Exploring the Phenomenon and Perspectives of Empathy and Compassion in the Caring Professions: Part I

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Authors Note

The authors originally approached the development of empathy within the context of a previous article on design thinking in the *Journal of Health and Human Experience*. The authors are solely responsible for the contents of this article. The contents do not necessarily reflect the position of the organizations and communities that they serve. The authors have no financial conflicts of interest.

Abstract

Empathy, one of the emerging approaches for the development of new and innovative initiatives, creates challenges for the education and training of caring professionals. This article addresses the complexity of the issues related to empathy and compassion, not only for the individual caring professional, but for those teaching and training those in the broader caring professions. By providing a deep-dive into broader definitions than the simple past statement, "I feel your pain," this article delves into the deep complexity of both empathy and compassion with the knowledge of their impact on individuals, families and communities in today's society. After defining the terms empathy and compassion to ensure that the complexity of these two terms are understood, this article addresses the challenges and questions emerging in the context of a complicated and changing healthcare environment. Historical, philosophical, bioethical, neuroscience and social science perspectives are critical to understanding the complexity of empathy and compassion for all entering and/or practicing in the caring professions. Challenges and questions emerging in the context of a complicated and changing healthcare environment with an increased focus on patient/person satisfaction and engagement are also addressed. This article provides a background for a thorough discussion of the approaches to education

and training of individuals who are entering the "caring professions" and for those providers/practitioners already struggling with these two phenomena in the arena called healthcare. This thorough discussion will be explored, investigated and presented in a second follow-on article to be published in future edition of the *Journal*.

Keywords: empathy, compassion, neuroscience of empathy, social empathy, caring, empathy impact, stress and burnout, compassion fatigue, neuroscience and mirror neurons, nursing ethics, bioethics, clinical ethics, virtue ethics, design thinking, education/training of caring professionals, self-compassion and self-care.

Introduction

When exploring the phenomenon of empathy as a follow-up for the first step of Design Thinking (published in a prior issue of the *Journal of Health and Human Experience* by Ramsey and Hinton Walker, 2018), the authors uncovered very diverse perspectives in the literature. Further exploration of both empathy and compassion highlighted the value of these phenomena, but also uncovered a number of challenges for individuals in the caring professions. In addition to the value highlighted in the literature related to patient satisfaction and improved outcomes, there is significant concern regarding burnout, moral distress and a potential cause for some caring professionals to leave their professions. Some authors relate the growing shortage of some health and caring professionals to these challenges that arise from burnout, compassion fatigue and moral distress.

The purpose of this first of two articles is to explore the wide-ranging literature related to both empathy and compassion. Since many individuals use the two terms interchangeably it is important that these definitions be clarified. Consequently, by differentiating between the two and taking a deep-dive into the issues related to the conceptualization of these terms, this article attempts to identify the relationship of the value of empathy and compassion in many interprofessional roles in the caring professions. The emerging literature related to empathy increasingly is highlighting questions related to neuroscience processes and impact. More scientists are exploring how empathy impacts the brain and the relationship of this to stress and burnout. Included herein are historical, philosophical and bio-ethical perspectives, along with knowledge and discussions related to neuroscience and social science. Empathy within the individual and the role of mirror neurons will be explored along with increased references within the literature related to "social empathy." To clarify, none of the content in this first article is provided for making any case against empathy and compassion, but to highlight the challenges and how these important topics need to be approached moving forward within the caring professions.

The follow-on article will build on the historical knowledge with attention to neuroscience and social science of this current article so as to identify some strategies for improving empathy and compassion in the context of patient/person care, engagement, improved satisfaction and outcomes. With increasing focus in the literature on burnout, moral distress and compassion fatigue, this article provides strategies designed to improve satisfaction for provider(s) with suggestions for improving one's own health, wellness and well-being. This will include attention to the role of compassion in the 'caring professions' along with specific strategies for developing and practicing self-compassion so as to maintain a positive self-identity in professional roles involving empathy, compassion and caring. Of particular notation, in the follow-on article,

challenges will be presented for the individual in the caring professions, as well as emerging strategies related to the education and training of members of the caring professions regarding empathy and compassion.

