

The Emotional Economy of Healthcare Systems: Understanding Compassion, Provider Well-Being, Emotional Labor, and Patient Experience

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Abstract

Healthcare depends not only on technical competence and resource allocation but also on sustained emotional work. Clinicians interpret suffering, regulate their own emotions, communicate concern, manage uncertainty, and repeatedly attempt to remain attentive under conditions that may either support or deplete these capacities. Existing approaches often separate compassion, emotional labor, provider well-being, and patient experience into distinct research domains. This article argues that their separation obscures a system-level problem: healthcare organizations continuously generate, distribute, constrain, replenish, and receive emotional demands and relational resources. We propose the Emotional Economy Model as a bounded conceptual framework linking organizational conditions, emotional-labor strategies, provider depletion and recovery, compassionate enactment, patient perception, and reciprocal care-experience feedback. The model distinguishes provider intention from patient-perceived relational quality, emotional regulation from compassion, and workforce well-being from assumptions about clinical outcome. It also treats staffing, time, autonomy, digital mediation, professional hierarchy, cultural expectations, and structural inequity as conditions that can alter emotional work rather than as peripheral contextual variables. The framework is intended as a testable conceptual synthesis, not an empirically validated causal model.

Keywords: Emotional labor, Compassion, Provider well-being, Patient experience, Healthcare workforce, Relational care

Introduction

Healthcare systems depend on an extensive form of work that is rarely represented adequately in organizational accounts of productivity. Clinicians must recognize distress, regulate reactions to suffering, convey attentiveness, manage conflict and uncertainty, and remain relationally available across repeated encounters. These activities occur within service conditions that can either enable or obstruct compassionate interaction. Qualitative evidence from healthcare workers and service settings indicates that organizational restrictions, crisis

conditions, and structural inequities can simultaneously intensify caring demands and constrain the conditions under which caring can be enacted [1-3]. Emotional work is therefore neither purely interpersonal nor reducible to an individual professional virtue.

The conventional emphasis on burnout or resilience can further narrow interpretation. Burnout among physicians has been theoretically related to diminished autonomy, control, and meaning within changing labor relations [4]. Broader analyses of burnout and moral injury similarly argue that staffing, workload, organizational priorities, and structural conditions matter alongside individual coping capacity [5]. These perspectives do not establish one universal mechanism, but they challenge explanations that locate emotional strain entirely within clinicians.

This article develops a different conceptual unit of analysis: the emotional economy of healthcare. The term does not imply that emotions can be reduced to monetary

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value or exchanged as fixed commodities. Rather, it describes the patterned generation, expenditure, conservation, restoration, regulation, and reception of emotional and relational capacity across clinical work. Compassion, emotional labor, provider well-being, and patient experience are treated as distinct constructs whose relationships depend on context.

The article proposes that healthcare organizations shape emotional work through the distribution of demands and resources; clinicians respond through heterogeneous regulation strategies; these strategies interact with depletion, recovery, professional identity, and moral conditions; relational behavior is then interpreted by patients rather than transmitted transparently from provider intention; and patient experience can become part of subsequent workforce and organizational feedback. The resulting Emotional Economy Model is explicitly proposed rather than validated. Its purpose is to organize testable relationships while preserving distinctions between association and causation, subjective experience and clinical outcome, individual process and institutional condition, and provider intention and patient reception.

Healthcare as an emotional system

Calling healthcare an emotional system does not mean attributing emotion to an institution. It means recognizing that organizations repeatedly structure the circumstances under which emotion must be perceived, regulated, expressed, and responded to. Job demands-resources theory provides one relevant premise: demanding work can consume psychological and physical resources, whereas resources may support motivation or buffer aspects of strain [6]. Healthcare adds a specifically relational dimension because many demands arise through encounters with vulnerability, pain, uncertainty, fear, conflict, dependency, and loss.

