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Patient Suffering

The following summaries of recent peer-reviewed articles identify factors that influence patient suffering and how patient suffering can be reduced. Citations are linked to full-text articles **[*]** when available. **[PG]** denotes Press Ganey research.

Study	Objective	Conclusion
Card, A. J., & Klein, V. R. (2016). A new frontier in healthcare risk management: Working to reduce avoidable patient suffering. *Journal of Healthcare Risk Management, 35*(3), 31-37.	To describe the problem of patient suffering, differentiate between avoidable and unavoidable suffering, and show that common risk management tools can be used to tackle the problem.	▪ Health care organizations have a moral duty to reduce preventable harm of all kinds across the biopsychosocial spectrum. ▪ Unavoidable suffering is an inherent part of the patient's diagnosis or treatment, whereas avoidable suffering is the result of faulty care systems. ▪ Failure to properly mitigate unavoidable suffering should be considered a form of avoidable suffering. ▪ Avoidable suffering due to faulty care systems is harm, and complete elimination should be the goal. ▪ Avoidable patient suffering is an important problem that requires systemic solutions. Risk managers may be well-positioned to help health care organizations diagnose the underlying causes of avoidable suffering and design robust solutions to prevent it.
[*PG] Dempsey, C., & Mylod, D. (2016). Addressing patient and caregiver suffering. *American Nurse Today, 11*(11), 17-23.	To discuss how to address patient and caregiver suffering through The Compassionate Connected Care™ framework.	▪ The Compassionate Connected Care™ framework addresses the challenges of reducing patient and caregiver suffering by integrating clinical, operational, cultural, and behavioral domains. ▪ Compassionate Connected Care™ for the patient is organized around six themes with specific action items that help caregivers achieve the greatest impact in reducing suffering: 1. Acknowledge suffering 2. Body language matters 3. Anxiety is suffering 4. Coordinate care 5. Caring transcends diagnosis 6. Autonomy reduces suffering ▪ Compassionate Connected Care™ for the caregiver is also organized around six themes: 1. We should acknowledge the complexity and gravity of the work caregivers provide. 2. Leadership needs to provide support in the form of material, human, and emotional resources. 3. Empathy and trust must be fostered and modeled. 4. Teamwork is vital to success. 5. Caregivers' perception of a positive work-life balance reduces compassion fatigue. 6. Communication at all levels is foundational.

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[*] Strauss, C., Lever Taylor, B., Gu, J., Kuyken, W., Baer, R., Jones, F., & Cavanagh, K. (2016). What is compassion and how can we measure it? A review of definitions and measures. *Clinical Psychology Review, 47*, 15-27.	To propose a definition of compassion and offer a systematic review of self- and observer-rated compassion measures.	▪ Compassion consists of five elements: – Recognizing suffering – Understanding the universality of human suffering – Feeling for the person suffering – Tolerating uncomfortable feelings – Motivation to act/acting to alleviate suffering ▪ Compassion can be both state-like and trait-like: – State-like: Sensitivity to one's own or others' suffering, emotional responsiveness, acceptance and nonjudgment in the face of suffering, and motivation to be helpful are all likely to fluctuate across time and situations. – Trait-like: Compassion can be seen as a quality that endures over time. ▪ Compassion-focused interventions often make the assumption that a trait-like general tendency to be compassionate towards oneself or others can be developed through repeated practice of skills that cultivate compassionate states, attitudes, or behaviors.
[*] Institute for Innovation (2015). *Inspiring Innovation – Meeting Unique Cultural & Religious Patient Needs in a Behavioral Health Setting*.	To reduce suffering for Orthodox Jewish behavioral health inpatients at New York Presbyterian Hospital (NYP) by designing care around their cultural and religious customs.	▪ Redesigning care around the religious and cultural traditions of Orthodox patients creates a level of trust between the Orthodox community and the hospital. This trust encourages patients seek care earlier and thus arrive for treatment in a less acute state. ▪ Customized care protocols do not necessarily result in increased cost. Orthodox patients do not require more care, just care that is more appropriate for them. ▪ Since the implementation of care redesign, NYP's patient experience scores have steadily increased and staff engagement has been high.
Body, R., Kaide, E., Kendal, S., & Foex, B. (2015). Not all suffering is pain: Sources of patients' suffering in the emergency department call for improvements in communication from practitioners. *Emergency Medicine Journal, 32*(1), 15-20.	To describe the burden of suffering in the emergency department (ED) and explore how it may be best addressed from a patient-centered perspective.	▪ Physical pain and suffering are different entities, which may be under-recognized in emergency medicine. ▪ Although pain is the most commonly reported source of suffering in ED patients, the majority of the sources of suffering are not related to pain. Patients reported suffering with a number of other physical symptoms (e.g., nausea, vomiting, dizziness, shortness of breath, drowsiness, hunger, thirst) and emotional distress (e.g., anxiety, concern, embarrassment). ▪ In seeking to ease suffering in the ED, clinicians must focus not only on providing analgesia but on treating Emotional distress, Physical symptoms, providing Information, Care, and Closure (EPICC).

