

# The Point of Care

**Enabling compassionate care in  
acute hospital settings**

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## Foreword

The aim of The Point of Care programme at The King's Fund is to improve patients' experience of care in hospital, and to help staff to deliver the sort of care that they would like for themselves and their own families. In December 2008 we published a review paper to launch the programme, *Seeing the person in the patient*, which drew on available published research and our own qualitative research with patients, their families and staff. We were aware that there were subjects that we would have liked to explore more fully but could not do so (either because they were complex, and we could not do justice to them in a short paper, or because good research is scarce). We therefore decided to hold a series of workshops, bringing people who work in hospital together with experts who have either written or researched a particular issue. 'Enabling Compassion,' was the first workshop in the series, and was intended to gain insight into what prevents and what enables compassionate care - a difficult and fascinating subject, and one that we knew needed more in-depth discussion than had been possible in our review paper.

The focus of The Point of Care programme is on care in acute hospitals, and our concern is with all health professionals, including support staff, who are involved with patients and their families. We hoped that the workshop would be the first step towards making practical suggestions for hospital staff who want to provide compassionate care day in, day out.

The workshop was prepared and led by Professor Jenny Firth-Cozens, a psychologist who has written about, among other things, medical training and careers, and the impact of providing patient care on the mental and emotional well being of healthcare professionals and other staff.

The contents of this paper come from a review of the literature on compassion, or concepts related to it, and from views and comments arising from the workshop on this topic held in November 2008. The experiences of workshop members were collected on the day and by anonymous written contributions, and we are very grateful to them for taking part.

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## Introduction

Compassion, in its original translation from the Latin, means 'with suffering'. Compassion is usually expressed towards others, when we experience their suffering – being there with them in some way that makes their pain more bearable. On the other hand, an experience 'with suffering' may indicate that being compassionate is painful for the person expressing it.

Through our review of writing on this subject and the workshop we held, we came to the view that both are true: compassion is a normal human response to suffering but, unless sufficient support is given to the person expressing compassion, it is also a potentially painful experience for them.

## The elements of compassion

*The afternoon that we arrived at the hospice a doctor and nurse came to talk to us. My husband was terminally ill and had just been discharged from three dreadful weeks in hospital where he'd been given procedures without us quite understanding why, had been left for an hour in excruciating pain, and had been starved for days on end because he dropped off the list day after day. He was so much worse now so a hospice was suggested and we'd gone there reluctantly just to get his medication right. I could see he wasn't going to be very welcoming to another doctor at this stage. But she asked about him, not about his illness: what had he done for work, what did he enjoy now, what did we do together. Gradually he seemed to grow back into the large, active, witty man he'd been. She spent all the time he needed, she answered his questions honestly, she allowed silence, and she addressed the whole man – the one he was as well as the one he had become. It was a generous, kind and honest conversation with lots of laughter as he entertained her. He stayed in the hospice till he died. (Workshop participant)*

Compassion includes 'empathy, respect, a recognition of the uniqueness of another individual, and the willingness to enter into a relationship in which not only the knowledge but the intuitions, strengths, and emotions of both the patient and the physician can be fully engaged' (Lowenstein 2008). A simpler definition is that it is 'a deep awareness of the suffering of another coupled with the wish to relieve it' (Chochinov 2007). When the NHS Constitution (Department of Health 2009) discusses compassion, it states: 'We respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for those we serve and work alongside. We do not wait to be asked, because we care.'

Compassion – both giving and receiving it – entails an emotional response. It goes beyond acts of basic care and is likely to involve generosity – giving a little more than you have to – kindness, and real dialogue (Frank 2004).

'Real dialogue' is a vital part of compassion and of good care in general. It is more than communication, which is the accurate giving and receiving of a message. It is spoken human to human rather than clinician to patient; it shows interest; never stereotypes but recognises and enjoys difference while also appreciating the common core of humanity; it includes honesty where necessary, and may need courage at times. This form of dialogue is crucial if the patient is to be seen as a whole person and should be engaged in by staff at all points of health care.