The distribution of these demands is unequal. Some encounters require sustained communication or repeated exposure to suffering; others involve moral uncertainty, high acuity, culturally or linguistically complex interaction, or disclosure of socially sensitive information. Organizations influence whether clinicians have time, continuity, staffing, autonomy, privacy, supervisory support, and recovery opportunities with which to meet those demands. Consequently, compassion cannot be treated simply as a stable amount of goodwill possessed by an individual clinician. A provider may value compassionate care while working in

conditions that truncate conversation, fragment continuity, or repeatedly require emotional suppression. The proposed emotional-system perspective therefore separates three analytical questions. First, what emotional and relational demands are generated by the clinical situation? Second, what resources and constraints shape the clinician's capacity to respond? Third, how is the resulting interaction received by the patient? These questions occur at different levels and should not be collapsed. Organizational scarcity can constrain relational care without proving that an individual lacks compassion; conversely, generous interpersonal intentions cannot compensate automatically for unsafe staffing, discriminatory structures, or inaccessible services.

Structural conditions are especially important because emotional work is embedded within power. Professional hierarchy may determine whose distress is recognized, whose workload is adjustable, or whose judgment carries organizational authority. Patients likewise differ in their capacity to disclose concerns, challenge decisions, obtain continuity, or interpret unfamiliar communication practices. The emotional economy is thus conditioned by resource distribution and institutional arrangements, not simply by personality.

Emotional labor in clinical work

Emotional labor refers here to the regulation of felt or displayed emotion in relation to occupational expectations. It should not be used as a synonym for compassion, empathy, exhaustion, or emotional distress. Longitudinal evidence among newly employed nurses is particularly important because it complicates the intuitive sequence in which emotional labor simply causes exhaustion: emotional exhaustion predicted later surface acting, while deep acting showed different temporal associations [7]. Emotional regulation and depletion may therefore influence one another.

Organizational expectations also matter. Nursing research indicates that display rules are associated with emotional-labor strategies and that these strategies relate differently to caring behavior and exhaustion [8]. Latent-profile evidence similarly suggests that combinations of surface and deep acting are associated with different patterns of well-being rather than forming a single continuum from “bad” to “good” regulation [9]. These findings support strategy differentiation while remaining limited by population, setting, and measurement.

Clinical context can intensify emotional regulation in other ways. Nurses caring for patients with infectious diseases describe intersections among risk perception, professional ethos, moral distress, and emotional labor [10]. Intensive-care evidence further shows that emotional labor, compassion fatigue, and missed nursing care can co-occur in high-demand environments [11]. Such associations do not establish that one produces the others. They instead demonstrate why emotional labor must be interpreted within clinical threat, workload, professional responsibility, and organizational context. Within the proposed emotional economy, emotional labor is therefore a regulatory process. It describes how professionals attempt to bring felt or displayed emotion into workable relation with role demands. Its cost or benefit cannot be inferred solely from the label used for a strategy. The same regulatory act may be protective in one encounter, depleting when repeated, ethically uncomfortable when organizationally imposed, or largely invisible to patients.

Compassion and relational demands

Compassion requires equally careful conceptual separation. Measurement scholarship, patient accounts, and provider accounts show that compassion overlaps with but is not identical to sympathy or empathy [12-14]. It is especially important to distinguish recognition or understanding of suffering from the motivation and relational action involved in responding to it. A healthcare system may therefore demand empathic understanding without creating sufficient time or authority for a clinician to act compassionately. Patient-reported measurement reinforces the importance of perspective. The Sinclair Compassion Questionnaire was developed specifically to capture patients'

perceptions of compassion rather than assuming that professional self-assessment can substitute for recipient experience [15]. Provider-focused research likewise identifies personal, relational, and systemic barriers and facilitators to compassionate care [16]. Qualitative evidence from intensive-care nurses further suggests that compassionate practice is learned through experience, training, ethical orientation, and role modelling rather than functioning only as an immutable trait [17].

Relational demand increases when suffering is complex, uncertainty is high, communication is difficult, or the provider must remain emotionally present while simultaneously managing technical risk. Prospective perioperative research has examined patient-rated clinician compassion in relation to postoperative pain and experience, illustrating that relational variables can be studied alongside clinical and experiential outcomes while still requiring caution about causal interpretation [18].

An especially important boundary is the gap between what clinicians possess or intend and what patients experience. Evidence from physician-patient encounters indicates that clinicians rated as more compassionate at the provider level do not necessarily have patients who report feeling more cared for [19]. Compassion must therefore be analyzed as a relational accomplishment rather than assumed to travel intact from professional disposition to patient perception.

