ADDRESSING THE HEALTH HUMAN RESOURCE CRISIS IN CANADA REQUIRES ‘AWAKENING COMPASSION COMPETENCE’ IN HEALTHCARE ORGANIZATIONS AND SYSTEMS

Discussion Paper

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Addressing the health human resource crisis in Canada requires 'awakening compassion competence' in healthcare organizations and systems

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Abstract

The health human resource (HHR) crisis has been building for years and has reached fever pitch in Canada, with many organizations across the country scrambling to address growing job vacancies and reported intentions to leave, staff turnover, and deep-rooted burnout. Here we draw from the rich literature and research on compassion, or the noticing, interpreting, feeling, and acting to alleviate suffering, as a way to organize ongoing and future organizational interventions to address the HHR crisis in Canada, and to identify additional opportunities to create supportive environments for healthcare providers. We submit that, without explicit attention to enabling systemic and organizational preconditions for compassion, the Canadian healthcare system will remain unable to resolve the growing HHR crisis. We employ the social architecture framework for "awakening compassion competence" to consider how the following five organizational components could enable organizational compassion competence to address the HHR crisis in Canada: 1) social network structures, 2) organizational culture, 3) defined work roles, 4) routines, and 5) stories and leaders. We aim to open a discussion into how Canadian healthcare organizations and systems may better center compassion as part of the HHR solution ecosystem, and how leaders, managers, change agents, and health and care providers themselves can become 'compassion architects' within those systems.

The health human resource crisis in Canada is reflected in a crisis of compassion

The health and care workforce is in crisis, with dire implications for healthcare performance and outcomes across Canada and globally. The World Health Organization (WHO) has projected a shortage of 18 million healthcare practitioners by 2030 (1), with conflicting assessments as to how and the degree to which the shortage will be affected by fallout following the COVID-19 pandemic (2–4). Canada, mirroring the global situation, is experiencing an historic shortage of health and care providers, with job vacancies in the healthcare sector reaching their highest ever recorded levels in the first quarter of 2023 (5). Newspaper headlines earlier this year read that we are in "deep, deep trouble" and "beyond crisis levels" as providers flee the workforce (6). Hospital staff of in-patient units in Canada worked a collective 14 million hours of overtime between 2021 and 2022, the equivalent of about 7,300 full-time positions (7). The end result are workplaces that are physically, culturally, and psychologically unsafe for health and care providers (HCP) (8). In response to the worsening health human resource (HHR) shortage, support and retention of healthcare workers is of the utmost importance in Canada (and globally).

The Canadian federal and provincial/territorial governments have formally developed and deployed strategies to support HHR through frameworks, action plans, and committees since 2000 (8). A Framework for Collaborative Pan-Canadian Health Human Resources Planning was released in 2007, but the promise of this framework has not been fully realized, nor does Canada have a coordinated health workforce strategy (8). Organizations across Canada have implemented and are implementing interventions to address the HHR crisis in the forms of wellness programming, targeted leadership and management support, reducing overall workloads, and addressing workplace hostility and bullying (8).

Across the Canadian healthcare sector, healthcare worker vacancies, absenteeism, turnover, and reported intention to leave have been "linked to workplace hostility, harassment, bullying and violence, unsafe working conditions, high and unsustainable workloads, and a lack of

recognition and job security” (7, p. 92). Burnout is a work-related syndrome which involves emotional or physical exhaustion, a feeling of reduced personal accomplishment, and depersonalization, itself defined as an inability to establish personal connections with patients (9). ‘Job stress and burnout’ was the most-cited reason why healthcare workers in Canada intended to leave their jobs within the next 3 years (10).

A recent report on Canada’s health workforce by the Canadian Academy of Health Sciences (CAHS) identified ‘Creating safe, healthy, just, and equitable workplaces that have diverse and representative workforces’ as one of five priority pathways in easing the workforce crisis in Canada (8), but the term ‘compassion’ was only referenced once in the 260 page report, in terms of the risk of compassion fatigue and burnout for health and care providers. Without using the term ‘compassion,’ the authors detail many root causes of the HHR crisis and burnout, and opportunities to address it, that fall under the umbrella of compassion. In this paper, we are going to argue that the current collection of strategies for the HHR crisis in Canada would be strengthened by layering in an explicit focus on compassion.