## The effects on patients

*The patient, though conscious that his condition is perilous, may recover his health simply through his contentment with the goodness of the physician. (Hippocrates)*

Patients interviewed about their health care experiences frequently ask 'where has all the humanity gone?' (Petit-Zeman 2006) and those who are dissatisfied with the care they

received often point to the lack of compassion given. When patient satisfaction is viewed as an outcome, then compassion clearly matters.

In a review of literature on the placebo effect, Turner *et al* (1994) concluded that 'the quality of the interaction between physician and patient can be extremely influential in patient outcomes...' Although evidence about the effect of compassion per se is rare, there are various studies which suggest that it can affect the quality of treatment; for example, patients talk more about their symptoms and concerns, yielding more accurate understanding and diagnoses when the caregiver shows empathy (Epstein *et al* 2005). Other clinical studies show that anxiety and fear delay healing (Cole-King and Harding 2001), and so any actions which reduce anxiety, such as compassionate behaviours (Gilbert and Proctor 2006), are likely to benefit outcomes. In a study that directly considered a form of outcome, Rendelmeir *et al* (1995), assigned frequent attenders in emergency departments to compassionate care or normal care. 'Compassionate care' consisted of volunteers explaining their role, establishing rapport, and spending time listening attentively, and 'normal care' was the usual care in the emergency department when volunteers were not there. Although the researchers did not assess clinical outcomes, they found that the group that experienced compassionate care had fewer repeat visits and were more satisfied with their care than those who received 'normal' care.

### **Assessing compassion**

The emotional side of compassionate care is something felt by both the carer and the patient, and so it needs to be measured, at least in part, through reports of their experience. However, actions – such as the touching of a patient's hand, greeting them with a smile or by making eye contact; or a dialogue where the whole person is recognised and responds – may be captured in observational /ethnographic studies and taken as proxy indicators of the emotional interaction.

*I had a call in the middle of the night [that my mother had worsened.] I travelled through the night. I got to the ward and staff were looking out for me. They saw me and I knew by the nurse's face my mother had died. She was in a quiet room; I was asked if I wanted someone with me but asked to be alone. She was clean, her hair was brushed, she wore a fresh nightgown and a red rose had been placed on her breast, a bible at her bedside. I was so glad these things had been done. (Workshop participant)*

Other actions, seen as 'the little things' are, as Smith (2008) points out, important aspects of care: making sure patients are helped to the toilet when needed; making sure patients have their glasses clean, their hair washed, their hearing aids switched on, their teeth in. Whether these are classified as providing dignity or respect, these small actions are part of compassionate care and they matter.

### **What stops compassion?**

It appears that there are factors at different levels which prevent compassion and compassionate behaviour: for individual members of staff; in teams and units, and at the level of the hospital as a whole. Most of the research and writing about compassion is concerned with the individual level.

#### **1. The values instilled in clinical training**

*We were looking after an elderly female patient who was due to go home. We were all intimidated by the consultant – academia came before compassion or care with him. I had presented the patient to him, along with our plan. He approached her and, without introducing himself, taking much history or examining her, he told her that she would not go home and needed further tests. He walked away at this, instructing me as he went on the tests to be arranged, and leaving the patient in tears. I had to follow him to listen to my*

*instruction and so was unable to stay and explain things to her. At no time could I do as I would have chosen.*

The quotation illustrates, and research evidence confirms (Wear and Zarconi 2008), that treating patients without compassion can be upsetting for professionals. Educators consider that most students enter health care because they want to make things better (Wear and Zarconi 2008 ; Lowenstein 2008) but during their training become less empathic and more distanced from patients. Maben *et al* (2007) found that newly qualified nurses have a coherent and strong set of espoused ideals around delivering high-quality, patient-centred, holistic and evidence-based care. However, within two years in practice the majority of these nurses experienced frustration and some level of burnout as a consequence of their ideals and values being thwarted. Among nurses who took part in the research, this led to disillusionment, 'job-hopping' and, in some cases, a decision to leave the profession (Maben *et al* 2007).

