

ORIGINAL RESEARCH

Safeguarding Compassion in Virtual Family Physician Care

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Introduction: Following the COVID-19 pandemic, the role of virtual family medicine care is evolving. It can be tempting to consider only the technological aspects of virtual care; we argue we must attend to compassion's essential role in virtual family medicine care. This research aimed to understand the components contributing to compassionate family medicine virtual care and how these were demonstrated.

Methods: We conducted a qualitative Constructivist Grounded Theory study with 2 components; individual interviews with patients and family physicians (FP), and Collaborative Discussions, informed by the interviews, that brought patients and FPs together. Data collection and analysis were iterative using a constant comparative analysis.

Results: We recruited nineteen patient and fourteen FP participants for the first component and 6 patient and 4 FP participants for the second. We identified 4 themes: Conveying virtual compassion through actions; External factors affecting virtual compassion; Virtual visits extending compassionate care; and Role of the patient-FP relationship. These themes can be characterized as a stance that FPs assume in their practice of virtual care.

Discussion: We highlight 4 themes important to the delivery of compassionate virtual care. We provide specific actions FPs may consider in delivering virtual care. Offering virtual visits was viewed as a compassionate bridge between in-person visits.

Conclusion: Our findings support that it is possible to convey compassion in virtual visits including telephone interactions. As virtual care evolves, our findings can support patients and family physicians to safeguard compassion so that it remains a hallmark of care for all modes of delivery. (J Am Board Fam Med 2025;38:661–674.)

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Introduction

As we enter a post-COVID-19 pandemic world, the role of virtual family medicine (FM) care is

evolving.¹ Within this evolution, it can be tempting to consider only the technological aspects of virtual care such as internet connectivity.^{2,3} This temptation suggests a simplistic understanding of FM care. Compassion has been associated with better health outcomes^{4–6} and patient experiences^{7–9} in in-person care; it is reasonable to expect that compassion also will be important in virtual care and warrants attention; we argue in this article that compassion must remain a hallmark of care irrespective of mode of delivery.

We define compassion as an essential component of the patient-family physician relationship where the family physician develops an emotional resonance and cognitive understanding regarding the suffering of a patient that leads to a desire to alleviate that suffering.¹⁰ Whereas empathy is the

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awareness and understanding of the patient's emotions and suffering, compassion adds the action of alleviating that suffering.^{10,11} We refer to virtual care as all technologically-enabled, synchronous modes of interactions between patients and family physicians (FPs).

The significant increase in virtual care during the pandemic afforded us the opportunity to learn how compassionate virtual care was experienced by patients and family physicians. Specifically, in this article we aim to understand the components contributing to compassionate virtual care and how they are demonstrated within virtual FM care.

Methods

Study Design and Context

We conducted a qualitative Constructivist Grounded Theory¹² study with 2 components. In the first component, we conducted individual interviews with patients and FPs. In the second component, we conducted Collaborative Discussions with patients and FPs together that were informed by the findings from individual interviews conducted in the first component.

The study took place in Ontario, Canada where the Ministry of Health created temporary virtual care billing codes in March 2020, at the start of the COVID-19 pandemic; new codes instituted in December 2022 require an on-going relationship between the patient and the FP, and distinguish between virtual care delivered by telephone and by video.¹³

Participants

We recruited patients with multimorbidity (self-identified as having at least 2 chronic conditions) who had at least 2 virtual visits, and FPs who had provided virtual care during the pandemic. We excluded FPs who had provided solely walk-in clinic virtual visits. We recruited participants within the province of Ontario, Canada through social media, printed posters, and reached out to colleagues to assist in the recruitment process. For the Collaborative Discussions, we recruited participants who had participated in the interview component as well as new participants. We obtained informed consent from participants and assured confidentiality before the start of data collection for both components of the study. Patient and FP participants

had no therapeutic relationship with each other nor with the research team.

Using principles of iteration and theoretical sampling, we aimed for maximum variation in participants concerning age, gender, urban/rural locality, and additionally for FPs, practice payment models (eg, fee-for-service, capitation, blended models).