We adopt the definition of compassion from Worline & Dutton (2017), which outlines four processes and distinguish it beyond related human affects, such as empathy. First, compassion necessarily involves *noticing* that suffering is present in an organization or person, as compassion “always unfolds in relation to suffering” (10, p. 5). Second, compassion involves *interpreting* the noticed suffering in a way that inspires a desire to alleviate it, for example through generous interpretations of suffering that avoid blame and highlight individuals’ worthiness of receiving compassion. Third, there must be a *feeling* of empathic concern for the people or person suffering. Finally, in a distinctive characteristic of compassion, one must *take action* to relieve or lessen the suffering in some manner. Compassion, directed towards others or towards the self, can be protective against health and care provider burnout and moral distress (12–14). The multi-faceted aspects of compassion (noticing, interpreting, feeling, and acting) make it an indispensable concept in understanding and addressing the work of care and the care of workers. Evidence that compassion is a necessity in healthcare rather than a luxury has steadily increased in recent years, demonstrating physiological and psychological health benefits for patients, acting as an “antidote to burnout” for providers, and increasing revenue and cutting costs for healthcare organizations (14). Despite the clear positive impacts both for health and care workers and the patients they serve, compassion is not sufficiently centralized in the ecosystem of proposed solutions to the HHR crisis in Canada.

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The aim of this paper is to review strategies to address the HHR crisis in Canada, prominently guided by the 2023 CAHS report, while focusing on how organizations and systems can act as catalysts to “awaken compassion competence.” We will first introduce why we opt to focus on systemic and institutional level interventions, then walk through five organizational components from the social architecture framework (15), before concluding with final thoughts on keeping compassion centered as Canada works to address its HHR crisis. Our goal is to open a discussion into how Canadian healthcare organizations and systems may better center compassion as part of the HHR solution ecosystem, and how leaders, managers, change

agents, and HCP themselves can become 'compassion architects' within those systems.

The HHR crisis requires systemic and institutional approaches to "awaken compassion competence"

Throughout the healthcare literature, compassion has been interpreted and understood in varied ways: as "an intrinsic identity, a learned identity, a finite resource, a performed action, a value, and an obligation" (14, p. 173). Although the diversity of interpretations may cause confusion, it also suggests that several entry points exist for invoking change, for example at the individual, managerial, organizational, or systems level (17). Individual-level training has repeatedly proven effective for increasing compassion (18), but overreliance on these approaches as a solution for the HHR crisis is problematic. Compassionate care interventions in healthcare settings often exclusively target the individual health care worker, introducing 'self-care' initiatives that may generate additional burdens for staff without giving sufficient attention to the underlying organization- and system-level issues that can aid or hinder compassion from flourishing (16,19). The onus of improving healthcare provider well-being, increasing compassion, and reducing burnout should not rest entirely with providers themselves, as this signals a shift of responsibility away from the organization and the broader healthcare system and policy space within which it operates (20). It is becoming increasingly evident that effective solutions to reduce burnout necessitate organizational reform (21). A 2017 meta-analysis of 20 controlled interventions seeking to reduce burnout for a combined 1550 physicians found evidence that many interventions were associated with significant reductions in burnout, but that the evidence was strongest for organization-directed interventions (22). The following were cited in the 2023 CAHS report (p. 8) as "long-standing system challenges [in Canada], exacerbated during the COVID-19 pandemic":

- physically, culturally, and psychologically unsafe workplaces,
- a distribution of the workforce whereby rural and remote regions have more limited access to care,
- healthcare service delivery models unsuited to an expanding and more diverse population, and from increasing complexity of patients' chronic conditions,
- unsuitably rigid funding models and structures that do not encourage adaptability or innovation in delivery models that could deliver improved outcomes and value for money, and
- a workforce that does not reflect the ethnocultural diversity of our country.

We note that the above challenges are all system- or organization-level challenges that are unlikely to be addressed through individual interventions, such as healthcare worker wellbeing trainings, alone. Indeed, the CAHS report suggests that, while HCP resilience can be promoted through individual-level interventions such as stress reduction or mindfulness therapies, workshops, and courses, "the organization is responsible for most factors related to professional wellbeing" (7, pg. 112).