Within the context of the 50 Year Perspective of Nursing Theory Celebration at Case Western Reserve University, this article will connect selected historical contributions to this subject as a way of emphasizing the connection of empathy and compassion specific to nursing as one of the caring professions. Specific contributions by Betty Neuman, Sister Callista Roy and Jean Watson will be highlighted beyond but consistent with historical contributions related to nursing as a caring profession (Hinton Walker and Neuman, 1996).

Broad approaches to nursing practice--along with many others of those in the caring professions--is shifting to community-based care. Consequently, the multifaceted approaches to care of individuals and communities is consistent with the emerging literature from both Goleman (1997) and Segal (2011) clarifying the different approaches to empathy and compassion from that given to an individual (affective and cognitive) to that given to a community (social). Of particular importance, this article also explores engaging implications that take the individual beyond one-on-one patient care and the historical primary focus on medical care so as to consider broader community-based care, and the linking of social empathy and/or compassion. This is of particular importance for understanding the intense relationship of healthcare with social justice and sensitivity to issues related to diversity and the need for inclusion.

Historical, Philosophical and Bioethical Perspectives

Introduction to Bioethics and Philosophical Perspectives

A considerable debate has occurred in the bioethics and philosophy literature that grappled with the question "Can You Teach Compassion?" and "Can Empathy Be Taught?" (Garden, 2007). These questions often lead to spirited discussions and at times are not asked in the context of an academic question to seek consistency or clarity, but rather one that caring professionals value deeply and take to heart as they engage in patient care and carry out their day to day work in contemporary healthcare settings. Written from the educator perspective, this article does not engage in this discussion. Rather, a historical and bioethical perspective is provided to help ground the importance and the value of these two virtues and to suggest possibilities for how best to strengthen in the larger question of impact on the caring professions. The latter will be discussed in the Part II article to follow.

Historical and Philosophical Perspectives

During the 18th century, the texts of David Hume and Adam Smith were frequently cited. Their writings included the word "sympathy" but not "empathy" (Agosta, 2011). Moving into the 21st century, during the Anglo-American Tradition, it was Hume and Smith's work that was further explored by Michael Slote and later by Stephen Darwall. However, it was John Rawls and Thomas Nagel who took this body of work and began to explore the interrelation of empathy, sympathy, and altruism. Additionally, during the Continental Tradition (the second tradition), it was there that spirituality was introduced by Johann Herder to the phenomenological movement of Edmund Husserl, Martin Heidegger, Max Scheler and Edith Stein (Agosta, 2011).

Philosophers and thinkers have distinguished the terms "sympathy" and "empathy." Sympathy is frequently used to mean one person's response to the negative effects (suffering) of another individual, thereby leading to pro-social (helping) behaviors toward another (Agosta, 2011). On the other hand, empathy typically means one person responding to positive effects and negative effects without requiring that anything be done (no pro-social behavior required) (Agosta, 2011). Agosta goes on to say that sympathy is understood to include agreement or approbation whereby empathy is often a "relatively neutral form of data gathering about the experiences and effects of others" (Agosta, 2011). Sympathy means a "...specific affective response such as compassion or pity whereby empathy once again encompasses effects in general, including negative ones such as anger, fear, or resentment" (Agosta, 2011).

> The words empathy and sympathy both point to the ancient Greek roots "pathos" in the etymological context of modern English (Partridge 1966/1977). Pathos in turn means to suffer in the sense of to endure, to undergo, or to be at the effect of. A single mention in Aristotle in the original Greek of empathes occurs in Aristotle's On Dreams in which the coward experiences intense fear upon imagining that he sees his enemy approaching. In the original Greek, the references to empathes are few and marginal, generally meaning "in a state of intense emotion," "passionate emotion," or "much affected by" (Agosta, 2011).
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> In contrast, the number of references to sympathy is hundreds of entries long and is diverse, extending from Aeschylus, Aristophanes, Aristotle, Demosthenes, and frequently breaking through to the English in Shakespeare. The meanings include the constellation of ones that we would recognize including "agreement," "pity," "compassion," "transmission of affect," and "suggestibility" (Agosta, 2011).