The distinctions developed in this section create a practical decision problem: the same apparent deficit in compassionate care may originate in very different relational states. **Table 1** separates these states so that intervention targets are not inferred prematurely from a single patient or provider rating.

Table 1. Relational demand states requiring different interpretations within compassionate healthcare

Relational state	What is demanding the response?	Where the principal constraint may arise	What can be observed without overinterpretation?	Competing explanation or uncertainty	Appropriate organizational or research implication
Recognized suffering with adequate response capacity	Patient distress, fear, pain, uncertainty, or vulnerability	No dominant constraint identified at encounter level	Attentive communication and responsive action may be perceived by the patient	Patient perception can still differ from clinician intention	Evaluate relational quality from both provider and patient perspectives
Recognized suffering with constrained response capacity	Need is perceived, but time, staffing, continuity, privacy, or authority is limited	Organizational conditions	Clinician may recognize need while providing abbreviated relational response	Abbreviated interaction must not automatically be	Target workflow and resource constraints before assuming an individual deficit

				interpreted as low compassion	
High emotional exposure with repeated relational demand	Recurrent suffering, deterioration, conflict, death, or high-acuity care	Cumulative encounter burden and insufficient recovery	Increased emotional regulation, fatigue, withdrawal, or variability may occur	Effects may reflect workload, moral distress, risk, or nonwork conditions	Assess cumulative demand and recovery opportunities rather than isolated encounters
Compassionate intention with weak patient reception	Provider intends concern or assistance	Communication mismatch, language, trust, culture, prior experience, power differential	Provider and patient ratings may diverge	Neither perspective alone identifies the cause of discordance	Measure intention, behavior, and patient reception separately
Institutionally prescribed caring display	Organizational expectation that emotion be displayed in a particular way	Display rules and role regulation	Surface or deep acting may become more salient	Display conformity does not prove authentic connection or deception	Examine how rules interact with autonomy, emotional strategy, and patient perception
Relational demand under structural disadvantage	Clinical need intersects with marginalization, restricted access, or sensitive social conditions	Institutional and structural power	Greater disclosure difficulty, mistrust, discontinuity, or constrained participation may be visible	Individual “engagement” explanations may obscure structural causes	Treat equity and power as causal candidates requiring direct investigation

Note: These relational-demand configurations are interpretive categories for comparing different forms of emotional work in healthcare. They should not be read as diagnostic labels, severity scores, or ordered stages.

Surface acting, deep acting, and authenticity

Surface acting generally involves modifying outward expression without equivalent alteration of underlying feeling, whereas deep acting involves attempting to change felt emotion so that expression is more congruent with occupational expectations. Their distinction is useful, but it becomes misleading when converted into a moral binary in which surface acting is automatically inauthentic and deep acting automatically produces compassionate care.

Evidence suggests different associations between the strategies and emotional exhaustion, with psychological resilience potentially modifying those relationships [20]. Yet resilience does not remove the organizational conditions generating emotional demands. Longitudinal evidence also indicates that existing exhaustion may increase subsequent surface acting [7], while display-rule research links organizational expectations to strategy selection [8]. A clinician's emotional strategy is therefore partly a response to context, not merely an enduring individual style.

Authenticity should consequently be treated as a separate interpretive question. Deep acting may increase felt-display congruence, but it does not guarantee that a

patient will perceive warmth, respect, or concern. Surface acting may sometimes function as professional regulation during an acutely stressful encounter without constituting deliberate deception. Conversely, apparently sincere feeling may fail relationally if communication is hurried, culturally discordant, inaccessible, or inattentive to patient preferences. Provider-level compassion and patient-perceived caring can diverge [19].

The proposed framework therefore locates authenticity between internal regulation and relational reception rather than equating it with either. What matters analytically is how emotional regulation shapes behavior under particular conditions and how that behavior is subsequently interpreted.

Provider well-being and emotional depletion

Provider well-being is often discussed as the opposite of burnout, yet the emotional economy requires finer distinctions. Emotional exhaustion, burnout, compassion fatigue, moral injury, reduced professional fulfillment, and inadequate recovery overlap but are not interchangeable. A recent meta-analysis of healthcare professionals found relationships among mindfulness, compassion fatigue, and compassion satisfaction while

also showing variation across settings and intervention studies [21]. These constructs describe different aspects of emotional and occupational functioning.