Data Collection

For the first component of the study, we conducted semistructured individual interviews by Zoom or telephone (BLR, MD). We began by asking participants demographic characteristics and how they would describe compassionate care. Additional questions aimed to understand actions indicative of compassionate care during virtual interactions. We invited participants to share their experiences, both of times they received (patients)/provided (FPs) compassionate care, and times when they did not. Interviews were audio-recorded and transcribed verbatim. Data were managed using NVivo 20 software. We conducted interviews until we attained sufficient data so we could make a reasonable interpretation of the data.¹⁴⁻¹⁷

For the second component of the study, we conducted Collaborative Discussions by Zoom (BLR, MD). Collaborative Discussions, adapted from deliberative dialogues,¹⁸ were conducted to bring patients and FPs together with the purpose being to discuss how they envision the delivery of compassionate virtual care. Demographic characteristics were collected by a questionnaire before the Collaborative Discussions began. During each Collaborative Discussion, the findings from the individual interviews were provided to the participants through 3 nonidentifiable vignettes. The vignettes focused on 3 different visits between one patient-FP dyad during an episode of care where the patient is experiencing an exacerbation of her fibromyalgia and is struggling with pain control with attendant issues such as anxiety. Each visit was constructed to highlight the themes that arose from the individual interviews. We started the Collaborative Discussion by providing a brief introduction into the goals of the research and overview of the exercise. Participants were provided with a video representation of the vignette after which patients and FPs shared their reactions to the vignettes and together identified actions that demonstrated compassionate care and situations that impeded the delivery of compassionate care. Collaborative Discussions were recorded and the

Table 1. Declaration of Author's Experiences

Author	Credentials and Expertise
BLR	PhD Epidemiologist with experience in mixed methods primary care research.
JBB	PhD in Social Work with expertise in qualitative research.
TRF	Family physician and researcher with experience in qualitative research.
MD	MSc in Health and Rehabilitation Sciences and has experience with qualitative primary care research.
MS	PhD Epidemiologist and has conducted multimethod studies of patient-centered interventions for persons with multimorbidity.
ALT	PhD Epidemiologist and teaches qualitative methods.

audio portion was transcribed verbatim. We conducted Collaborative Discussions until we had reached data sufficiency.¹⁴⁻¹⁷

Data Analysis

For each of the 2 components, data collection and analysis were iterative with data analyzed using constant comparative analysis with 3 coding phases (line-by-line, focused and theoretical coding).¹² For the first component, 4 research team members (BLR, JBB, TRF, MD) independently conducted line-by-line coding. The team members met regularly in the focused phase of the analysis to discuss their line-by-line coding and develop codes. As the codes stabilized, the team moved to the theoretical coding phase, immersing themselves again in the data and the memo notes, to establish the theoretical codes. For the second component, the same coding process was followed and conducted by BLR, JBB, MD.

In both components of this study, we ensured trustworthiness and credibility of the analysis by audio-recording and transcribing verbatim, incorporating both independent and team-based analysis, and keeping detailed analysis notes.

The researchers engaged in reflexivity by discussing their potential biases resulting from their professional and personal experiences.^{19,20} This was ongoing throughout the data analysis and manuscript preparation. Author credentials and expertise can be found in Table 1. Four of the authors (BLR, JBB, TRF, MS) have a long association with the development, teaching and research of the Patient-Centred Clinical Method. Throughout the study, from the conception of the research question to the preparation of the manuscript, we were cognizant of not imposing this theoretical approach.

Ethics approval was received for both components of the study from The University of Western

Ontario Review Board for Health Sciences Research Involving Human Subjects in London, ON (REB#120814).

Findings

Participant Characteristics

We recruited 19 patient participants and 14 FP participants for the interview component. Interviews lasted an average of 40 minutes for patient participants and 50 minutes for FP participants. Table 2 describes the participant demographics. The majority (58%) of patient participants lived in one large urban center and the remaining represented the geography of Ontario. FP participants reflected a distribution from across Ontario with most in capitated practice models.

We recruited 6 patient participants and 4 FP participants for the Collaborative Discussion component. The Collaborative Discussions lasted an average of 2.5 hours. Table 2 describes participant demographics. The participants were located across the province of Ontario, Canada with FP participants reflecting a variety of practice models.