If compassion at the individual level is defined as noticing, interpreting, feeling, and acting to alleviate suffering, then compassion competence within an organization can be understood as a *pattern* of "*collective* noticing, interpreting, feeling, and acting" to alleviate suffering (10, p. 113). Dutton et al. (2006) propose a social architecture framework for "awakening compassion competence" through five organizational components: 1) social network structures, 2) organizational culture, 3) defined work roles, 4) routines, and 5) stories and leaders (15). The authors of this discussion paper submit that, without explicit attention to enabling the "preconditions for compassion" (23) to thrive for and from healthcare providers, the Canadian healthcare system will remain unable to resolve

the growing HHR crisis. We employ the social architecture framework (11,15) below to consider how the five elements could enable organizational compassion competence to address the HHR crisis in Canada.

1) Network Structures

The social ties between people working within a healthcare system form a network structure that allows HCP, staff, and leaders to support one another. Healthcare organizations can foster deep connection across social networks to enable compassion competence both for their healthcare teams and for the patients they serve. Workplaces where providers feel supported by their networks of coworkers and employers can facilitate compassionate care (24–27).

A phenomenological and autoethnographic study with critical care and palliative care clinicians in Alberta found that the network structures formed by peers provided invaluable wellbeing support:

“We also see distress in our colleagues. And we’re compassionate towards how they are feeling about caring for someone who’s suffering… they’re also suffering… a lot of our compassion is actually towards each other.” (23, pg. 204)

As a provider in another compassion study in Alberta put it very simply:

“I couldn’t do my job everyday if I didn’t have my coworkers to support me.” (26, pg. 2093)

Relationships with colleagues, and compassion towards one another during difficult times at work, constitute an important protective factor against burnout (29).

Interventions to address the HHR crisis in Canada can aim to enable supportive network structures that improve compassionate workplace environments and reduce staff burnout. While the CAHS report (rightly) promotes interventions addressing workplace hostility and bullying as a pathway to supporting HHR in Canada, we did not see interventions featured which explicitly aim to foster strong network structures among staff; this may unveil an additional opportunity for compassion intervention and evaluation in addressing the HHR crisis. The CAHS report does, however, promote an array of policies and practices addressing social justice issues, and specifically addressing the makeup of healthcare staff as a key part of confronting the HHR crisis. Increasing diversity and ensuring network structures that are free from discrimination is key to addressing the growing HHR crisis (alongside the myriad benefits for diverse patient populations) (8).

2) Organizational Culture

Organizational culture can be understood as “a pattern of shared basic assumptions learned by a group… which has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel” (30). An organization’s culture can also be understood through its espoused values, or the “stated and lived-out ideals, goals and aspirations” (30), which could be anything from established policies to employees’ understanding of ‘the way things are here’ (11). Negative aspects of organizational culture (e.g., excessive workload and inadequate staffing) have been identified as some of the biggest constraints to the provision of compassion within healthcare settings (31).

A forthcoming nursing retention toolkit, developed “by nurses for nurses” in Canada, identifies many aspects of organizational culture that could facilitate better nurse wellbeing and retention, including prioritizing “physically safe and psychologically brave” spaces, promoting cultures of mutual respect between management teams and nurses, and supporting increased nurse autonomy and flexibility (32).

The CAHS report includes a plethora of policies and practices for supporting an organizational culture of compassion. The report raises the importance of “enhancing autonomy, recognition and growth” as key in addressing the HHR crisis (pg. 108); as just one example, the report cites a study in which paramedics identified their lack of control over organizational factors, such as when their breaks could be taken or the length of their shift, as key stressors in the workplace (33). Developing a culture that supports openness for HCP to seek out and receive confidential mental health services and wellbeing supports is also raised in the CAHS report (pg. 111). Implementing ‘zero-tolerance’ policies for workplace hostility and bullying, and supporting leaders to model appropriate group norms for positive workplace behaviors, are also raised as creating a culture free from hostility (pg. 105) (8).

Burnout for HCP can begin even in residency (34), and opportunities to impart cultures of compassion that are supportive of HCP may therefore exist at the training stages for Canadian healthcare providers and staff. A 2021 grounded theory study conducted with resident physicians and faculty members across Canada found that residents were suffering from moral distress associated with their inability to act on structural stigma resulting from COVID-19 policies, but that faculty acted as mediators in this distress by modeling “transparency and honesty” that made the residents feel seen and supported (35). One resident stated that “openly trying to create a culture of inclusion or culture of transparency makes such a difference” (pg. 224).