As we consider the English language, it was Cornell University psychologist Edward Bradford Titchner's neologism in translating the German word "Einfuhlung" that introduced the word empathy in his lectures based on his work in the laboratory of Wilhelm Wundt (E. B. Titchener,1909) (Agosta, 2011). In German, a phrase such as "feeling one's way into," is used, and the thinking is that there would be an advantage by having a single word. It was described that the use of the word was a technical error when one of the foremost researchers on empathy uses the word empathy as a substitute for sympathy (Agosta, 2011). It was David Hume, Adam Smith and others that valued research on empathy, compassion and the morality of caring (Agosta, 2011). This was the British version of utilitarianism and the word "empathy" did not exist in the English language when Hume (1739) and Smith (1759) wrote about engaging the foundations of morality in sympathy (Agosta, 2011). Moreover, prior to the word empathy being introduced to the English language, sympathy captured the distinction "communicability of affect." It thereby distinguished between a method of data gathering about the experiences (sensations, affects, emotions) of other persons and the use of this experience for good (Agosta, 2011).

It is important to note that the Continental tradition also had challenges with the use of the German language when related to the word sympathy in the British tradition. However, when reflecting upon innovation and the use of the word empathy, in the 1950s psychoanalyst Heinz Kohut's usage is based on the philosophy of science rather than the uses of the term used by Freud who neglected the word but not the underlying distinction (Agosto, 2011). "Kohut's use of empathy is a method of data gathering oriented towards a listening base immersion in the affective, experiential, and mental life of the other person" (Agosta, 2011). When making

a value neutral inquiry, the psychoanalyst's use of empathy as a method of data-gathering is of great interest to ethicists. "Issues around coherence and integrity of character and the self as a bulwark against unethical behavior which includes such things as rampant cheating, drug abuse, gambling, moral malaise and other individual, social, and communal ills" (Agosta, 2011).

Anglo-American Tradition

Notable leaders in the Anglo-American tradition were David Hume, Adam Smith, John Rawls, Thomas Nagel and Michael Slote. Philosopher David Hume's contributions related to differentiating meanings of sympathy with four distinct meanings of this important concept are highlighted here. The first two meanings of sympathy, Hume argues, functions in the "communicability of affect" and "emotional contagion." His third and fourth meaning(s) of sympathy includes the "power of suggestion" and "an element of benevolence." (Agosta, 2011). One of the ways that sympathy is viewed today clearly is related to Hume's initial definition of "communicability of affect." Later, in his 1741 essay *Of the Delicacy of Tastes and Passion* (eBooks@Adelaide.edu.au, 2015), Hume makes note of all the advantages of human interactions of sympathy and especially highlights the importance of friendship, intimacy and interpersonal warmth to his concept of "delicacy." Interestingly, by the time of the *Inquiry* (1751), sympathy had been pushed down behind compassion; and "compassion takes on the content of qualities useful to mankind as benevolence" (Agosta, 2011).

Bioethical Perspectives

The ethics of care is often interpreted as a form of virtue ethics (Beauchamp, 2013). It is important in healthcare, medical care and nursing care (Beauchamp, 2013). The ethics of care looks at intimate personal relationships such as sympathy, compassion, fidelity and love (Beauchamp, 2013). When one considers caring, it refers to the feelings of caring for others, actual taking care of others or the emotional commitment to and willingness to act on behalf of persons with whom one may have a significant relationship. Beauchamp further argues that caring is expressed in the actions of "caregiving," "taking care of" and "due care" (Beauchamp, 2013). It is important to note that the ethics of care also reminds physicians and nurses of their responsibilities--not merely of what should they do but also how they perform those actions, the motives and feelings that underlie them and whether the actions promote or indeed thwart positive relationships (Beauchamp, 2013).

Continuing to consider the ethics of care from a philosophical perspective, it originated initially in feminist writings. Some of the early literature in this area emphasized how women were seen as displaying an ethics of care, compared to men who predominantly were seen to exhibit an ethics of rights and obligations. In the 1980s, psychologist Carol Gilligan argued that women speak in a different voice that is often not heard when analyzing traditional ethical theory. Gilligan, through her empirical research, sought to explore the "voice of care" and interviewed women and girls. She argued that "empathetic association with others is not based on the primacy and universality of individual rights, but rather on... a very strong sense of being responsible" (Gilligan, 1982).