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Cagle, J. G., Pek, J., Clifford, M., Guralnik, J., & Zimmerman, S. (2015). Correlates of a good death and the impact of hospice involvement: Findings from the national survey of households affected by cancer. *Supportive Care in Cancer, 23*(3), 809-818.	To provide evidence for the positive impact of hospice on reducing suffering at the end of life.	▪ Physician attention to non-medical factors—including ways to improve communication about end-of-life matters, enhance bedside compassion, manage pain and other distressing symptoms, and attend to non-medical factors like coping and social support—plays a significant role in reducing suffering at end of life. ▪ Hospice's high-quality pain management and patient/family-centered care model reduces suffering and is strongly associated with quality of death. ▪ Providers should be vigilant about tailoring end-of-life treatments to patient wishes and making timely referrals to hospice.
[*] Singer, A. E., Meeker, D., Teno, J. M., Lynn, J., Lunney, J. R., & Lorenz, K. A. (2015). Symptom trends in the last year of life from 1998 to 2010: A cohort study. *Annals of Internal Medicine, 162*(3), 175-183.	To describe changes in pain intensity and symptom prevalence during the last year of life from 1998 to 2010.	▪ Between 1998 and 2010, reports of serious pain and many other distressing symptoms became more common near the end of life. ▪ Some patients may not have consistent access to services that reduce suffering such as palliative services in outpatient, home, and long-term facility settings (where most of the course of a terminal illness takes place). ▪ Patients who have short hospice stays may not be able to realize the full benefits of suffering reduction through symptomatic relief.
[*] The Schwartz Center for Compassionate Healthcare. (2015). Building compassion into the bottom line: The role of compassionate care and patient experience in 35 U.S. hospitals and health systems. [White Paper]	To detail successful programs and approaches that enhance caregiver compassion and patient experience.	▪ Compassionate care is based on active listening, empathy, strong communication and interpersonal skills, and knowledge of the patient as a whole person. ▪ Organizations that place a high priority on delivering compassionate care benefit from lower staff turnover, higher retention, recruitment of more highly qualified staff, greater patient loyalty and reduced costs from shorter lengths of stay, lower rates of rehospitalization, better health outcomes, and fewer costly procedures. ▪ Caregivers who are able to express compassion for patients, families, and each other experience higher job satisfaction, less stress, and a greater sense of teamwork. ▪ When you combine empathy and compassion, it makes for the best overall experience for the patient. Patients who are treated compassionately benefit from improved quality of care, better health, fewer medical errors, and a deeper human connection with their caregivers.
[PG] Dempsey, C., Wojciechowski, S., McConville, E., & Drain, M. (2014). Reducing patient suffering through compassionate connected care. *Journal of Nursing Administration, 44*(10), 517-524.	To define Compassionate Connected Care™ as a framework to reduce patient suffering by helping caregivers learn to better express empathy and compassion to patients,	▪ As organizations seek to reduce suffering, they must support opportunities to improve skills that help caregivers connect with patients. ▪ The Compassionate Connected Care™ framework provides nurse leaders and managers with a framework to look at patient experience data strategically with a goal of reducing patient suffering.