Although compassion is regarded as important to the ethos of most health care professions, and features to some extent on most curricula, the core of teaching, training and practice, certainly within clinical medicine and increasingly in nursing, adheres to the biomedical model. Effective clinical care is clearly fundamentally important, but human aspects of medicine and care must also be valued in training and in terms of career progression. Without this, there is always a risk that the emphasis on professionals developing the necessary ability to detach themselves from the patient's distress and personal circumstances risks strengthening an (undesirable) objectification of patients. Curbing the inclination trainees sometimes have to over-identify with the patient, has to be balanced by a recognition of the importance of empathy (Shapiro 2008).

The biomedical model explains and focuses on disease in scientific, pathological and physiological terms, and undoubtedly accounts for spectacular advances in health care. However, workshop participants argued strongly for greater weight to be given in the course of professional training and education to psycho-social aspects of care, in order to foster and support clinicians' capacity to 'see the person in the patient' and engage fully with him or her in a compassionate way.

## **2. A fear of distress and dying**

The experience of illness and human suffering can arouse a primitive and unconscious fear of disease and death that is particularly apparent in modern, industrial, secular societies. In the environment of the acute hospital, untreatable and terminal illnesses, disfigurement, suffering, and pain of loss for patients and families, can arouse such fears in staff, resulting in distancing and avoidance, eroding and making it more difficult to feel and show compassion (Shapiro 2008).

This account, from a 57-year-old patient with malignant mesothelioma, who is a GP, shows how even humour is sometimes used inappropriately to deny the seriousness or hopelessness of a patient's situation:

*I went down for a chest X-ray having been so invited by the nurse on duty thus: 'Could you get this young man to go down for a chest film when you're finished?' My guess is that the nurse was about 22 years old. ... Please, can we avoid crass attempts at humour? There is nothing funny about clutching a plastic bag with all your clothes in, except your pants, socks and shoes – just stop and think what that must be like – while trying to secure a hospital gown around you, and following, like some faithful gun dog, a radiology attendant who without introduction commands you, with a smug grin, acknowledging his witty lack of grammar, to 'Follow !!'*

In the right place, at the right time, humour can be part of compassionate care. But humour is complicated, and it can be used by staff unhelpfully, to distance themselves from patients and reduce their own fear, calling patients derogatory names and using cynical humour about people who are, for example, obese or addicted or elderly (Wear *et al* 2006). These fears and distancing

may well be adaptive from times when disease, distress or death were – and sometimes still are – signals of danger and a need to escape. If this is the case, they will inevitably influence staff behaviours unless they are given the means and the support to reflect on and withstand their fears, and so remain in touch with what patients are experiencing.

The problem lack of compassion creates for patients is obvious, but there is also a cost for staff who cut themselves off from the feelings from which empathy and compassion could flow – especially important as, with support, higher empathy is related to lower stress (Latif *et al* 2008).

### **3. Stress, depression and burnout**

*I went to work on an elderly ward where patients died daily and there was great pressure on beds. At first I did all I could to make the lead up to a death have some meaning and to feel something when one of them died. But gradually the number of deaths and the need to strip down beds and get another patient in as fast as you can got to me and I became numb to the patients; it became just about the rate of turnover, nothing else. (Workshop participant)*

Self-reported stress of health service staff in general is considerably greater than that of the general working population: around 18 per cent of the British workforce suffer above threshold symptom levels on the General Health Questionnaire, compared to an average of 28 per cent for health service staff (Wall *et al* 1997), with some groups of nurses, doctors and managers being particularly at risk. Depression levels too are high (Caplan 1994). The causal relationship between the emotional work and stress of caring for patients and rates of depression in health care workers is not known. But depression and high stress affect the performance of staff in a variety of ways (Firth-Cozens 2001) through the resulting difficulties in memory, decision-making, concentration and irritability, and the links to the abuse of alcohol and other drugs. With depression in particular, people withdraw, perhaps for their own emotional protection, and the uniforms, procedures and targets of modern health care provide ample barriers to retreat behind (Menzies-Lyth 1998).

Burnout is similar to stress, consisting of the three key areas of a lowered sense of personal effectiveness, emotional exhaustion, and depersonalisation (developing negative perceptions about patients) (Schaufeli 1999). Depersonalisation is the area that is most likely to limit compassion or, worse, produces cruelty in dealings with patients.