Evidence connecting burnout to quality of care also requires restraint. A large systematic review and meta-analysis found associations between provider burnout and measures of care quality, but heterogeneity was substantial and study designs did not permit a simple universal causal claim [22]. Burnout measurement itself is inconsistent across physician studies, with prevalence estimates varying markedly according to definitions and instruments [23]. Treating “burnout” as one stable quantity therefore risks constructing a false precision. Recovery conditions provide another part of the picture. Among US physicians, working during vacation and insufficient coverage were associated with greater burnout, whereas more protected recovery was

associated with more favorable well-being patterns [24]. These observations do not prove that vacation policy alone causes or prevents depletion, but they demonstrate that nonclinical recovery is partly organized through staffing and work design.

The emotional economy therefore conceptualizes depletion as the possible result of several nonidentical processes: repeated emotion regulation, excessive workload, insufficient recovery, moral conflict, exposure to suffering, low control, professional insecurity, and structural disadvantage. Different pathways can converge on superficially similar exhaustion while requiring different responses.

Table 2 is needed because intervention decisions depend on what kind of evidence supports each interpretation of depletion rather than on the shared vocabulary of “burnout.”

Table 2. Evidence–interpretation crosswalk for emotional depletion in healthcare work

Observed pattern	Interpretation supported by the evidence synthesized here	Interpretation that remains unsafe	Context that should be examined	Consequence for measurement or action
Persistent emotional exhaustion	High demands and regulation costs may coexist with insufficient resources or recovery	Exhaustion proves absence of compassion	Workload, recovery, staffing, autonomy, clinical acuity	Measure demands and resources in addition to exhaustion
Increased surface acting	May be associated with existing exhaustion or organizational display expectations	Surface acting necessarily causes exhaustion or indicates dishonest care	Prior depletion, display rules, encounter demands	Use temporal designs before assigning direction
Compassion fatigue with continued caring motivation	Exposure to suffering may coexist with continued professional commitment	Compassion itself is inherently damaging	Frequency/intensity of exposure, recovery, moral conflict	Separate compassion from fatigue constructs
Burnout associated with poorer care ratings	Workforce distress and care quality can covary	Burnout automatically causes every adverse patient outcome	Measurement method, setting, staffing, reciprocal effects	Preserve outcome-specific and design-specific inference
Low recovery opportunity	Work design may limit restoration of psychological resources	Personal resilience training can compensate fully for inadequate recovery	Leave coverage, after-hours work, workload	Treat protected recovery as an organizational variable
Similar exhaustion scores in different clinicians	Comparable scores may arise through different pathways	One intervention should work uniformly for all depleted workers	Emotional labor, moral injury, workload, autonomy, social/structural conditions	Pair symptom measures with pathway-sensitive assessment

Note: This crosswalk distinguishes evidence-supported interpretations from claims that would exceed the available evidence. It is not a clinical diagnostic instrument.

The resulting distinction is visually important because emotional regulation and organizational demand can produce both convergent and divergent trajectories.

Figure 1 therefore represents depletion as an interaction between two analytically separate processes rather than as the endpoint of a single linear pathway.