Overview of Themes

We identified 4 main themes reflecting the components contributing to compassionate virtual care and how they are demonstrated: (1) Conveying Virtual Compassion through Actions; (2) External Factors Supporting or Hindering Virtual Compassion; (3) Using Virtual Visits to Extend Compassionate Care; and (4) The Patient-FP Relationship as the Bedrock of Virtual Compassionate Care. Quotes are demarcated for interviews as *P#* for patient interviews and *FP#* for family physician; and for each of the 3 Collaborative Discussions as *CD#*.

The 4 themes can be characterized overall as a *stance* that FPs assumed in their practice of virtual

Table 2. Characteristics of Participants

Characteristic	Interviews		Collaborative Discussions	
	Patients (n = 19)	Family Physicians (n = 14)	Patients (n = 6)	Family Physicians (n = 4)
Age (\bar{x} , Standard Deviation (SD))	66.4, 16.2	47.9, 13.3	63.8, 24.7	55, 10.7
Gender (n, %)				
Man	3, 16%	5, 36%	2, 33%	1, 25%
Woman	15, 79%	9, 64%	4, 67%	3, 75%
Non-binary	1, 5%	0, 0%	0, 0%	0, 0%
Race (n)				
Caucasian	16	11	5	3
Other	3	7	1	1
Years in Practice (\bar{x} , SD)	N/A	17.9, 14.9	N/A	24, 13
Self-reported health conditions (n)				
Arthritis	13	N/A	2	N/A
Cancer	4	N/A	2	N/A
Diabetes	5	N/A	0	N/A
Gastrointestinal	3	N/A	2	N/A
Hypertension	4	N/A	2	N/A
Mental Health	7	N/A	3	N/A
Musculoskeletal conditions	9	N/A	6	N/A
Other	18	N/A	7	N/A
Self-described rating of health (n, %)				
Good to Excellent	16, 84%	N/A	5, 83%	N/A
Fair	2, 11%	N/A	1, 17%	N/A
Poor	1, 5%	N/A	0, 0%	N/A

care, “[Patients] do not need me physically present but they need my mind and my energy and my soul” (FP9). While our findings focus on compassionate virtual care, participants shared the belief that, in many cases, the ability to be compassionate transcends the mode of health care delivery, “if someone’s a compassionate [physician], I think it is part of their being. So they can show compassion on the phone and in person” (P14).

Conveying Virtual Compassion through Actions

When describing specific actions that conveyed compassion, participants described 3 inter-related actions: listening, attending to context, and planning. First, participants characterized compassion as listening, with the following FP highlighting the importance of listening in virtual visits as a way of the patient knowing the FP was truly present.

As long as I’m actively listening and resonating with the patient, then the patient must be comfortable, right, because as soon as the patient starts to [feel uncomfortable] there starts to be a disruption of trust... You have to be in the moment; like every moment. (FP5)

A patient highlighted how listening enabled compassion within virtual visits, “If the [provider’s] listening... if the person’s truly listening, they are able to convey that [compassion]. Even if they are on the phone” (P15).

Listening occurred some times to a deeper degree, where the FP would express not just that they were listening but that they understood the importance of the patient’s statements. Patients experienced this virtually as “reassuring” and “validating” (P4) with compassion being, “the willingness to take what I am saying as important and not dismissing. And I’ve been with doctors where they dismiss, and they – that is nothing, nothing to worry about. Like, she never does that” (P14). Participants shared that sometimes listening during a telephone visit meant the FP was comfortable “listening” in silence, “I think most of it was the patience, he just – he let me sit with it [the news of a breast cancer diagnosis]... it was really, really reassuring to me” (P3).

The second activity participants characterized as compassionate was attending to a patient’s context and humanity as well as concerns about medical

issues regardless of mode of delivery. This was reflected by a patient participant's experience that, "*she [the patient's FP] really takes every aspect of my care into each visit*" (P19). A FP participant explained, "*I am really taking my time to understand what they are experiencing, how their health has been impacted, how they may be suffering*" (FP14).

In the third activity, some participants expressed that being compassionate in virtual visits went beyond listening to helping the patient create a plan, and decide on the course of action; "*she validated the fact that I was scared . . . this was brand new territory for me. So she did teaching, reassurance, a plan, asked me how I was coping, ask how my husband was coping*" (P4). Many FP participants described how compassion was demonstrated, regardless of mode of delivery, through their ability to reach a plan of action with patients, even when, as expressed by this FP participant, there are disagreements.