Gilligan's work was important in that two views of moral thinking were identified: an ethic of care and an ethic of rights and justice (Beauchamp, 2013). Important to note that Gilligan did not claim that these two views of thinking were strictly linked to gender in that all women

or all men spoke in the same moral voice. She argued, however, that men tend to embrace an ethic of rights and justice using quasi-legal terminology, impartial principles and dispassionate balancing and conflict resolution. On the other hand, "women tend to affirm an ethic of care that centers on responsiveness in an interconnected network of needs, care and even prevention of harm" (Beauchamp, 2013).

Divergent Perspectives on the Ethics of Care

There are largely two perspectives that are often used to criticize traditional ethical theories and deemphasize the virtues of caring (Beauchamp, 2013). They include: 1) challenging impartiality; and 2) relationship and emotion. When considering challenging impartiality, some argue that theories regarding norms of obligations are overemphasized and there is detached fairness. Moral detachment may also demonstrate a lack of caring responsiveness when people interact as equals in a public context of impersonal justice and institutional constraints (Beauchamp, 2013).

"In the absence of public and institutional constraints, partiality towards others is morally permissible and is the expected form of interaction" (Beauchamp, 2013). Some would even argue it is an element of human condition that cannot be destroyed (Beauchamp, 2013). It is said that without having the ability to exhibit partiality, our most important relationships could be harmed or severed (Beauchamp, 2013). "Proponents of care ethics do not recommend a general abandonment of principles as long as principles allow room for discretionary and contextual judgment" (Beauchamp, 2013). Yet, defenders of the ethics of care find principles "irrelevant, unproductive, ineffectual or unduly constrictive in the moral life" (Beauchamp, 2013). On the other hand, one could argue that the principles of care, compassion and kindness help others to respond with caring, compassionate and kind ways (Beauchamp, 2013). Moral experience suggests that individuals do indeed rely on emotions, the capacity for sympathy and the sense of friendship and sensitivity to determine appropriate moral responses (Beauchamp, 2013).

"The ethics of care places a special emphasis on mutual interdependence and emotional responsiveness" (Beauchamp, 2013). Feelings for and being immersed in the other person are important and necessary aspects of a moral relationship. The rights-based or obligation-based account may omit meaningful forms of empathy because the focus is on protecting persons from wrongdoing by others (Beauchamp, 2013). Notwithstanding, having a certain amount of emotional attitude is relevant and necessary when a person lacks both. Caring has an important cognitive dimension and requires a range of moral skills in that it involves "insight into an understanding of another's circumstances, their needs, and feelings" (Beauchamp, 2013).

Empathy: Definitions and Value

For most individuals within the caring professions, empathy is and has been a necessary component of successful "caring" for patients, person, clients, families and communities. It is clearly an important element in all health and other caring professionals and even in pastoral care. According to Pastor E. Marume (2019), empathy and listening are critical keys that are

interwoven and must be present to assist the pastor to be allowed to enter and help from within. These are like the backbone of professional counseling for spiritual counseling and therapy. Michael Jacobs (1988; pg. 9) indicated that "The ability to empathize, or to identify with how others might be feeling . . . and means the ability to put oneself in someone's shoes, to get into their skin, to experience what they might be experiencing." It is a mirroring of feelings of someone's suffering. The relationship of empathy to mirror neurons will be discussed in detail in the section on neuroscience and social science that follows.

Depending on the particular type of caring professionals, there are a different number of definitions and particular names and numbers of components used to describe empathy in the literature. One early example is the identification of two components to empathy: emotional and cognitive states (Vinton and Harrington, 1994). Another approach involves three components: 1) affective sharing perceptions and action coupling; 2) self-other awareness; and 3) mental flexibility and self-emotion regulation.