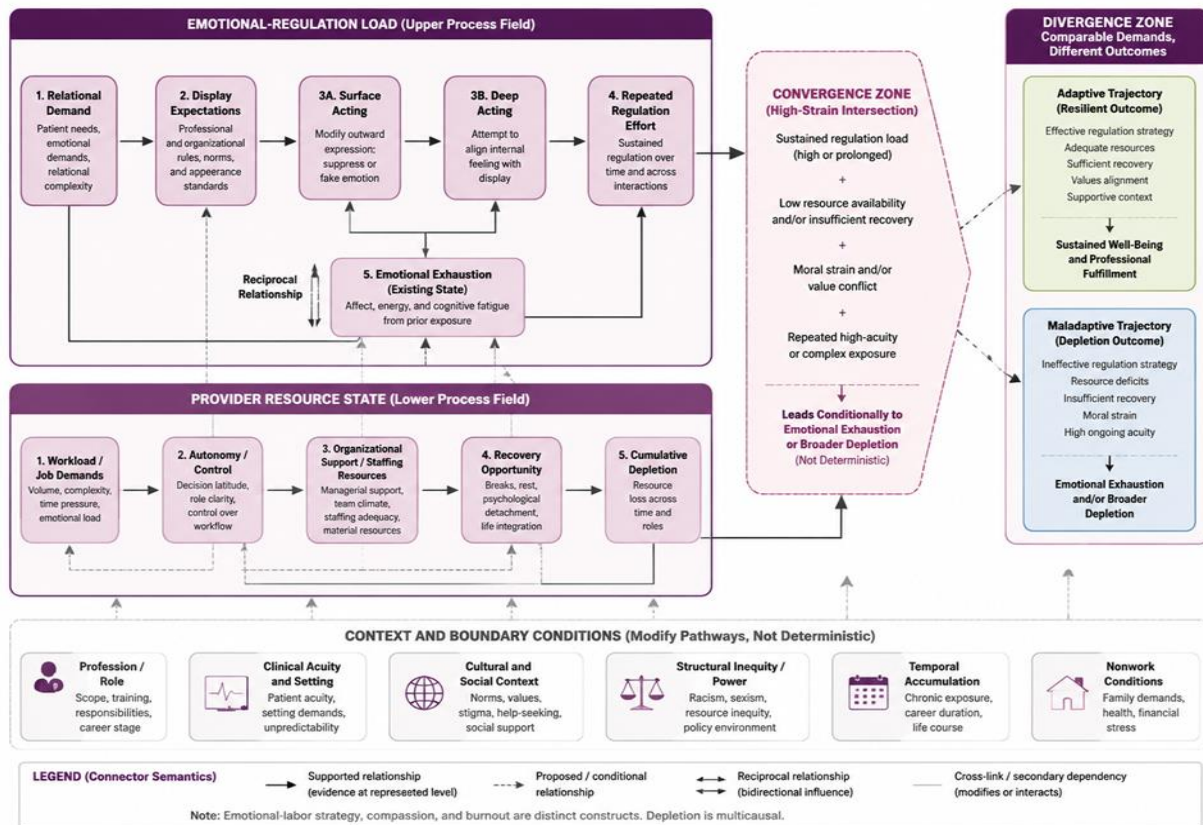


Figure 1. Convergence and divergence between emotional-regulation load and resource depletion in clinical work

Organizational conditions shaping emotional work

If emotional work is treated only as a clinician attribute, organizational conditions become invisible precisely where they may be most consequential. Work-environment evidence from emergency departments shows that nurses and physicians can experience the same organization differently and that less favorable or discordant work-environment assessments are associated with poorer clinician and patient-care evaluations [25]. Organizational climate is therefore neither uniform nor reducible to a hospital-level label.

Technology can redistribute emotional work rather than simply remove it. Studies of large-language-model drafting for patient messages demonstrate that digital assistance can alter communication characteristics, perceived empathy, and clinician workload, while usefulness varies across messages and users [26]. A digitally mediated interaction should not consequently be classified automatically as either emotionally

impoverished or emotionally supportive. Its effect depends on how technology changes attention, editing burden, continuity, accessibility, accountability, and patient interpretation.

Information practices provide another organizational boundary. Patients and clinicians describe distinct concerns when sensitive social determinants of health information is collected or exchanged, including privacy, trust, relevance, and uncertainty about how information will be used [27]. Emotional availability is therefore affected by informational power: asking a patient to disclose hardship may increase relational demand if confidentiality, responsiveness, or meaningful action is uncertain.

Within the proposed emotional economy, organizations regulate emotional work through at least six mechanisms: allocation of time, distribution of workload, protection of recovery, specification of display expectations, design of communication technologies, and allocation of decision

authority. These mechanisms may either support or intensify emotional regulation. Their effects are unlikely to be uniform across professions, cultures, care settings, or groups differently positioned within healthcare hierarchies.

Emotional transmission to patients

The phrase emotional transmission can suggest that clinicians' internal states simply pass into patients. The evidence does not support such a deterministic interpretation. What patients encounter are behaviors and interactional conditions: attentiveness, listening, tone, responsiveness, explanation, continuity, participation, respect, and the practical consequences of how care is organized. Internal clinician states may influence these behaviors, but patient perception is an additional interpretive layer.