Trying to understand [the] factors that may play into someone else's decision making and being respectful of those. We don't have to agree – we will not always agree, but it is incumbent upon us as physicians to be respectful of everyone that we deal with. (FP4)

Findings from the Collaborative Discussions were consistent with the interviews regarding the importance of listening and attending to context, "*really acknowledge and validate what the patient is going through rather than kind of treating it like facts in a medical textbook*" (CD3). The findings from the Collaborative Discussions expanded listening to include the importance of *attending to patient's cues*.

I find you have to be listening. Your patient drops these little cues and I always want to make a point to follow up on them. . . because I think they're kind of the crux of the suffering. . . they hold things back and they drop these cues and they almost wait for permission to actually explore them more. (CD2)

It was seen as "*especially [important] with telephone appointments to pick up on verbal cues because you do not get the facial ones*" (CD2).

External Factors Supporting or Hindering Virtual Compassion

Within the 3 kinds of actions (listening, attending to context, and planning), participants shared factors that impact whether compassionate virtual care is provided or received. FPs shared that "*it is possible*

to [show compassion] in a virtual visit. But it requires a bit more intention and not to get distracted by things" (FP8). Patients also mentioned how compassion could falter in virtual visits when their FPs appeared to be distracted, "*Just spend a few more minutes listening and paying attention to what [the patient is] saying, because you hear a lot of typing in the background*" (P13). In contrast to in-person visits, because they could not see their FP, patients were not sure in telephone visits if the typing was about them or if the FP was distracted. Another factor hindering compassionate virtual care took place outside the actual visit; that is, FPs not calling at the appointed time. A patient described the stress of waiting, "*[My FP] was not keeping to his time appointments at all. He would – he was just calling when and where he wanted to. And that is what his receptionist told me too.*" (P17). When patients arranged to have a virtual visit in a private or quiet location, this location was not always available to them when the FP ran late; "*[I] did not have a lot of privacy [then]*" (P17). Another participant explained that they had other commitments they would miss by waiting, "*After I waited 2 hours. . . I went on with my day*" (CD2).

The patients in the Collaborative Discussions also spoke about the experience of feeling "rushed" or "dismissed" in virtual visits when the FP was running behind and they were not notified, "*so it is kind of making them [patients] think that you are [family physician] very rushed and you do not have a lot of time to spend with them, and really consider in depth about everything that they say*" (CD3). Participants in the CDs discussed ways FP clinics could keep their patients informed if the FP is running significantly behind for their virtual visit.

When I'm late. . . I just message my staff to call that patient and tell them I'm running behind, which has worked so far. . . I think this line of communication is extremely important, and it is therapeutic for me too, because at least for the next 15 minutes, I'm able to focus with the patient in front of me, instead of being so anxious someone else is waiting for me. (CD1)

Using Virtual Visits to Extend Compassionate Care

During the FP interviews, participants emphasized how offering virtual care could be characterized in certain situations to be in and of itself compassionate. This was supported by a patient during the Collaborative Discussion, "*sometimes even just offering the virtual option can be compassionate too*" (CD3).

This theme was outside of what happens within an interaction but spoke of virtual care as part of the overall care an FP provides. This ability to “*extend care*” virtually (FP12) took the shape of being able to provide more frequent and more immediately accessible visits, “*Perhaps having virtual care means you have more points of access so you can capture these things more often*” (FP6). This could be especially helpful to families caring for a dying patient, “*I had a palliative patient. . . I did. . . home visits. I was able to [also] do scheduled phone calls, mainly for the family; just to provide that support in between. . . see how they are doing*” (FP12). Offering virtual visits could extend care when patients found it difficult to leave the house. A FP participant described how a patient with complex health issues requested video visits:

That made a big difference for him, to be able to see me, and I think he really appreciated the calls – he [said] ‘it’s good to see you doc’ and we could still engage and he liked showing me his apartment and I think that made a lot of difference for him. (FP11)

The offer of a virtual visit created a bridge between in-person visits that provided supportive and compassionate care in particular for vulnerable patients.

