and I think that is very important. They have very good attention and the facilities are very nice (Participant 13, personal communication).

Compliance with treatment. All of the patients interviewed were able to describe the diagnosis or procedures superficially, which indicates adequate understanding and effective communication with the professional. However, not all of them were aware of the recommendations or changes in their habits. The knowledge and clarity that facilitate adherence to treatment are the result of bidirectional communication between patient and professional.

> Yes, everything was very clear, very clear. I understood very clearly everything about the system, from the beginning to where I have to go with the transplant. And that is one of the reasons why I am here, because if I had not understood what they had told me, I would be calm on the street, relaxed, without worrying about the drug. But then, as they explained it well, I am here for the reason that I need the drug, because it is one hundred percent, for the rest of my life, but it is for my well-being. (Participant 14, personal communication)

Comprehensive analysis of quantitative and qualitative findings

The results show evidence of emotional exhaustion and work overload on the part of health professionals, while at the same time they develop compassionate behaviors. Even in cases of burnout, professionals maintain a compassionate treatment with the patient, probably due to the organizational culture that prioritizes humanized treatment. However, physical and mental health problems are beginning to emerge in this population. Among others, high levels of exhaustion have been reported, accompanied by low levels of cognitive empathy, which prevents the establishment of limits in the face of what is happening to the patient and his family, and increases emotional exhaustion.

In this sense, patients report high levels of compassionate care and satisfaction with care. Professionals, on the other hand, show high levels of compassion, even when they are exhausted, and underline the organizational emphasis on humanized care; compassion stands out even when it implies going to the detriment of the professional, that is, when a limit is not established in the face of adverse events during care.

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Discussion

The objective of this study was to evaluate and understand how compassionate care is understood by patients and health professionals, and the implications of providing it in a specialized hospital setting in Medellin. This is due to the medical premise that adopts compassion as an ethical principle during care, through which benefits such as improved clinical outcomes and increased patient satisfaction have been reported (Strauss et al., 2016).

In this regard, high levels of burnout were found, accompanied by low levels of cognitive empathy and, despite this, high levels of compassion. In particular, high levels of emotional exhaustion and work overload were identified; humanizing treatment in these professionals is a consequence of high affective empathy in the absence of cognitive empathy, which generates a risk factor for themselves and for the sustainability of the culture of humanization.

Although emotional exhaustion can occur in any environment, there are highly demanding units whose characteristics can be considered higher risk, as is the case of the evaluated institution, where professionals are exposed both to high complexity and to the care of patients with disabling and life-threatening diseases, situations that increase the pressure on health personnel (Arimon-Pagès et al., 2023). However, the finding of high levels of compassion in the absence of resources contradicts the findings of Davison and Williams (2009), who suggest that working in conditions of staff shortages, time constraints, and workloads that exceed the professional's capacity affects compassionate care.

Accordingly, the attitude of prioritizing patient care over the well-being of the professional, which includes investing more resources to investigate the patient's pathology and possible treatments, as well as time spent explaining and interacting with users, became apparent. However, it is clear to the interviewees that the demands of interaction between health professionals and patients are wearing them down. Although there is still no consensus on the relationship between levels of empathy, compassion, and burnout, the greater the perceived demands of the environment and the lower the perceived resources, the greater the burnout (Egan et al., 2019). This phenomenon has been referred to as the 'cost of caregiving', which occurs in the absence of the mechanisms necessary to identify and manage emotions related to the environment (Arimon-Pagès et al., 2023).

Another barrier to compassion and perspective taking found in this and other studies was the description of patients or families as demanding, difficult, or aggressive (Pehlivan and Güner, 2020). This situation may also be a risk factor for the development of burnout. In addition, and in line with what has been found, a study by Lamothe et al. (2014) reported that burnout was lower in physicians with high levels of perspective taking when empathic concern was also low; that is, empathic concern was only negative for physicians when it was present in the absence of perspective taking, as it impedes emotional regulation.