#### *The causes of stress and burnout*

##### 1. Individual causes

Stress and depression is evidenced by high self-criticism (Brewin and Firth-Cozens 1997); a lack of compassion towards oneself is likely to work its way through to a lack of compassion towards patients (Gilbert 2009).

Making errors is a major stressor for health service staff, and there are links between error, stress and compassionate care. For example, a number of people have found that distressed, burnt-out or depressed young doctors make more errors than those who do not show these symptoms (West *et al* 2006). Distressed clinicians are also more self-critical (Firth-Cozens & Morrison 1989) and so less likely to show compassion to themselves or to others (Gilbert 2009). Moreover, making a mistake leads to lowered empathy (West *et al* 2006); this can lead to a cycle of burnt-out health care staff being less compassionate and more likely to make errors, which in turn makes them even less compassionate and so less likely to respond well to the patient concerned. This cycle that needs breaking at any one of several points, including interventions directed at self-criticism and distress.

The emotional labour of health care – ‘the induction or suppression of feeling in order to sustain an outward appearance that produces in others a sense of being cared for in a convivial, safe place’ (Hochschild 1983) – can be a source of stress in itself. Smiles and ‘little things’ are seen as necessary for good-quality care (Smith 1992, 2008), but if they become part of your job

description, expected of you and even assessed,: you might do the smile and the greeting, but actually be feeling irritable and impatient. If your behaviour is at odds with your emotional state – if you are simply acting being kind – then you are more likely to become emotionally detached from those around you and from your own feelings (Brotheridge and Grandey 2002) and suffer burn-out (Gross and Levenson 1997) . The more you act in ways different to how you feel, the more burnt-out you may become, which in turn can make you feel more negative towards your patients. Psychoanalytic theory also captures the problems of kindness as an obligation rather than a desire: Phillips and Taylor (2009) tell us: ‘Ordered to be kind, we are likely to be cruel; wanting to be kind we are likely to discover our generosity.’

Burnout in health service staff is more likely in: younger staff with less work experience; those with lower self-esteem; and those with less resilient personalities. They have more unrealistic job expectations, high dissatisfaction and increased intention to quit (Schaufeli 1999).

## 2. Quality of teamworking

The characteristics of a good team are well established.

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| Its task is defined and its objectives clear  |
| It has reasonably clear boundaries and is not too large (ideally fewer than 10 people)                              |
| Its members know who leads it and the leadership is good  |
| There is participation in decision-making by all members, good communication, and frequent interaction between them |
| It meets regularly to review its objectives, methods and effectiveness  |
| Its meetings are well conducted   |
| Its members trust each other and feel safe to speak their minds   |
| There is a shared commitment to excellence of patient care  |

Studies have shown that members of good teams have lower stress levels (Carter and West 1999). Although most health service staff see themselves as working in teams, data from the national staff surveys show that a large proportion of them work in ‘pseudo-teams’; that is, the staff say they are in a team, but the team does not match the criteria above. The lower the number of criteria that are met, the stronger the association between team members making errors, and the more results for the organisation as a whole show lower quality of care, worse use of resources and higher patient mortality. The shift from uni-professional hospital teams, such as a medical firm or a nursing team, to team-based medicine and multi-professional groups working together within the same clinical area, poses exceptional demands on team leaders in particular, and teamwork skills more generally.

## 3. Organisational causes

Although individuals differ in their capacity to withstand stressful jobs, health care organisations vary considerably in the levels of stress they induce. In a study of levels of stress in young doctors in their first postgraduate year in London hospitals, it was found that these varied considerably, with no relationship to hospital size, or whether it was modern or old.<sup>1</sup> (Firth-Cozens 2005).

The job-related causes of stress and burnout at work – both in health service jobs and beyond – are manifold, but the known principal causes are: high workload, time pressures, low autonomy and participation in decision-making, role conflict, lack of social support, and lack of feedback. In relation to health levels of stress and burnout experienced in healthcare in particular (Schaufeli, op cit) the factors identified, most frequently are: high patient contact and contact with patients with severe problems. One study found that working on

<sup>1</sup> General Health Questionnaire (GHQ12) scores (maximum of 36) varied from 8.1 (within the normal range) to 15.3

overcrowded wards (bed occupancy of 10 per cent or more above the recommended top limit for six months) was linked to antidepressant use by doctors and nurses; and the higher the bed occupancy of the ward, the more likely the use of antidepressants (Virtanen *et al* 2008). Moreover, higher patient workload was found, with burnout, to link to compassion fatigue (Udipi *et al* 2008).