I can give them a quick call back to help to ease some of the anxiety they might be feeling about a particular question. . . But when you know the patient and you can just help to alleviate a little bit of anxiety it can go a long, long way. (FP4)

A pre-existing patient-FP relationship could enhance the FP’s capacity to extend compassion through virtual care.

It allows me to kind of extend a compassionate connect and remind them that even though I’m not there, or they’re not coming in, that we – I’m still following them and I’m still wanting to know how things are. I think – so it’s sort of like an extender to an existing relationship. (FP12)

The Patient-FP Relationship as the Bedrock of Virtual Compassionate Care

Patient and FP participants emphasized specifically that the provision of compassionate virtual care was contingent on the presence of a strong patient-FP relationship, “*virtual care is so much easier because they are my patients*” (FP7). In addition, participants

spoke about the importance of the patient-FP relationship regardless of mode of care delivery, “*it is the relationship and the two-way street. . . I guess feeling gratitude following the connection, and that somebody is aware of and appreciates [and] understands that I am suffering*” (P9). Many patient participants highlighted this two-way street by acknowledging the current pressure under which FPs practice with one stating, “*as patients, we have to be compassionate to our doctors as well*” (CD3).

Discussion

Our findings support that it is possible to convey compassion in a virtual visit including telephone interactions. We identified 4 themes, 2 of which emphasized compassion within the context of a specific patient-FP interaction: *Conveying virtual compassion through actions*, and *External factors supporting or hindering virtual compassion*. The third theme highlighted the potential for *Virtual care to extend compassionate care*. The fourth theme reflected how the *Patient-FP relationship is the bedrock enabling virtual compassionate care*.

We characterized these 4 themes as the stance which, at its core, is part of the work that FPs do. This characterization is consistent with the writings of others who stated that foundational components of primary care involve the appreciation of the patient and every interaction within a larger context,²¹ attention to,¹⁹ and empathy for,²² the subjective experience,²³ mindfulness,²⁴ and a willingness to be in the moment with the patient²⁵ and to be present with the patient.^{26–28}

There are best practices available in the literature on providing patient-centered virtual care^{29–30} which discuss technology-related actions such as speaking slowly and pausing to allow the patient to speak. While these are valuable guidelines, we identified specific actions that encouraged compassionate virtual care. In some cases, these are actions that participants believed support compassionate care irrespective of mode of delivery. That we found some actions consistent with what we know about providing compassionate care in person is heartening to FPs who may worry that virtual care requires a new skill set.

The actions demonstrating compassion in virtual care were: (1) listening, (2) attending to context, and (3) planning. Our interview questions did not impose any theoretical framework; therefore, we

were struck that these 3 actions paralleled 3 of the 4 components of the Patient-Centred Clinical Method (PCCM)³¹: (1) exploring health, disease and illness experience (listening), (2) understanding the whole person (attending to context), and (3) finding common ground (planning).³¹ These components were developed within an in-person health care environment, and our findings echo these exemplar in-person practices with participants talking about the need for these actions in FP care regardless of mode of delivery. However, there were particular features of virtual care that merit discussion with respect to listening and context.

Listening took on special importance in virtual visits as a way of making sure patients knew their FPs were present for them in the absence of physical presence. In virtual visits, patients appreciated that FPs used listening to demonstrate reassurance and validation. Further, being willing to wait, to be comfortable listening in silence, was seen as supportive in virtual visits given the absence of nonverbal behavior. Turning to context, our participants spoke of the importance of considering more than just the patient’s medical issue. The need to attend to context was highlighted as particularly important in virtual telephone visits where FPs cannot pick up on visual cues.

While our findings highlighted that compassionate care was possible in virtual interactions, compassion was sometimes *hindered by external factors* (Theme 2). These external factors were often described by patient participants as feeling that

their FP was distracted or running behind. While similar to in-person hindrances, being distracted could be particularly problematic on the telephone when the patient did not have visual cues that their FP was paying attention. Loxterkamp in 1991, described this focus on the patient as “being there”; being “in this place and no other.”²⁸ When FPs address external factors, they can provide compassionate care by ‘being there’ with their patient. In addition, an important distinction was made between waiting for a visit to begin virtually versus waiting in the FP’s office in person. In the case of virtual visits, patients became particularly anxious waiting when their FP was running behind. Patients sitting at home or at work or waiting to attend to other obligations had no way of knowing if and when the FP would call. Unlike in-person visits that may also run behind, there is no one to notice the patient is still in a ‘virtual waiting room’.