Affective sharing perceptions and action coupling is the involuntary first step that most individuals would recognize with mirror neurons enabling us to see the other person's actions, gestures, facial expressions and other behaviors and truly hear the words, tone of voice and content of their story. Then during component 2, during self-other awareness, it is important that the caring professional be able to disengage and begin to make cognitive inferences of others (Decety & Lamm, 2006). When this component is not used well, this is where burnout and deep experience of the burden of the other person can occur. Finally, during component 3, mental flexibility and self-emotion regulation allow the caring professional to avoid, inhibit and/or modulate the intensity or the "feeling state" of empathy. Decety & Lamm, 2006).

Finally, it is important to highlight herein the identification of a newer concept of "social empathy." According to E.A. Segal, "Social empathy is the ability to understand people by perceiving or experiencing their life situations and as a result gain insight into structural inequalities and disparities." Segal highlights that this type of empathy builds on individual empathy and will impact social and economic justice and wellbeing. This is an important contribution but not unusual since many different disciplines are analyzing and defining components of empathy with attempts to measure it, to engage meaningful comparisons and to explore how to cultivate or teach it. Ultimately, there is no question about the value of empathy for individuals and groups within all of the caring professions, including those not often considered (Segal, 2011).

Social empathy is the ability to understand people by perceiving or experiencing their life situations and, as a result, gain insight into structural inequalities and disparities. Increased understanding of social and economic inequalities can lead to actions that effect positive change, social and economic justice and general wellbeing (Segal, 2006, 2007a, 2007b). It is built upon individual empathy. Generally, empathy includes "the act of perceiving, understanding, experiencing, and responding to the emotional state and ideas of another person" (Barker, 2003, p. 141). For decades, empathy was analyzed and defined from the perspective of social and cognitive psychologists (Gerdes, Segal, & Lietz, 2010). In recent years, empathy has received a great deal of attention within the field of social-cognitive neuroscience (Decety & Jackson, 2004, 2006; Singer & Lamm, 2009).

Compassion: Definitions and Value

Compassion is an important virtue for healthcare professionals. Other importantly related virtues include discernment, trustworthiness, integrity and conscientiousness. They are all important parts of the development and expressions of caring, a fundamental nursing value. Compassion is a prelude to caring. Beauchamp further states that compassion predisposes sympathy, has affinities with mercy and is expressed in beneficence to alleviate suffering (Beauchamp, 2013).

Compassion is an essential component of good quality healthcare. However, despite its value and importance in healthcare, the construct of compassion is complex and multifaceted. Researchers grapple with how best to define the term and how to identify the specific factors, situations, patient groups and even healthcare professionals that define and relate best to the term compassion. In a physician--patient study where compassion was investigated through recordings, researchers identified three components to help define the term. These include: recognition, emotional resonance and movement towards addressing suffering. Little wonder then that healthcare professionals conceptualize compassion as "acting with warmth and empathy, providing individualized patient care, and acting in a way that one would expect others to act towards them" (Bickford, 2019).

Nursing, on the other hand, clearly identifies that the need for compassion, and respect for the inherent dignity, worth and unique attributes of every person is a core foundation for any and all healthcare professionals, including all those who call themselves nurses. The ANA Code of Ethics for Nurses in 2001 and again in 2015 stipulated the need for compassion in Provision 1, "...the nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person" ANA Code (2015). This is a fundamental value and commitment of the nurse and was a term introduced to the Code of Ethics Revision process during the 1996-2001 revisions, Provision 1, to establish the 2001 Code of Ethics (Ramsey, 2001). The term compassion was also included in the updated 2015 Code of Ethics to further stipulate that nurses have a duty and obligation to provide compassionate care to "patients, whether that word refers to an individual, family, group, community or population" (ANA Code 2015).

Compassion requires empathy and being able to put oneself in the individual's place with the ability to communicate an understanding and appreciation of what concerns them. Compassion also involves patience and treating an individual with dignity and respect. Nurses need not feel hurried, impatient or overwhelmed with a myriad of tasks that would negatively impact the compassionate care they desire to provide. When feeling anxious, overwhelmed and simply stressed, negative emotions could create a barrier to providing high quality compassionate care. The many demands on nurses in clinical practice today, coupled with a lack of time, have negatively impacted clinicians' emotional state. Many times, this has resulted in providers experiencing suffering due to a reduction of compassion and quality of care (Bickford, 2019).