Participants at the workshop felt strongly that staff stress from organisational causes was a major factor in reducing compassionate care but had much more difficulty identifying effective organisational strategies for responding to this well-known problem (Firth-Cozens 2003).

#### **4. The wider hospital context**

The ways that hospitals deal with fears of death and dying have been well described by Menzies-Lyth (1988). She outlined how the division of labour on in-patient wards, nursing routines and uniforms provide forms of distancing and the means of keeping patients as the 'Other'. Although some of these aspects of the organisation of care have improved since she wrote, very high and sustained levels of activity, rapid throughput of patients and shorter lengths of stay in hospital can have detrimental effects. The workshop provided a number of examples of ways in which these changes, partly externally driven and partly internally, affect staff and potentially reduce compassion

- The attention senior managers and boards must give to achieving financial balance and meeting national targets deeply affects the priorities and behaviours of staff throughout the hospital. If finance and productivity are perceived as being the only things that matter it can have profound negative effects on the way staff feel about the value placed on their work as care-givers. This makes it more difficult to cope with the inevitable emotional and psychological demands of the job.
- Reductions in bed numbers and very high occupancy rates, combined with efforts to improve productivity and patient flow results in patients being moved between wards. This makes it more difficult for staff to get to know them and their needs, and continuity of care suffers. Staff too are often peripatetic and so are less likely to feel part of a team, and less likely to feel supported.
- For a variety of clinical, economic and quality reasons, hospital stays have reduced in length dramatically. This means more in-patients are seriously ill and yet individual staff have less time to get to know them. This and the increased bed turnover also mean that burn-out in staff is more likely.
- Specialisation in all professions has become narrower and narrower, making it more difficult for staff to see and relate to the whole person.
- The physical tasks of washing patients, helping them to get comfortable, providing personal care and helping them with eating and drinking all take time, and are increasingly delegated to staff with the least qualifications and lowest status in the hierarchy. By implication, spending time with patients is devalued, so that nurses say they are made to feel guilty if they do this when there are 'more important' things to be done.
- Meals in many hospitals are not available for patients after 5pm. This means that patients who have had procedures requiring nil by mouth will often not be fed that day.
- Risk management regimes that, for sound safety reasons, require two members of staff to sign off pain control can result in unacceptable delays in meeting patients' urgent needs. If two members of staff are not in the area at the same time, patients can be left to suffer for long periods in intense pain.
- Care is increasingly protocol driven and reliant on technology. While these innovations have improved aspects of clinical effectiveness, compassion can sometimes be forgotten.

It may be that, when the protocol or technology is absorbed into more automatic practice, staff are able to adhere to it without affecting their interactions with patients. However, before this happens staff getting to grips with new protocols and technologies may be so absorbed in the mental processing required, that they forget the type of person-person dialogue and recognition necessary for compassion.

## **Enabling compassion**

In the review paper written to inform the development of The Point of Care Programme (Goodrich and Cornwell 2008) a framework for interventions to improve patients' experience of care is suggested. It has four levels at which efforts for improvement can be made the level of: the individual (which will affect one-to-one relationships between staff and patients); the group or team; the whole hospital; and the wider health care system.

### **1. Teaching compassion**

#### *The professions, training and education*

The health care professions have a role to play in increasing compassion in health care. While medical training now focuses on aspects of care that are important in establishing a good relationship with patients, training in other professions, particularly nursing, has become more academic, with a focus increasingly on the physical aspects of care, and old values may have slipped away in the process (Hudson 2008).

Many aspects of compassion described in this paper exist in the Nursing and Midwifery Council's code of conduct: treating patients with kindness and consideration, not discriminating, being honest and collaborative. The General Medical Council's *Good Medical Practice* lays down that patients should be treated as individuals, with respect and dignity, politely, honestly and considerately to establish and maintain a good relationship. The professional regulators can and should provide significant leadership in relation compassionate care; talking explicitly about what is not acceptable in terms of conduct, attitudes and behaviours; and setting standards.