Randomized-trial evidence synthesized across practitioner-empathy interventions indicates that enhanced empathy can improve patient satisfaction in some contexts [28]. Satisfaction, however, is not equivalent to compassion, trust, safety, or clinical outcome. Prospective work on anesthesiologist compassion similarly illustrates that patient-rated relational qualities can be investigated alongside experience and pain measures without proving a universal causal pathway [18]. Conversely, the weak correspondence between physician-level compassion and patients' feelings of being cared for shows that clinician disposition cannot substitute for encounter-level reception [19].

Burnout-quality evidence adds another caution. Associations between provider burnout and care-quality measures are heterogeneous [22]. Emotional depletion may affect attention, communication, teamwork, or availability in some circumstances, but organizational problems can also contribute simultaneously to worker distress and poorer care conditions. A third-variable explanation is therefore plausible. Digital systems can

further mediate how emotional communication is produced and perceived [26].

The proposed emotional economy consequently treats transmission as relational translation rather than emotional contagion. Provider states are filtered through behavior, organizational conditions, communication modality, patient expectations, cultural interpretation, power relations, and prior healthcare experience before becoming patient experience. This translation may preserve, amplify, mute, or reverse what the provider intended. The model therefore predicts that interventions aimed only at changing clinicians' internal emotional states will have inconsistent effects unless the encounter and organizational conditions through which those states are expressed are also considered.

Patient experience and relational quality

Patient experience is the reception layer of the emotional economy, but it cannot be reduced to satisfaction. Empathy, perceived compassion, caring, participation, trust, and self-reported health represent different outcomes and should remain analytically separate. Evidence across empathy interventions, patient-centered communication, and caring research shows that relational quality depends on both clinician behavior and the conditions under which patients interpret that behavior [28-30].

Patient-centered communication has been associated with trust through patient participation and preference-sensitive processes [29]. An integrative review of caring similarly indicates that relational experience depends on presence, interaction, time, and surrounding care conditions [30]. Patient-perceived empathy has also been associated with self-reported health status in multisite primary care, although this does not establish that empathy caused better health [31].

Table 3 therefore treats discordance as informative rather than as measurement error.

Table 3. Heterogeneity of relational quality across provider action, patient reception, and care context

Relational condition	Patient-facing signal	Why experience may differ	Principal interpretive boundary	Consequence
Responsive communication	Listening, explanation, involvement	Preferences for participation vary	Communication quality $\neq$ compassion	Measure participation and trust separately
Compassionate clinician intention	Concern and attempted support	Patient may not perceive caring	Provider trait $\neq$ patient reception	Obtain patient-reported measures

High empathy ratings	Feeling understood	Empathy may affect satisfaction without changing clinical outcome	Satisfaction $\neq$ health benefit	Specify the endpoint measured
Caring under resource constraint	Presence may be abbreviated	Staffing, time and continuity alter interaction	Short encounters $\neq$ low compassion by definition	Assess organizational context
Sensitive disclosure	Discussion of social hardship	Privacy, trust and power shape willingness to disclose	Nondisclosure $\neq$ disengagement	Examine informational and structural conditions
Digitally mediated care	Written responsiveness and accessibility	Modality changes timing, tone and interpretation	Digital empathy $\neq$ relational equivalence	Evaluate modality-specific experience

Note: The distinctions summarize evidence-supported heterogeneity while the cross-level interpretation is proposed.

Feedback between workforce climate and care experience

The emotional economy becomes dynamic when workforce conditions and care experience are considered together. Physician recovery outside work has been associated with patient-centered communication through nonwork-to-work enrichment and empathy pathways [32]. Work-environment research likewise connects clinician experiences of organizational conditions with assessments of care quality [25].

These findings do not validate a closed causal loop. Poor organizational conditions could simultaneously influence workforce well-being and care processes, while difficult encounters may themselves increase subsequent emotional demands. The proposed feedback principle is therefore conditional: workforce climate can shape the circumstances of relational care, while repeated relational experiences can alter future emotional workload, professional meaning, and organizational response. Longitudinal multilevel studies are required to determine direction, lag, and strength.

The emotional economy model

The proposed Emotional Economy Model integrates five analytically distinct domains: organizational conditions, emotional demands, professional regulation, relational enactment, and patient reception. Resources such as time, autonomy, staffing, support, recovery, and communication infrastructure condition—but do not determine—how clinicians respond to suffering. Emotional-labor strategies then interact with prior depletion, professional expectations, moral conditions, and encounter characteristics. What reaches the patient is not the clinician's internal state itself but its behavioral and organizational expression.

