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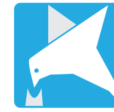

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“More than kindness”

David Haslam

Abstract

Background: Recent high profile cases in the UK have all too often demonstrated care which lacked compassion or dignity, although this is far from being a new phenomenon

Discussion: There needs to be understanding as to why people in the “caring professions” cease to demonstrate care. Compassion fatigue through overwork and excessive demand, and lack of continuity leading to a failure to see the patient as a full human being may all play a part. Support for staff and colleagues is something that everyone working in healthcare can contribute to, and compassionate leaders create compassionate organisations.

Summary: Compassion is not an optional extra, but far too frequently it is seen as being much less important than other aspects of care. There is extraordinary potential for blending the best of evidence-based medicine with real patient centredness, performing medicine with patients rather than doing it to them, to the benefit of all

Keywords: Compassion, Dignity, Leadership, Patient-centredness

As I walked in my Mum was on the bed, on a bed pan, and she was falling off and she was in agony. She had been left like that for over an hour. The nurses’ button which, if you read in the notes, my Mum had said before, please don’t put it out of reach, was left on top of a drip. I struggled to reach the nurses’ button. My Mum was in absolute agony, I can hear her screams now, as I walked into the ward. I slammed the nurses’ button, the emergency button. Nobody came and I ran out and said: please, somebody come and help my Mum. As we went back in with the nurse, they went: “ooh, we’d forgotten about her. I said: “can’t you hear?” And at that point she grabbed my hand and said: please don’t let me die in here… the nurse came that came in said: I am so sorry, we had forgotten about her; yes, she has been there for some considerable time [1]. (Francis Report)

Who can read that transcript from the Mid Staffordshire enquiry in the UK without a sense of absolute horror? Where was the compassion? Where was the care? Stories like this appear all too frequently in the media, but horrifying though they are, there is a real danger that we simply demonise these stories, and demonise individuals–individual clinicians, individual hospitals, individual systems. Indeed, the more we say there was something rotten there, the more we risk failing to recognise the potential for rottenness elsewhere.

The issues are much more complex, and are nothing new. Compassion is an issue that is simultaneously topical and eternal. From prehistory when the first humans began to interact socially, up until today, compassion has been the key to caring relationships. From my earliest days in the medical profession–some four decades ago–I witnessed care that was carried out with great compassion, and sadly I also witnessed care that was anything but compassionate. On my first ever clinical ward round I will never forget a consultant physician gathering a group of students around the bed of a wizened old man and being forced to run through the differential diagnosis of his enlarged liver as if he–the person–wasn’t there. The consultant didn’t ask his consent, didn’t take any notice of his fear when one of us said the liver could be cancerous, did nothing to exhibit an iota of human sensitivity. The Good Old Days were not automatically good at all.

But I felt incredibly strongly–and indeed angry–about this then. And I feel it now. Indeed the issues sometimes mystify me. I am as certain as I can be that the vast majority of people entering the so called caring professions care–there’s a clue in the name. So what happens? I’ve never declared myself to be an expert in the topic, but I do feel passionately about it, and I rather suspect that’s because I’m potentially a very frightened patient.

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My preferred personal definition of compassion is "The humane quality of understanding suffering in others and wanting to do something about it" [2]. There are many other definitions, and whilst compassion may be hard to describe, it's also pretty straightforward. As patients or as relatives, we know when care is being delivered with compassion and when it is not.

Compassion involves demonstrating characteristics such as empathy, sensitivity, kindness and warmth–and when these are lacking, all too frequently one of the factors that underpins poor care is an attitude to care that is task based rather than person centred care. Task based care is frequently impersonal and not what people want. Instead they want to be treated with respect, dignity and compassion, attributes that cost nothing.

So–that is the case, and the solution is obvious, what on earth is going on? How can it be that people can wait an absolute age for pain relief in Emergency Rooms whilst few miss process targets for getting patients seen on time? We can blame the target–but what has happened to professionals who take more note of the target than of compassion? Again–I don't want to demonise. I want to understand.

What do we do to people, to caring young people who enter our professions, that results in their behaving in this way? What are the barriers and facilitators to compassionate practice?

I have no evidence for this, but I wonder if a lack of continuity could be an issue. In hospital, for extremely good reasons, the turnover of patients is extraordinarily rapid. Patients are discharged as quickly as is humanly possible. This is good–it is certainly safer, economically preferable, and almost certainly what the patients want. But there is minimal opportunity for clinicians to see the patient as a real person. When I was a junior hospital doctor, patients stayed in for days and often weeks. I can still remember–after nearly 40 years–patients who were in hospital for several weeks. They were real people to me. It's much easier to be compassionate to someone you get to know as a real person.