Most medical and nursing courses tend to teach about empathy and compassion in some way or other, often as part of psycho-social courses or ethics. Young doctors in particular report that these subjects are seen as somewhat irrelevant because they perceive an emphasis on clinical teaching as the thing that matters most, both academically and clinically (Wear and Zarconi 2008). In nursing, educators attempt to select those with compassionate traits, but lament that altruism wanes towards the end of nurse training (Johnson 2008).

In fact, many staff come into health care with the compassion that they have learnt from their parents and other family members, and it has been suggested that some of the ways that we teach our students actually reduce this. In a study that asked students how their medical education had fostered compassion (Wear and Zarconi 2008), one student wrote: '...with every test score posted...it was a constant reminder that competition and personal gain were the essence of medical school. Knowledge to succeed in medical school was the "end all", not knowledge to help people battle diseases and decrease suffering.'

At our workshop one junior doctor told us:

*It's part of what is seen as soft and fluffy. People ask 'Is it on the exam?' and of course it isn't so it's hard to see it as important. Where it is judged, it's like a tick-box exercise – a mark for shaking hands, for saying your name...'*

Nurse education too has changed, with conduct and interpersonal aspects of care now put in second place behind the more technical factors (Johnson 2008). Workshop members pointed

out that nowadays nursing students are no longer part of the workforce; they are not integrated into the team and it is difficult to be clear about who is leading their learning. The use of simulation in both nursing and medical training is increasingly common and undoubtedly necessary. However, it remains even more important to ensure that this is complemented by experiential learning that focuses on the staff–patient experience (Hanna and Hins 2006).

It seems very unlikely that people in other frontline roles, such as porters and receptionists, are selected for or taught about compassion, nor supported in behaving compassionately. After the Omagh bombing, it was management, administration and cleaners at the local trust who suffered some of the highest levels of post-traumatic stress disorder, but perhaps felt they had less right or opportunity to admit to their distress (Luce *et al* 2002). Managers at the workshop felt that it was difficult for them to show compassion to frontline staff, but it was acknowledged frontline staff often had less opportunity than clinical staff to deal with any emotions that arise from interactions with patients or carers.

### *Getting close to the patient*

If we are going to use education to facilitate compassionate care, then the more traditional teaching methods may not be the best way to do it. Our workshop offered positive experiences of enabling discussion in the area. For example, the use of real patient stories was seen as powerful, particularly if the patient was actually speaking. From personal accounts of illness and care written up in a variety of journals, it is clear that doctors change their attitudes and recognise the importance of emotional care once they have been patients themselves. Health professionals who have been patients, or who have had someone close as a patient, might play a useful role in leading discussions on what could have been different.

*I doubt there is a more distressing experience for a health professional than seeing a loved one in excruciating pain within a system with the resources to treat that pain rapidly, but where no one is willing to take responsibility for the necessary steps.*  
(Youngson 2008)

Our workshop gave examples of practical ways to expose trainees to the realities of being a patient; for example, in Nicaragua, young health care students adopt a patient and the patient's family and follow them through their home life and the ups and downs of their illness, take them to their appointments, and so on. In this way, they can become aware of when care is good or communication is poor, compliance with treatments is difficult, or compassion is missing. Other suggestions would be using role play, or for managers and others to spend a whole day with a patient or spending time observing a ward in detail.

### *Role models*

Role modelling compassionate care is a vital way of demonstrating its importance to younger staff and peers. Although the aspects of care that are being modelled are often subtle, they are still recognised by the other person, perhaps because as humans we are adapted to give, receive and benefit from affiliative behaviours such as holding, stroking, voice tone and facial expressions (Gilbert and Proctor 2006). For example, a student remembered 'a surgeon who holds his patient's hand while she undergoes anaesthesia, ensuring that his face and voice are the last comforting sensations she experiences before surgery' (Wear and Zarconi 2008). In fact, studies of good role models show that their important qualities include compassion and integrity as well as clinical competence and the emphasis they place on the importance of the relationship with the patient (Paice *et al* 2002).