We started our inquiry asking how compassionate care can be delivered virtually but participants shared with us that just the *offer of a virtual appointment* (Theme 3) could be characterized as compassionate. Participants often referenced this with respect to caring for vulnerable patients regarding issues such as fear of leaving their home or mental health struggles. Offering virtual visits was seen, not as a substitution for in-person visits, but as an extension of care that offered a compassionate bridge between in-person visits. This is similar to Hedden et al.,³² who found that virtual care

Table 3. Considerations for Family Physicians to Support Compassionate Virtual Care from Our Findings

Theme	Considerations
(1) Conveying Virtual Compassion through Actions	<ul style="list-style-type: none"> • Listen to a deeper degree, expressing that you are listening and understanding the importance of the patient’s statements, using verbal cues and listening in silence • Inquire and attend to a patient’s context and humanity as well as medical concerns, being aware that context may be harder to discern when not seeing non-verbal behavior • Create a plan with your patient as you would in an in-person visit
(2) External Factors Supporting or Hindering Virtual Compassion	<ul style="list-style-type: none"> • Be aware that you may be more easily distracted in virtual visits; remove distractions when at all possible • Verbalize what you are doing and why (e.g. typing notes in the patient chart) when the patient cannot see you • Develop a method to inform the patient when you are running behind • Understand that the patient may have other commitments and if you are running behind, this may cause considerable anxiety for your patients
(3) Using Virtual Visits to Extend Compassionate Care	<ul style="list-style-type: none"> • Offer virtual visits to extend care, allowing more points of access or a bridge between in-person visits
(4) The Patient-FP Relationship as the Bedrock of Virtual Compassionate Care	<ul style="list-style-type: none"> • Use every visit, including virtual visits, as an opportunity to build the patient-family physician relationship

facilitates touching base more frequently with vulnerable populations which can improve continuity of care.

Throughout our study, participants spoke of the importance of the *patient-FP relationship* regardless of mode of delivery. This tells us that every visit – including virtual visits – should be seen as opportunities to build this relationship. Participants shared the belief that the provision of compassionate virtual care was contingent on the presence of a strong *patient-FP relationship* (Theme 4). Consistent with other literature, patient and FP participants often reflected on the ease of providing compassionate virtual care because of pre-established relationships.^{33,34} This is consistent with the fourth component of the Patient-Centered Clinical Method that discusses how compassion displayed by the FP is an essential contributor to enhancing the patient-clinical relationship.³¹

Our findings of compassion as a stance, including concrete actions embedded within a strong patient-FP relationship, suggests that the Patient-Centred Clinical Method can provide a roadmap to compassionate care where the family physician develops an “emotional resonance and cognitive understanding regarding the suffering of a fellow human being [*the stance and the relationship*] that evolves into a desire to alleviate said suffering [*listening, attending to context, and planning*].”¹⁰ Consistent with Stewart et al.,³¹ our findings emphasize that what patients actually require to feel compassion, regardless of mode of care, is the acknowledgment of their suffering and the presence and support of their FP. In Table 3, we offer considerations for FPs that can support them in providing compassionate virtual care.

This article provides a unique contribution to the literature as we study compassion within virtual care by not only seeking input from patients and FPs individually but also bringing them together in Collaborative Discussions. These Discussions helped to integrate and elaborate the findings that arose from the individual interviews. The absence of new data in the Collaborative Discussions could be considered a limitation or alternatively, a triangulation with the interview data in that participants often shared the same themes as those found in the individual interviews. We examined a population – those with multimorbidity –

that may benefit from virtual care because of their vulnerabilities.³² We included patients with multimorbidity based on participants’ self-identification of 2 or more chronic conditions; we had a majority of patients with arthritis and musculoskeletal conditions. While there was some diversity in our participants, the majority were female, and in the case of patients, from one urban center. FPs represented a broader geography in Ontario. We recruited participants through multiple methods including reaching out to colleagues to assist in the recruitment process which may have affected the diversity of our participants. In addition, participants spoke of compassion from their own experiences; we were not present during any of their virtual visits and cannot conclude that what participants said is congruent with what they do. While we studied compassion within virtual FM care, we believe that our findings can be extended to other primary care disciplines.