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	and to better equip nurse leaders to engage nurses at the bedside.	▪ Using the four components of optimal performance—clinical excellence, caring behaviors, operational efficiency, and culture—organizations can refine their measurement of patients' unmet needs and highlight the types of actions that must be taken in order to better meet those needs. ▪ Compassionate Connected Care™ enables targeted suffering reduction of patients with specific process, physical, and emotional needs based on service line or clinical condition.
Detsky, A. S., & Krumholz, H. M. (2014). Reducing the trauma of hospitalization. *The Journal of the American Medical Association, 311*(21), 2169-2170.	To define "post-hospital syndrome" and identify solutions for reducing the suffering caused by the trauma of hospitalization.	▪ The hospital environment causes patient suffering by exposing patients to incessant loud noises, a lack of privacy, awakenings in the middle of the night, and examinations by strangers who fail to identify themselves. ▪ Post-hospital syndrome occurs when patients discharged from the hospital have had their physiological balance disrupted such that they are susceptible to a broad range of medical problems. ▪ To become a true healing environment, hospitals should implement suffering-reducing innovations such as promoting personalization, ensuring patients get enough rest, minimizing disruptions, eliminating unnecessary tests, decreasing medication alterations, encouraging activity, and providing a post-discharge safety net.
[*] Institute for Innovation (2014). *Inspiring Innovation – Redesigning Care and Alleviating Suffering for Patients Who Need Sleep*.	To redesign care and reduce suffering for Yale-New Haven Hospital patients for whom nighttime interventions are medically unnecessary.	▪ Redesigning care for patients who do not require medical care at night prevents avoidable suffering by allowing these patients to rest and be protected from unnecessary and stressful interventions. ▪ After the intervention was implemented, HCAHPS "quiet at night" top box scores improved from 16% to 47% "Always" responses without any concomitant efforts to reduce noise.
McClelland, L. E., & Vogus, T. J. (2014). Compassion practices and HCAHPS: Does rewarding and supporting workplace compassion influence patient perceptions? *Health Services Research, 49*(5), 1670-1683.	To examine the benefits of compassion practices on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) overall hospital rating and likelihood of recommending.	▪ Compassionate care that notices, feels, and responds to the suffering of others represents a specific form of patient-centeredness. ▪ Patient perceptions of care quality are associated with a set of concrete organizational compassion practices. ▪ When hospitals explicitly reward compassionate acts by staff, and support them during hard times, patients more highly rating the care experience and are more likely to recommend the hospital. ▪ Practices that provide support for employees and recognize and reward employees when they exhibit compassion reinforce compassion as a critical aspect of the type of caregiving patients deserve.
[*PG] Press Ganey. (2014). Measuring patient needs	To describe a new construct that enables providers to measure	▪ Unmet patient needs are a reflection of inherent and avoidable sources of suffering. "Inherent" sources of suffering are those caused by disease and treatment

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to reduce suffering. South Bend, IN: Author.	unmet patient needs to reduce suffering.	while "avoidable" sources stem from dysfunction in care delivery. ▪ The goal of medicine must be to mitigate inherent suffering to the greatest extent possible and to be cognizant of opportunities to prevent additional, unnecessary suffering. ▪ A critical strategy for creating value is measuring what matters to patients, identifying unmet needs that contribute to suffering, and systematically improving performance to better meet those needs.
Winch, S., Henderson, A. J., Kay, M., Burridge, L. H., Livesay, G. J., & Sinnott, M. J. (2014). Understanding compassion literacy in nursing through a clinical compassion cafe. *Journal of Continuing Education in Nursing, 45*(211), 484-486.	To present a method of reconnecting and reaffirming with nurses the importance of compassion toward the suffering patient by using a clinical compassion café.	▪ The practice of compassion is a key factor in the delivery of high-quality nursing care. ▪ Compassion fatigue can impact quality of care as well as measures of quality, such as patient satisfaction. ▪ Clinical compassion cafés provide a supportive environment for clinicians to converse about the stresses of patient care, create plans to care for themselves to maintain their compassion, and renew their commitment to compassionate care for themselves and their patients.
Hanratty, B., Lowson, E., Holmes, L., Grande, G., Jacoby, A., Payne, S., … Whitehead, M. (2012). Breaking bad news sensitively: What is important to patients in their last year of life? *BMJ Supportive & Palliative Care, 2*(1), 24-28.	To understand patients' perspectives on how a diagnosis of a life-limiting illness was first communicated to them and how to mitigate suffering by improving the practice of communicating bad news to patients.	▪ The pace and clarity of communication are particularly important to patients when they are receiving bad news from their care provider. ▪ More time to build up to the giving of bad news is required, especially for new patients where a relationship with the care provider has not already been established. ▪ Planning is needed to meet the practical and emotional aspects of breaking bad news, for example suggesting a relative accompany a patient receiving results or having a nurse or counselor available.

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