3) Roles

Roles within a healthcare organization outline the patterns of behavior and actions expected of different positions. Wrzesniewski and Dutton distinguish between ‘role taking’ and ‘role making’ for enabling compassion competence: *role taking* describes the ways we learn to fulfill prescribed and formally designed roles, for example through training, onboarding, and responsibilities, while

Implementation of task shifting and redefining roles also invites us to consider the question: optimization for who?

role making involves innovation and ‘job crafting’ to sculpt purpose within the bounds of defined roles (36). The ways that healthcare organizations define and train for roles has the potential to facilitate or stem the flow of compassion, as does imparting the flexibility for individuals in role making to add layers of meaning and compassion to their day-to-day work. For example, a hospital case study found that janitorial staff sometimes sculpted their roles to enable interaction and caring for patients, which elevated the meaning and purpose behind their jobs (37).

Task shifting, defined by the WHO as “the rational redistribution of tasks among health workforce teams,” is increasingly looked to as a solution to increase efficiency and optimize available HHR, and to help to address shortages of healthcare workers (38). The Canadian Academy of Health Sciences report raises task shifting and role flexibility as important aspects of a coordinated response to the HHR crisis, for example through reassessing roles for documentation and non-clinical tasks to reduce administrative time for clinicians. Task shifting may be especially important in the Canadian context, where rural and remote health facilities are typically under-resourced, particularly in terms of HHR, and staff must rely heavily on team-based models of care and have a broad range of skills to “provide best ‘possible’ practice when best practice is not possible” (7, pg. 54). Because roles set the “internal expectations… on how to be and how to act,” they present an opportunity to consider how compassion can be embedded in day-to-day interactions in healthcare settings (10, pg. 122).

Implementation of task shifting and redefining roles also invites us to consider the question: optimization for who? We propose that task

shifting and role flexibility can move beyond aims to reduce costs and 'increase efficiencies,' to be crafted explicitly to support HHR wellbeing.

4) Routines

In healthcare organizations, routines can especially frustrate compassion from flourishing. Embedded routines resulting from rigid funding structures or introducing extensive administrative burdens notably influence HHR burnout and intention to leave their jobs in Canada (8). Conversely, routines hold great potential to provide the 'architecture' to build compassion into everyday actions, because it is woven into day-to-day activities and processes.

The same phenomenological study of clinicians in Alberta identified an example of routines interfering with compassionate care, pointing to a facility's routine of ICU rounds taking place directly outside of patients' rooms, where the rounds are often observable through glass windows:

"We don't look compassionate when we huddle up in a ball, talk about you, and walk away. We could be saying the most supportive things… but the medium is the message. And people have told me that. They're half awake, and they'll mouth out or they've got tracheostomy, so I can't really read their lips… 'What are you guys talking about out there?'" (23, pg. 203)

A systematic review of organization-directed interventions to reduce physician burnout identified promotion of team-based care, process improvements for workflow, and improvements to technology (specifically electronic health record interventions) as delivering the largest benefits (39), all of which largely revolve around routines. The CAHS report likewise promotes policies that can influence HCP routines, highlighting many studies and interventions that aim to reduce workload, reduce documentation time, and address electronic health record time constraints. Other opportunities to weave compassion into routines include through hiring practices (e.g., assessing for compassion capabilities), training and development (e.g., incorporating compassion capabilities training), performance reviewing (e.g., explicitly outlining expectations of compassion towards colleagues), and rewarding processes (e.g., rewarding and recognizing individuals who demonstrate exemplary compassion towards patients and colleagues) (40). Positive Organizational Scholarship, which focuses on supporting "positive, flourishing, and life giving" organizations, is an under-utilized concept in healthcare which could provide direction in sparking compassion through routines (40).