On the other hand, all the patients interviewed emphasized their satisfaction with the treatment and care they received during their stay in the institution. The behaviors mentioned by the professionals as part of their daily actions and those highlighted by the patients, such as not underestimating the patient's level of pain, perceiving the patient as a human being, and being aware of the level of affectation in the other spheres of his/her life, are part of what has been conceptualized within compassionate treatment (Pehlivan and Güner, 2020). In this regard, Dewar et al. (2011) found that constant communication with the patient and family and involving them in decisions about their health is important for the outcomes of care and the overall experience.

This component of compassionate care has been emphasized as fundamental for patients to be active participants in health care. Similarly, the empathic attitude of the professional has been identified as an aspect that facilitates trust and openness from the patient, improving communication (Reynolds et al., 2021) and contributing to a better understanding of the patient, accompanied by the search for solutions (Yue et al., 2022).

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Therefore, it is appropriate to train health professionals with the aim of increasing the level of cognitive empathy, both with the purpose of preventing emotional fatigue and burnout, and to increase the adoption of perspectives and emotional understanding of the patient, promoting an action in accordance with the need, the professional's capacity and his/her environment. Furthermore, considering that differences in burnout levels have been reported according to the position held and even the level of training (Almadani et al., 2023; Ferreira et al., 2020; Kartsonaki et al., 2023), it is appropriate to continue research on how to intervene differently and according to the needs of each position within the hospital institution.

It has previously been reported that the high risk of burnout, together with the desire of professionals to receive training, supports the need to implement training plans and institutional policies for prevention and support (Arimon-Pagès et al., 2023), as this makes it possible to maintain optimal levels of compassion, reaping the benefits and reducing the risks associated with care. Providing compassionate care has been shown to have multiple benefits for patients, such as increased satisfaction with medical care, reduced anxiety, increased pain tolerance, and improved stress response (Baguley et al., 2020; Sinclair et al., 2020; Sinclair et al., 2021; Smith et al., 2017), but it can also lead to lower levels of burnout if it succeeds in promoting not only compassion for others, but also self-compassion (Román-Calderón et al., 2022).

Similarly, emphasizing the organization's recognition and support for its professionals, maximizing their emotional and cognitive resources, and providing resources and processes to reduce perceptions of strain can optimize the resources needed to meet the demands of compassionate care that are present and necessary in the clinical setting. Increased support, both from the organization and from other health professionals, is fundamental to reducing burnout and increasing health worker satisfaction (Moscu et al., 2023; Pontes et al., 2023).

Given that participation in the study was voluntary, it is possible that those who responded to the questionnaires and survey were professionals with lower levels of burnout or higher levels of compassion, which may bias the results. In addition, this is a study with a relatively small sample size, which may increase the effect of bias. Finally, the working population has low hourly availability and high turnover, either in terms of schedules (health professionals) or length of stay in the institution (patients and family members).

Conclusions

In general terms, patients recognize and appreciate the compassionate treatment they receive from health professionals and cite it as a facilitator of adaptation to hospitalization. In addition, bidirectional communication facilitates understanding of the diagnosis and adherence to treatment and is part of the compassionate care described by study participants.

On the other hand, health professionals provide compassionate treatment that is the result of high levels of affective empathy in the absence of optimal levels of cognitive empathy, which increases the risk of professional and, in particular, emotional burnout, demonstrating a risk both to themselves and to the sustainability of the health care system in general.

Conflict of interest

The study was developed within the framework of a program of the Colombian Ministry of Science called 'Young Researchers 2022', in which the agreement between the University EAFIT and the CardioVID Clinic is established.

Ethical responsibilities

Prior to its initiation, the study was approved by the Ethics Committees of the Universidad EAFIT and the CardioVID Clinic, in accordance with Law No. 200 of October 6, 2022.

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Contribución

All authors participated in the preparation of the manuscript, read and approved it.