Conclusion

Our article adds to the literature on virtual family physician care by elaborating the nature of compassion and characterizing it as a stance in this mode of delivery. As virtual care evolves, our findings can support patients and family physicians to safeguard compassion so that it remains a hallmark of care for all modes of delivery. Given how compassionate virtual care has been characterized by patients and FPs, our findings support the use of the PCCM as framework to discuss compassion in future interventions and education on the delivery of virtual care.

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To see this article online, please go to: <http://jabfm.org/content/00/00/000.full>.

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Appendix

Consensus Reporting Items for Studies in Primary Care CRISP Checklist

The CRISP Checklist¹ can help researchers meet readers' needs by including content that the primary care community feels is important for the validity, quality, and usefulness of primary care research reports.

The Checklist summarizes recommendations for authors to consider in crafting their report. Nothing is intended to limit the effective or creative reporting of research. Authors and editors make final decisions.

Primary care research involves a wide variety of methods, study designs, topics, and settings. The Checklist covers this broad spectrum and therefore, not all items apply to all studies. Some items may not apply to your study. Some may ask for information that is not available. Check such items off and use the rest of the Checklist in whatever way helps you improve *your* report of *your* research.

How to use the CRISP Checklist:

- Each item is listed. Please respond to each item, even if it is not included in your report.
- Check if the item is included in your report: yes, no, or not applicable to your study.
- If the item applies to the study design but is not included in the report, please provide a brief explanation in the "Notes" section.
- The "Suggested Section" indicates where the item usually appears in a research report following the IMRaD format (Introduction, Methods, Results, and Discussion). These are suggestions only. If the item is in a different section of your report, you might add that in "Notes."
- You can note the location of the item in your report by line, page, or section in "Notes."

For more information plus an explanation and examples of each item, please see the supplemental guidance in the Appendix to the CRISP Statement.²

You may choose to submit the completed Checklist along with your manuscript to help editors and reviewers see how you have included the suggested items in your research report. Authors should also consider using other reporting guidelines that are appropriate for their study and report. (See Table 2.¹) Some CRISP items may overlap with other guidelines.

For more information, see **CRISP**: <https://crisp-pc.org/>

References:

1. Improving the Reporting of Primary Care Research: Consensus Reporting Items for Studies in Primary Care—the CRISP Statement. William R. Phillips, Elizabeth Sturgiss, Paul Glasziou, Tim C. olde Hartman, Aaron M. Orkin, Pallavi Prathivadi, Joanne Reeve, Grant M. Russell, and Chris van Weel. *Annals of Family Medicine* November 2023, 21 (6) 549-555; DOI: <https://doi.org/10.1370/afm.3029>
2. Supplemental Appendix. Consensus Reporting Items for Studies in Primary Care (CRISP) Explanation and Examples Guide. <https://www.annfammed.org/content/annalsfm/suppl/2023/10/02/afm.3029.DC1/Phillips-Supp-App-Table-2023.pdf>

Reporting Item - 1	Included?			Section*	Notes
	Y	N	N/A		
1. Include “primary care” and/or discipline-specific terms in the title, abstract, and/or key words.	X			I	We have used the term primary care and family medicine in the title, abstract and key words.

Reporting Item - 2	Included?			Section*	Notes
	Y	N	N/A		
2. Describe the study rationale and importance for primary care.					
2a. Explain the rationale for the research question and how it relates to primary care.	X			I	Lines 2-6
2b. Describe the importance or relevance of the topic under study in the primary care setting.	X			I	Lines 2-6
2c. Identify any theory, model, or framework used, and explain why it is appropriate to the research question in primary care.			X	I	We did not use a theory, model or framework

Reporting Item - 3	Included?			Section*	Notes
	Y	N	N/A		
3. Describe the research team’s primary care experience and collaboration.					
3a. Describe the research team’s expertise and experience in primary care practice and/or research.	X			M	Lines 76-86
3b. Describe whether and how primary care patients, practicing clinicians, community members, or other stakeholders were involved in the research process.	X			M	Lines 27-38 describe participant recruitment which included both patients and family physicians. Lines 40-58 describe the data collection process. Lastly, lines 76-82 describe the various background of the research team members; this includes epidemiologists, family physician, and a social work background.