A second distinction concerns feedback. Patient reception may reinforce meaning and professional fulfillment, generate additional emotional demand, expose relational rupture, or remain disconnected from provider intention. These processes occur across different timescales and should not be represented as a single causal cycle.

Because the model combines constructs usually measured from different perspectives, measurement choices materially affect the conclusions that can be drawn (**Table 4**).

Table 4. Measurement consequences for testing the proposed Emotional Economy Model

Model element	Appropriate evidence source	What the measure can establish	What it cannot establish alone
Emotional demands	Workload, encounter and contextual measures	Exposure conditions	Subjective depletion
Emotional-labor strategy	Provider-reported regulation measures	Reported regulation approach	Patient-perceived authenticity
Provider depletion	Exhaustion, burnout or fatigue instruments	Construct-specific distress	Cause of distress
Compassionate enactment	Behavior or encounter-level assessment	Observable relational response	Stable provider compassion

Patient reception	Patient-reported compassion, empathy, trust or experience	Recipient appraisal	Provider internal state
Organizational conditions	Staffing, autonomy, climate, recovery and workflow measures	Context of emotional work	Individual causal pathway
Cross-level feedback	Repeated multilevel measurements	Temporal covariation and possible direction	Causality without suitable design

Note: The measurement architecture is proposed. Constructs should not be combined into a single index without empirical validation.

Figure 2 integrates these distinctions while retaining the boundaries between organization, provider regulation, encounter behavior, and patient reception.