Role modelling compassion and good supportive behaviours towards the trainee is also likely to be important in terms of allowing that trainee to show compassion to himself or herself as well as to patients. If staff stress and burnout are major barriers to this flow of compassion, then it becomes essential that staff too are shown affiliative and supportive behaviours; for example, that they get time to eat their meals, have pressures lowered after a night on call, that there is an awareness of their life events, so social support is increased where necessary, and that both positive and negative feedback is given where appropriate and constructively. While

warm, compassionate behaviours lower stress levels (Gilbert and Proctor 2006) shame and negative evaluations by others are likely to induce cortisol stress responses (Dickerson and Kemeny 2004). Like high stress levels, a lack of compassion too flows through teams and organisations rather than just occurring in occasional dyads; the opposite is also true – providing kindnesses to staff will enable more to reach patients. The increasing use of trained mentors is likely to go some way towards this.

The problem with role modelling as a form of teaching is that bad role models may be equally as if not more powerful. In Wear and Zarconi's study (2008), just as many students wrote about negative role models as positive ones. While many trainees will use these people as examples of what they do not want to become, others may emulate them. For example, Sinclair reports that trainees are attracted to those with status rather than those who work inter-professionally, sharing their power, and looking behind the clinical symptoms of the patient (Sinclair 1997). Perhaps the recognition that certain seniors make better role models could be used to make that aspect of training rewarding in terms of status, alongside recognising and providing training to those who appear to model the wrong behaviours.

### *Assessment and feedback*

Assessment is an important part of training, and we perhaps need new ways to assess compassion. Perhaps the only way compassion can be assessed is by asking the patient if they feel it was given. The regular use of such an assessment with constructive feedback throughout training and even beyond would be a powerful way of keeping compassion on the agenda for both staff and patients alike. The most important concern in terms of teaching is to avoid the one-off course or discussion, but to integrate it into the whole of health care.

## **2. Dealing with staff stress and burnout**

There are many ways of addressing staff stress individually, providing preventive strategies such as regular support groups, taking time out, or stress management workshops. These workshops teach staff effective coping strategies such as relaxation, mindfulness training (Shapiro *et al* 1998) and cognitive restructuring, as well as ways to listen to their own bodies in order to recognise what effect different aspects of the workplace are having on them. These preventive interventions lie alongside secondary ones such as counselling and occupational health services and will in turn help to improve patient care (Jones *et al* 1988).

### *Group work*

As we described earlier, attempts to deny or distance yourself from an unhappy experience is a poor way of coping with stress; tackling problems and talking about them are associated with lower stress levels (Koeske *et al* 1993). A series of studies show that speaking about traumatic events has strong physiological effects, improving both mental and physical health (Pennebaker *et al* 1988). The regular support of a group of colleagues who face similar situations can be an ideal opportunity to speak out about traumatic and difficult encounters and dilemmas faced recently (Macpherson 2008). The benefits appear to come not only from the actual speaking, but also in the feedback and discussion that follows, which help to put the event into context or to reinterpret its meaning in some way. Although the experience of compassion can cause pain, given enough support it can also lead to psychological well-being (Post 2005).

Such groups have been shown to be beneficial over many years, although the numbers participating in them are relatively low. In the United Kingdom, **Balint groups** were introduced for general practitioners in the 1940s and emphasised the importance of the doctor–patient relationship in terms of the benefits to patients, but also were a means of group members being able to get away from their normal stoicism and repression of emotions. In the United States, and now spreading to England the **Schwarz Center Rounds** perform a similar role and are available for all staff within a health care organisation. They are monthly multidisciplinary forums in which staff reflect on important psychosocial issues faced by patients, their families and their caregivers, and gain insight and support from colleagues.

What this does is to tackle the fears and conflicts that cause repression of emotion and distancing that are the result of the biomedical model used alone; they provide role models who can discuss their decision-making processes in depth; and they provide an effective means of stress reduction in allowing staff to talk about difficult situations. The multidisciplinary nature of these groups may increase solidarity between the professions so that organisational and political practices that affect care negatively can be more effectively challenged. Even after our first workshop, several members reported that they felt re-inspired by the discussions and openness of others at the workshop.