One study found that negative emotions and situational stress among medical and nursing students impeded compassion (Bickford, 2019). Empathy is a risk factor among helping professionals in that the more the professional is empathically attuned while working in stressful conditions, the greater the vulnerability to experience poor professional quality of life (Laverdiere, 2019). A recent study explored individual and social empathy in the context of

responding to social issues such as racial tensions, gender issues, immigration, health disparities and socioeconomic issues of this current era. Social empathy is defined as "...the ability to understand people by perceiving or experiencing their life situations and as a result gain insight into structural inequalities and disparities" (Segal, 2018).

It is reported that medical students are often overwhelmed and even distressed by first time encounters and experiences with emotionally charged clinical matters addressing the social determinants of health. These experiences can often be devastating, especially when the clinician does not have an opportunity to mediate this distress, and reflect within the context of the institutional culture. Such experiences may stand as a barrier for healthy, reflective and empathic engagement with self and others. This raises important questions related to empathy associated with vulnerable groups and social justice issues. It is important to help students in all of the caring professions to address and manage their emotions in an effort to stop empathy decline and reduce burnout (Wellbery, 2019).

Neuroscience and Social Science Perspectives

During the past decade, researchers in the social-cognitive neuroscience field have conducted research using neural brain imaging to help other scientists and practitioners understand that empathy is mediated in the brain. Decety and Jackson applied their knowledge on empathy and delineated four key components:

1) the capacity for an automatic or unconscious affective response to others that may include sharing others' emotional states;
2) a cognitive capacity to take the perspective of another;
3) the ability to regulate one's emotions; and,
4) a level of self/other awareness that allows some temporary identification between self and others (2004).

Further exploration by Decety & Moriguchi resulted in the conclusion that

> Empathy is a multidimensional construct that includes both bottom-up and top-down components. The bottom-up part of empathy is the automatic or unconscious affected process . . . The top-down part of empathy is the conscious cognitive process that enables us not only to explain and predict our own behaviors, but the behaviors of others, as well (2007).

With the knowledge of a relationship between neuroplasticity and the development of empathy now physiologically observable through brain imaging, this creates an opening for a new discussion of mirror neurons. To summarize briefly for the purposes herein, "the mirror neuron system (MNS) is a network of brain cells that fire during our own motor behaviors, but more important, also fire when we hear other people speak" (Gazzola, Aziz-Zadeh & Keysers, 2006). Additionally, according to Enticott, Johnson, Herring, Hoy & Fitzgerald, (2008), "... the mirror neurons are involved in watching gestures and facial expressions." Examples like those from neuroscience mentioned above, "are presently making the definition of empathy richer, more precise, and more actionable" (Gerdes, K.E. Lietz, C.A., & Segal, E.A., 2001). It is also important to note, that men and women are not the same--with females having a stronger activation system causing them to be wired for more emotional resonance while males are

wired to remain more detached or cognitively driven in empathic response (Schulte-Ruther, Markowitsch, Fink & Piefke, 2008).

Another aspect of this discussion is important to note. It has been shown that when mirror neurons fire and are in distress or experiencing the distress of others, individuals may experience adrenalin and cortisol impact, which may contribute to burnout and stress. Scientists now know from a neuroscience perspective that cortisol once released can last up to 72 hours. This may be part of the cause of burnout when caring professionals take home at the end of the day/shift the empathic response of "I feel your pain." Also, great exploration is needed for the impact of social empathy and moral distress on the ethical and moral values of caring professionals when identifying with individuals and families where care is needed but cannot, for "systems reasons," be provided. This has specific importance when the needs are those in diverse and underserved populations. Strategies for addressing this and other responses to foster improved health and wellbeing of the caring professionals will be discussed in the future article already mentioned.