You have to be much more skilled to build up caring relationships in a short space of time. A combination of shift work and rapid patient turnover in hospitals means that the doctor or nurse has minimal time to learn about the real human in front of them. If this has been an unintended consequence of an undeniably appropriate change, we need to understand how best to address it. And perhaps allied to this would be the loss of a profound sense of personal responsibility for a patient–if many members of a team see a single patient, perhaps on a shift basis, this could be the perfect recipe for a collusion of anonymity, a phrase first used many decades ago by Michael Balint [3], and which describes the taking of important decisions, without anyone feeling ultimately responsible for them.

And as General Practice has become encouraged to focus on rapid access rather than continuity, perhaps it has affected that area of healthcare too. In the UK, if you ask non-medical friends who their doctor is, the typical answer will now be, "whoever I can get to see". Real personal relationships are becoming harder to form, something compounded by the sheer busy-ness of primary care medical practice. More and more doctors feel under siege, a sense compounded by reading some medical blogs or comments in an on-line forum, which sometimes makes me wonder to what extent clinicians see demanding patients as "them against us". Some practices, some wards, feel beleaguered and threatened. This can trigger a similar dehumanising response.

But that can't be enough–it can't be the whole explanation. It can be part of the explanation, but it can't be an excuse. And remember, when I experienced that first clinical ward round way back in 1970, we had teams, we had continuity, we had matrons, we had no targets, we had absolutely everything that the Daily Mail would now term the good old days–but on an almost daily basis I saw care that lacked compassion. So what was that about?

Research has shown that some medical students may lose the ability to empathise with their patients during clinical training and instead identify with the hero model of the medical practitioner [4]. Students may be drawn to doctors who are authoritative, skilled and effective–the Dr House's of the world (a popular fictional television doctor who is portrayed as lacking sympathy for his patients, a practice that then allots him time to solve complex pathological enigmas, and which was probably inspired by Sherlock Holmes) [5]. They worry that too much compassion can lead to compassion fatigue [6]. They fear if they share their patient's pain, they won't be able to bear it. And so much of this is linked to the very motivations that may have made them want to join the caring professions in the first place.

There are real challenges here for the impact of empathy on compassion. Compassion often flows spontaneously from empathy–the ability to imagine another's experience. The greater the doctor's repertoire of imaginable situations, the more empathic he/she becomes.

Indeed empathy is a trainable quality if we cultivate the habit of self-reflection, and learn from humanities such as literature, film, theatre, poetry which will help us imagine the lives of others. We shouldn't let our essential scientific training get in the way of learning from the humanities–and isn't there such a clue in that word?

What is the solution?

So what is the solution? We can start by valuing compassion, care, and dignity. Regulators and those who set quality standards absolutely have to recognise the absolute

essential importance of these aspects of care. This isn't to denigrate the technical, the simple bio-medical. It is to recognise the fact that these are synergistic–we absolutely need both. Patient-centredness has to be more than a slogan or a mission statement. It has to be real–involving patients, understanding their wants and needs and fears, their ideas, concerns and expectations.

There is extraordinary potential for blending the best of evidence-based medicine with real patient centredness, performing medicine with patients rather than doing it to them. Humanising the individual will be the first step to empathy–the very opposite of the task-based care that risks getting in the way of empathy and compassion. Finding out what matters to a patient, rather than imposing expectations on them, is critical.

Refocusing medicine to be genuinely centred on patients will take time. And while we wait, the caring professions will continue to include professionals who suffer from near total compassion fatigue. What made the nurses at Mid Staffordshire–or indeed any other hospital–change from being caring individuals with a vocation to help patients, to individuals who showed such an utter lack of compassion? Could it be that relentless demands, lack of appreciation for their efforts, an intolerable push for process, procedure, cost-savings; the desperate lack of staff and support, simply drained the capacity of those nurses to respond with care and humanity? We can–and we must-recruit for compassion at the outset–but that compassion needs to be nurtured and retained, or it will very soon wither on the vine.

Role of leaders

There is a strong role for leaders here. Compassionate leaders create compassionate organisations. And individuals can change cultures too. It can be as simple as thanking a colleague, or sharing a compliment. Improving morale must impact on minimising compassion fatigue. It is something every clinician can participate in. We don't have to wait for others.

Teamwork

And it's so easy to get into a way of delivering care that fails to be compassionate. Perhaps we should encourage colleagues to observe each other and point out positive behaviours and challenge negative behaviours constructively and in a supportive way. Discussion on compassion should also be part of clinical supervision as well as appraisal. We all know how important this is–do we ever discuss it? And teams could consider if there are other factors that get in the way of delivering compassionate care such as the stress of workload and discuss how these can be overcome to ensure the patient is central to care.

In his first report on Mid Staffordshire, Robert Francis wrote….

"People must always come before numbers. Individual patients and their treatment are what really matters. Statistics, benchmarks and action plans are tools, not ends in themselves. They should not come before patients and their experiences. This is what must be remembered by all those who design and implement policy for the NHS."

Summary

So, in the end, it all comes down to patient-centredness. And it takes every single person involved in healthcare–from Governments all the way through to the frontline–to remember this. And to behave as if they believe it.

Competing interests
David Haslam has no relevant competing interests.

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