5) Stories & Leaders

Stories are vessels for sharing knowledge, building trust, and sharing values among staff, and when compassion is centered in stories, people come to see their organization as a more compassionate place, as well as viewing their colleagues as more compassionate people and feeling that they themselves can be more compassionate in their workplace (41). Even stories of emotional pain and failures of compassion can serve as a positive force for change, if they are appropriately acknowledged and managed (42). Leaders are also a key aspect of enabling compassion competence, through meaning-making of events, mobilizing resources for enabling compassion in the workplace, modeling compassion, and supporting and sustaining existing patterns of compassion (11,43).

"Developing and enhancing supportive leadership" is listed as one of the leading policies & priorities to increase support and retention for HHR in the CAHS report. Specifically, the report outlines that the following are attributes and skills that have been shown to improve HCP wellbeing and retention: supportive leadership behaviors, offering praise and recognition, fostering team cohesion and an atmosphere of respect and trust, promoting honest and transparent

communication, valuing and implementing staff suggestions, and supporting HCP growth and development through organizational resources (8,44). Beyond leaders' direct influences on staff wellbeing, mental health, and retention, decisions related to the many opportunities to weave compassion into existing or new policies and practices in the sections above are typically made at the leadership level.

The literature on compassionate leadership have primarily originated in the field of health and medical industry, in contrast to gaps in the business and management sector (44). The Canadian Medical Association began collecting the National Physician Health Survey in 2017, which collects indicators aimed to identify opportunities for individual-, organizational-, and systems-level supports for physicians and, since 2021, for medical students and residents as well (45). The resources and knowledge base are there. Tapping into these to support current and future healthcare leaders to be compassionate leaders is a concrete step towards addressing the HHR crisis in Canada.

Compassion and technology in the HHR crisis

There are arguments as to whether our ability as humans to identify suffering and provide compassionate care to others and ourselves would be augmented or weakened by advances of technology in the healthcare setting. Some HCPs perceive advancing technology as creating a barrier to providing compassion by distracting them from attending to their patients' emotional needs, instead shifting their focus necessarily to the physical and corporeal aspects of care (28,46). On the other hand, some feel that artificial intelligence has the potential to free HCP from the mundane roles that hold them back from providing compassionate care. Discussing his book *Deep Medicine: How Artificial Intelligence Can Make Healthcare Human Again*, author Dr. Eric Topol says: "What is at the core is the human bond, and the ability to experience compassion. That's what we've lost [in healthcare], and [through artificial intelligence] we can get it back" (47). While not all writers share Dr. Topol's optimism, the question does emerge: could technology allow for better "noticing" of suffering among colleagues and patients? If technology can create more efficiencies at work, how can we ensure that those efficiencies translate into better, more compassionate care practices?

Compassion is, rightfully, often featured as a critical aspect of providing care to patients; [..] supporting compassion from, for, and among HCP and staff is a critical lens to bring when addressing the HHR crisis in Canada

Keeping compassion centered as Canada works to address its HHR crisis

Evidence increasingly demonstrates that compassion is not a luxury, but a requirement for a high-functioning healthcare system, patient satisfaction and outcomes, and for HCP wellbeing (14). While compassion can be learned and enhanced (18), it is also an innate human feature (48,49). Here we have reflected on the question – how can healthcare organizations across Canada allow the compassion that is innate to the human experience to thrive?

Martimianakis et al. (2020) identify a set of principles for establishing and sustaining an organizational culture of compassion, including incorporating commitment to compassionate care in the mission statement, recognizing the commitment to caring and compassion across recruitment and evaluation practices, and addressing potential misalignments between the compassionate mission and existing organizational policies, priorities, and protocols (16). Compassion is, rightfully, often featured as a critical aspect of providing care to patients (50);

we argue that supporting compassion from, for, and among HCP and staff is a critical lens to bring when addressing the HHR crisis in Canada.

Not only does a non-compassionate work environment have implications for the HHR crisis, research shows that burnout inhibits providers' ability to then provide compassionate care to patients (51) having serious implications for patient safety and satisfaction, quality of care, adverse medical events, and healthcare costs (14,31,52). Compassion drops when the number of "victims" is higher (53) in a phenomenon known as numeracy bias or "compassion collapse" (54); compassion fatigue, depersonalization, and subsequent burnout among healthcare providers and staff have increased substantially following the overwhelming influx of patients throughout COVID-19 pandemic (55). The HHR crisis is reflected in a crisis of compassion within the Canadian healthcare system.

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