Reporting Item - 4	Included?			Section*	Notes
	Y	N	N/A		
4. Describe the study participants and populations in the context of primary care.					
4a. Use person-focused language to refer to the research populations and participants, or use terms based on patient preferences	X			R	An example can be found on line 27. We have used person-focussed language throughout our manuscript.
4b. If reporting personal characteristics of participants, report the source of the data, the rationale for using it, and the rationale for any classifications used.	X			R	Lines 41-42 and 51-52. Rationale is included in lines 36-38.
4c. Describe the participants and populations in sufficient detail to allow comparison to other primary care patient populations.	X			R	Lines 90-99 describe the participant characteristics as well as Table 1

4d. Specify whether participants have pre-existing therapeutic relationships with the clinical team or are new patients.	X			M/R	Lines 34-35
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Reporting Item - 5	Included?			Section*	Notes
	Y	N	N/A		
5. Describe the conditions under study in the context of primary care.					
5a. Describe whether the condition under study is acute or chronic.	X			M/R	Lines 27-28 include our recruitment criteria that include two or more chronic conditions for patients.
5b. Report how multimorbidity is considered and how it might affect interpretation of the study findings/ results.	X			M	Line 27 demonstrates that our study is focused on understanding the experiences of patients with multimorbidity.

Reporting Item - 6	Included?			Section*	Notes
	Y	N	N/A		
6. Describe the clinical encounter under study in the context of primary care.					
6a. Specify whether the study focus is an isolated clinical encounter or a longitudinal course of care. If it is an isolated clinical encounter, specify whether it is the first visit or a follow-up visit for the condition under study			X	M	This question is not applicable as our study does not focus on a specific condition.

Reporting Item - 7	Included?			Section*	Notes
	Y	N	N/A		
7. Describe the patient care team.					
7a. If care is delivered by teams, describe the team members and their roles.			X	R	This question is not applicable as we are not involved in the delivery of care.
7b. For each clinician category, report profession, specialty, and qualifications.			X	R	This question is not applicable as we are not involved in the delivery of care.

Reporting Item - 8	Included?			Section*	Notes
	Y	N	N/A		
8. Describe the study interventions in the context of primary care.					
8a. Describe interventions and their implementation in sufficient detail to enable the reader to assess applicability in their own setting.			X	M	This question is not applicable as we did not implement an intervention.
8b. Describe any clustering or grouping of patients, participants, clinicians, teams, or practices, and how it was addressed in the analysis.			X	M/R	This question is not applicable as our study did not involve clustering or grouping of participants.
8c. Describe the health care system in sufficient detail to allow comparisons to other systems.	X			I/D	Lines 22-25

Reporting Item - 9	Included?			Section*	Notes
	Y	N	N/A		
9. Describe study measures used and their relevance to primary care.					
9a. Report whether study measurement tools have been validated in primary care populations or settings.			X	M	This question is not applicable as this is a qualitative study.
9b. Describe how the measurement tools used are meaningful to primary care patients and their care.			X	M	This question is not applicable as this is a qualitative study.
9c. Report findings/results to be clinically interpretable by primary care clinicians and patients.	X			R	Lines 103-282 report our findings in a way that can be easily interpreted by family physicians and patients.

Reporting Item - 10	Included?			Section*	Notes
	Y	N	N/A		
10. Discuss the meaning of study findings/results in the context of primary care.					
10a. Discuss implications of the study findings/results for research, patient care, education, and policy with specific focus on primary care.	X			D	This is included throughout the discussion and conclusion sections with examples on lines 253-258 and 275-282.
10b. Discuss the implications of study recommendations on demands and priorities in primary care practice.	X			D	This is included throughout the discussion and conclusion sections with examples on lines 253-258 and 275-282.
10c. Comment on any research processes that might influence the applicability of the study findings/results in diverse primary care settings.	X			D	Lines 271-273 discuss some limitations that might influence the applicability.

*Section: I = Introduction, M = Method, R = Results, D = Discussion