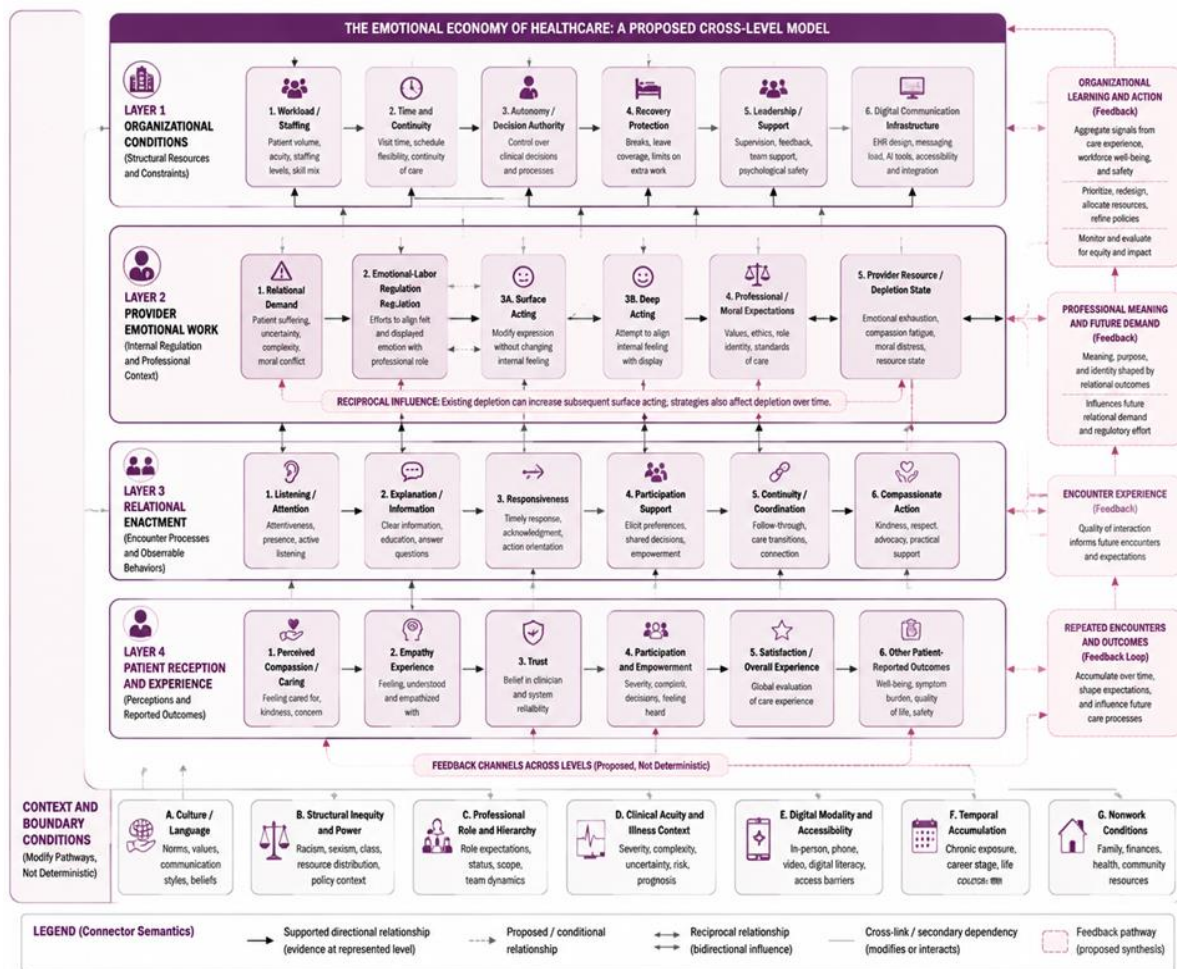


Figure 2. Cross-level circulation, constraint, and feedback within the healthcare emotional economy

Organizational interventions and leadership implications

The model implies that intervention level should correspond to the source of emotional demand. Communication and compassion training can strengthen interpersonal skills, but umbrella-review evidence

remains heterogeneous and does not justify treating training as sufficient system reform [33]. Co-design work with clinicians and leaders similarly supports multilevel approaches incorporating leadership, connection, cultural safety, and structural considerations [34].

Burnout intervention evidence further suggests that organization-directed approaches can produce benefits, although effects are generally modest and context-dependent [35]. Self-compassion should also not be treated as a validated surrogate for compassionate care toward patients [36]. Importantly, a recent cluster randomized trial of peer support found no overall improvement in the primary psychological outcomes, with variation across contexts and participation [37]. Intervention plausibility therefore cannot substitute for evaluation.

Leadership implications follow from alignment rather than universal prescription: protect recovery where inadequate recovery is the problem; redesign workload where demand is excessive; modify rules that unnecessarily intensify emotional regulation; support culturally safe relational practice; and evaluate digital tools for both workload and relational consequences.

Results and Discussion

The emotional economy perspective reframes compassion and provider well-being as connected without making one the simple cause of the other. Emotional labor may contribute to depletion under some conditions, yet depletion can also precede changes in emotional strategy [7]. Provider compassion does not guarantee patient-perceived caring [19], and burnout-quality associations remain heterogeneous [22]. These findings undermine linear models in which compassionate effort inevitably produces exhaustion or worker distress inevitably produces poor patient experience.

The proposed model instead identifies translation boundaries. Organizational conditions shape available resources; providers regulate emotion; behaviors emerge within encounters; patients interpret those behaviors; and repeated experiences may feed back into later work. Each boundary introduces alternative explanations.

The framework also makes equity analytically central. Resource scarcity, professional hierarchy, cultural expectations, language, accessibility, and differential power can alter both emotional demand and the capacity to respond. Treating these influences as individual resilience problems risks mislocating intervention responsibility.

The model remains theoretical. Most contributing evidence is observational, profession-specific, or context-dependent, and no included study tests the

complete architecture. Future research should therefore prioritize longitudinal multilevel designs, repeated provider-patient measures, explicit comparison of competing pathways, construct-specific measurement, culturally diverse settings, and intervention studies that distinguish individual from organizational mechanisms.

Conclusion

Healthcare contains an emotional economy because care repeatedly requires recognition of suffering, regulation of emotion, relational response, and organizational support for those processes. Compassion, emotional labor, provider well-being, and patient experience are connected but not interchangeable. Their relationships depend on how healthcare systems distribute emotional demands, time, autonomy, recovery, communication opportunities, and power.

The proposed Emotional Economy Model organizes these relationships across organizational, provider, encounter, and patient levels while preserving uncertainty and reciprocal influence. Its central implication is not that emotional work should be minimized, but that healthcare systems should understand where it is generated, how it is regulated, when it becomes depleting, how it is translated into relational care, and under what conditions patients experience that care as compassionate. Empirical validation must determine which proposed pathways generalize, which are context-dependent, and which require revision.

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