Empathy & Compassion: Challenges and Questions to Consider

The emerging literature related to empathy increasingly is highlighting questions related to neuroscience processes and the impact of social empathy related to concerns regarding access to care for many economically challenged communities. It is cited in some of the literature that stress, burnout and complicated ethical decision-making also contribute to moral distress that results in some groups leaving the professions. This is reflected in a recent paper on moral distress developed with interprofessional leaders in the National Academies of Medicine Global Innovations in Health Professions Education (Coffey, et.al. 2017).

There are a number of articles and other resources which highlight the challenges related to empathy, specifically burnout and moral distress. For example, the stress that occurs when providers continue to experience the impact of empathy because of the impact of cortisol, even after their interaction with patients/clients, also can take a significant toll contributing to burnout. It is important to be aware of the challenges that such opinions, even those more controversial and negative, pose to the understanding and advancement of empathy and compassion for patient care.

One example of an author so concerned about this is Yale researcher Paul Bloom. In his book, Against Empathy, he posits that empathy is one of the leading motivators of inequality and immorality in society and that it muddles judgment, in addition to creating distress. (Bloom, P. 2016). In this controversial book, he makes the case against empathy and advocates instead for a more distanced and rationale compassion. Other authors discuss challenges related to providers from many professions who experience moral distress and compassion fatigue due to situations such as conflicting goals between and among decision-makers in healthcare, patients/persons and family members. Additionally, increasing challenges occur with staff shortages due to some caring professionals choosing to leave the profession, providers overwhelmed due to lack of time to take care of patients, and even an increase in reports of suicides in some of these groups. This even includes veterinarians where compassion fatigue and stress has caused an increase in suicides (Best, 2016). The intensity of moral distress depends on personal values and life experiences. Examples include unexpected discharge roadblocks,

conflicting goals between providers and family and inadequate time because of administrative duties or sick calls. These types of ethical conflicts and constraints are ubiquitous for hospital caregivers, including case managers. Ultimately, moral distress generates adverse outcomes for patients who depend on professional advocacy.

Clinician burnout can be tied directly to massive adoption and updates of technology infrastructure under the 2009 Health Information Technology for Economic and Clinical Health Act (HITECH). Electronic health records (EHR) provide many benefits to patients and clinicians, but in their current state often create an unnecessary documentation burden that is a significant contributor to clinician burnout and reported moral distress (McBride, Tietze, Robchaux, Stokes & Weber, 2018). EHRs and additional clerical burden are resulting in stressful work environments. In addition to clerical burden, there are challenges with the usability of EHRs and the lack of support for effective and efficient collaboration and communication across the interprofessional team. This is also a factor in burnout and increased stress of clinicians. Physicians are also experiencing burnout and moral distress related to the use of EHRs (Baxter, 2018).

There are results in some studies of ethical situations often associated with feelings of moral distress. In addition to EHRs and challenges with technology, there are significant challenges related to staffing, preparation of healthcare providers and other caring professionals specific for changing demographics, more community-based versus hospital-based medical care and growing emphasis on patient/person engagement which adds another layer of need for compassion and empathy beyond face-to-face care.

Empathy and Compassion in Education and Training for the Caring Professions: The Bridge to Part II

Based on the diverse literature and studies that have been done related to empathy and compassion, it is clear that educators and trainers of individuals and groups of caring professionals are challenged. It is also clear that both empathy and compassion are key to patient/person satisfaction and meaning and purpose for providers. Empathy and compassion are a necessary part of delivering a wide variety of services by caring professionals.

In Part II of this article to be published in a future edition of the Journal, strategies will be proposed to identify some of the changes that need to be highlighted in the preparation of caring and health professionals, as well as strategies to enhance the health and wellbeing of the professionals through self-compassion. Indeed, it is time for a good, hard and needed assessment of some of the challenges for individuals, families and communities as they interact with a variety of health and caring professionals. Polarity Management (Johnson, 1998) will be highlighted with 'both/and' approaches such as embracing the challenges of technology which can destroy empathy, yet exploring creative use of technology such as the immersive use of virtual reality which can create and enhance empathy as well. (Manney, 2015).

Moving forward, it will be important to embrace an old saying "It Takes A Village" since many of the approaches will go beyond the individual to the organization, to examination of the implementation and adoption of technology, and to exploring support systems needed to foster retention and health/wellbeing of our caring professionals.

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