Compassion in healthcare

Report from the multidisciplinary conference hosted by the open section of the RSM and The Human Values in Healthcare Forum

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William Osler said 'the good physician treats the disease, whilst the great physician treats the patient who has the disease'. Osler understood the true therapeutic encounter to be a meeting of unique individuals. And I think we can also infer from this famous quote that he is also invoking the idea of compassion: compassion as a … 'deep awareness of the suffering of another coupled with the wish to relieve it'. (Chochinov, 2007). In this profoundly systemic and humane view of medicine, compassion is integral to the holistic treatment of patients as unique individuals, and the doctor's ability to support them and their family members and friends. Consequently, compassion should be a crucial element in healthcare education and practice. But, as many a headline has demonstrated of late, this is clearly not the case. Could it be that our current climate of 'healthcare delivery' ruled by the QOF, quotas, targets, cuts, assessment-geared learning and ever more biomedically oriented medical training, makes it more difficult to work compassionately?

The conference, in addressing the tensions between medicine's timeless ethical and imperatives and the unfolding challenges of 21st century industrialised healthcare, brought together a diverse group of speakers. Together they explored compassion from philosophical, neurobiological, psychological, clinical and pedagogical perspectives. That so many viewpoints can now be brought to bear is perhaps a unique phenomenon of our time – and one which implies that inter-professional approaches will be needed for restoring compassionate care to the health service.

Two divergent perspectives

The convenor, Dr Paquita de Zulueta, compared two divergent perspectives of healthcare organisations – one as a machine or business whose priorities are efficiency and commodification, and the other as a living human system with relationships and caregiving at the foreground. She proposed that the former system is in danger of dehumanising individuals and eschews compassion. Professor Paul Gilbert gave an evolutionary neurobiological perspective to compassion and explained how the three basic systems of emotional regulation in the brain need to be in balance. The threat system – the most powerful – can inhibit the affiliative system – essential for compassion – and can also restrict resourcefulness and creativity (the incentive system). He described two models for delivering healthcare: The first involves a top-down model, using targets as the driving force and threats to ensure an efficient service. The second incorporates a more holistic, patient-centred model, involving trust between patients and practitioners and between practitioners. He outlined evidence that the latter model enables compassionate care, benefits patients and improves health outcomes. Dr Alys Cole King showed us a film of different patients giving their stories of depression and attempted overdose and interviews with their family members. The film revealed how each person's experience is unique and requires individualised treatment. Film can also be used as a tool to raise awareness, break down barriers, develop empathy, and stimulate a sharing of perspectives – all-important aspects for developing compassionate care.

Compassion in education

Professor Jenny Firth-Cozens discussed compassion within the education of doctors, and Dr Ann Gallagher talked

about compassion in the education of nurses. Professor Firth-Cozens challenged the educational dogma of 'professional distance' and proposed that this leads to the idea that compassion is to be avoided and to students frightened into believing that to be 'professional' one must always remain emotionally detached. She suggested setting up Balint-style groups, with physicians coming together to discuss interactions with their patients and reflect on their responses. Such reflective groups would also enable students to process their emotional responses to patients before they start working as doctors.

Dr Gallagher took this a step further by suggesting that healthcare incorporates aspects of the Slow Movement, an ethos for life that values quality over quantity and encourages followers of the movement to take time over things of value. This would allow for more compassion towards patients, but also for practitioners to take care of themselves in the process. Feeling pressure to be constantly emotionally available and compassionate could lead to burn out amongst practitioners, particularly if they feel they are not fulfilling their duties in all areas. In order to prevent this from occurring, structures and systems need to be available to support nurses and doctors.. On the whole, however, evidence suggests that compassionate care benefits those who carry it out as well as those who receive it. Professor Ranaan Gillon gave examples of successful strategies to enable and achieve compassion. Dr Jocelyn Cornwell of The King's Fund informed us about the Point of Care Programme, including the introduction of Schwartz rounds in the UK – multi-disciplinary Balint-style group discussions within hospitals. After this, delegates worked in small, facilitated groups, using an appreciative inquiry model, to generate key ideas as to how to achieve more compassionate care. One member from each team presented these at the plenary.

Emerging themes

Various themes emerged. These included:

- Making time to listen and reflect. Mindful communication. Presence.
- Improved training and resilience building.
- Responding empathetically to patients' authentic needs and rights.
- Reduced wasteful bureaucracy.
- Constructive criticism, and learning from past mistakes.
- Using multidisciplinary Appreciative Inquiry conversations to develop creative strategies.
- The importance of teamwork, focusing on individuals' complementary strengths.
- Using other resources available within the healthcare setting, such as the chaplaincy service.
- Respecting patients' autonomy and dignity, and finding out from them what they need. Working with patients and their representatives to improve care.
- The importance of self-care, such that health professionals can maintain the resilience and motivation necessary to deliver optimal compassionate care.
- Leadership is key, and courageous, authentic 'resonant' leadership is required at all levels to achieve compassionate healthcare,
- A systemic approach is required for wholesale organisational change. This means engaging with leaders at the top level as well as fostering bottom-up grassroots' initiatives. Individual and organisational changes need to occur concurrently, with the elimination of threats and a fear-based culture. Proposals to achieve this included consultations at all levels, interdisciplinary training, the cultivation of a no-blame culture and remembering to show compassion toward colleagues as well as patients.
- Compassion needs to be encouraged not just within healthcare settings, but also within the wider community, as this is central to human flourishing.

These were positive and useful ideas to leave with, all of which could be implemented in a variety of healthcare settings.

Most students are drawn to healthcare wanting to be the great physicians that Osler described. They see the role of the healthcare professional as treating and caring for patients, restoring health where possible and enabling quality of life. Unfortunately, there are many constraints and barriers to providing compassionate patient-centred rather than disease-orientated care, and this often leads to apathetic practitioners who forget why they were drawn to medicine in their youth. Conferences like these re-inspire that passion, as well as create the scope for forums of practitioners who share the same values and aspirations to work together in pursuing the goal of cultivating greater compassion and humanity in clinical medicine.

The content of this conference resonates with the words of Kleinman (2012):

> *'The great failure of contemporary medicine to promote caregiving as an existential practice and moral vision that resists reduction to the market model or the clarion call of efficiency has diminished professionals, patients and family caregivers alike. Leaving out caregiving demeans the profession and leaves something hollowed of its humanity and moral values.'*

We seek to remedy this failure.

Chochinov H (2007). Dignity and the essence of medicine: The A, B, C, and D of dignity conserving care. *BMJ*, 335: (7612).

Kleinman A (2012) Caregiving as moral experience. *The Lancet*, 380 (9853).