### **3. The team**

For the sake of patients and of staff, teams need consistent and stable membership and to meet as many of the criteria of 'good teams' outlined above (see p 7) as possible (Carthey *et al* 2003). Good regular interactions between team members are especially important. These allow members to know when colleagues are experiencing difficulty within or outwith the workplace, and can support them over difficult times and so improve performance (Firth-Cozens and Moss 1998). Teams can make rules about simple caring actions for members such as ensuring lunch breaks and providing social situations. There was an argument too, made by workshop participants, that a team can compensate in terms of compassion for the shortcomings of one of its members – for example, someone who may have particular difficulty in showing it. However, the earlier quote shows that those who feel the need to compensate are often distressed at the lack of compassion shown by their colleague.

### **4. The organisation of hospital care**

The factor that has arisen again and again in terms of producing stress and reducing compassion is the heightened bed occupancy within hospitals. As hospitals cope with increasing patient demand and higher levels of throughput, it becomes even more important to address humanity within the process, dealing compassionately with staff so that they in turn can do the same for patients. There is of course nothing wrong per se with technically focussed, rapid treatment, high-turnover, and short lengths of hospital stay – only a minority of patients would willingly prolong their stay in hospital – but it is important for compassion to be seen and valued as essential to the delivery of care, not an option or an add-on. There are a number of possible solutions.

- There must be formal recognition from team leaders and supervisors that staff need time to mix and discuss with each other and to have real dialogue with patients.
- Teams and team leaders should be trained and supported to enable them to deliver more compassionate care.
- Explicit recognition and reward should be given for providing compassionate care. Staff greatly value managers' appreciation and thanks for their contribution, especially when they succeed in retaining their compassion towards individual patients in difficult and pressured circumstances.
- Boards can elect an executive and a non-executive director to take a special interest in the humanity of care and support for staff. They can also invite 'critical friends' – non-executive directors, foundation trust governors and members, PALS staff – to undertake formal observations of care in clinical areas and report back direct to them. This can be a way of making sure staff are recognised for care-giving and that problems with delivering compassionate care are seen and tackled early on.
- Youngson (2007) talks about the need for a paradigm shift away from what he calls the 'machine thinking' shaping the culture of medicine in modern industrial societies, and towards a culture that recognises and gives due weight to the complexity of human dynamics and human processes involved. He calls for senior leaders to build and shape organisational cultures that are committed not to service delivery but to 'being of service', and strive to provide not 'clinical facilities' so much as healing environments.

## 5. Research

Good research can sometimes be compelling to policy-makers, but a lack of research can be an excuse to do nothing. It is very important therefore that funding is made available to fill the gaps that exist in terms of good research around compassion in similar ways that have existed for clinical interventions. A suggested research agenda would:

- agree definitions for compassion and ways of assessing it
- agree and assess *uncompassionate* care: food placed too far from patients to reach; being moved from ward to ward; being prepared for procedures and operations which then do not take place
- test whether patients know when kind words and behaviours are not supported by emotional factors, and whether this matters to them
- investigate whether increasing compassionate care promotes better clinical outcomes and patient satisfaction
- develop and test teaching and training methods
- investigate the relationships between stress reduction and caring behaviours
- explore how aspects of teamwork contribute to compassionate care, and which have the most impact.

## Conclusions

**This paper argues that compassionate care is important to patients and staff alike and has outlined some of the ways that we can address the natural and the socially constructed forces that operate to stop staff feeling and acting upon compassion.**

The NHS Constitution highlights the importance of values within health care. Workshop members welcomed this after what has been perceived as an era of focus on standards and targets. We are optimistic that the need to transform services is recognised at the highest level. In Lord Darzi's review, *High Quality Care For All* (Darzi 2008), the meaning of high-quality care includes compassion, dignity and respect, and staff are 'respected for the caring and compassionate nature of the services they provide'. In terms of compassion, the report makes this claim: 'We find the time to listen and talk when it is needed, make the effort to understand, and get on and do the small things that mean so much – not because we are asked to but because we care'. We hope that this paper will provide some steps to help this process on its way.

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