J R Coll Physicians Edinb 2018; 48: 69–70 | doi: 10.4997/JRCPE.2018.116 **COMMENTARY**

Some thoughts on compassion inspired by Sir Thomas Legge

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Education

Declaration of interests: No conflict of interests declared

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In the decade since the Stafford Hospital scandal began, the NHS has been regularly accused of an institutional lack of compassion. The witness statements to the two Francis inquiries documented in uncomfortable detail the culture of unkindness which dominated that hospital. But Stafford was nothing new, and was not an isolated case. The story of inhumane and appalling treatment of patients at Ely Hospital in Wales broke in 1967; an inquiry chaired by Geoffrey Howe reported in 1969.[1] Between Ely and Stafford there were several official inquiries into poor care at various NHS hospitals. The ranks of doctors and nurses have always contained a minority of the lazy and the unkind. We delude ourselves if we believe that this minority can be identified and weeded out at recruitment.

What did change between Ely and Stafford, however, was the unintended, unforeseen, and perverse organizational disincentivisation of compassion. I have chosen a few examples:

1. Senior ward nurses – who were once called ward sisters if female, and charge nurses if male – provided leadership on acute wards. They were listened to and respected by nurses, doctors and ancillary staff. The tone and atmosphere of the ward was set by the senior nurse. Acute ward work has become increasingly less attractive for senior nurses; this is due to a combination of staff shortages, an older, sicker and frailer patient population, excessive paperwork and box-ticking. Many experienced nurses now view this work as intolerable, and leave for less stressful positions as specialist nurses and managers, chiefly because there is no incentive for them – professional or financial – to continue on the wards. This has created a vacuum where leadership is most needed.

2. Since the Janet Tracey ruling by the Court of Appeal in 2014,[2] discussions on cardiopulmonary resuscitation (CPR) seem to be mandatory for elderly patients admitted acutely to hospital, regardless of whether such discussions are either necessary or kind. Our fictional patient Mary[3] is shocked to be asked her views on CPR during the course of her admission by a junior doctor. A nurse explains: 'Don't worry Mary, they ask everyone that these days.'

3. The target culture, which has dominated the NHS for over two decades now, has created many new unintended adverse consequences and perverse incentives.[4] Targets skew clinical priorities and distract staff from providing compassionate care. Metrics have become more important than patients.

4. The fetishisation of safety in hospitals prevents some patients from enjoying simple daily pleasures, such as food. For example, in *A Patient's Story*, Mary is vegetarian, and doesn't much like the food provided: 'Her family tell the nurses that she will eat the food they prepare if they can bring it in. The ward staff say that they cannot reheat anything that family bring in, due to infection control and health and safety considerations…' Food, which should be a source of comfort and sustenance, has now become a battleground in general medical wards. The NHS now spends more on prescribed artificial oral nutritional supplements than it does on food. Concern over unsafe swallowing regularly leads to patients being subjected to 'NPO' and tube-feeding.

5. The two words which appear most frequently in *A Patient's Story* are 'sorry' and 'apology'. Nurses and doctors now feel they must take responsibility for the failings of the institution (the hospital), and the wider organisation (the NHS). The total number of NHS beds has halved over the last 30 years, while the population has grown and aged. This inevitably leads to patients like Mary being accommodated on trolleys in emergency departments while they await a bed, and then being moved from one ward to another after admission. Nurses and doctors cannot be blamed for a shortage of beds.

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Empathy is commonly proposed as the solution to all our societal woes. The words 'compassion' and 'empathy' are often used interchangeably, yet they are radically different, and, indeed, opposing qualities. I and others have argued that you can be compassionate without being empathetic, just as you can be empathetic without being compassionate.[5] In healthcare, compassion is more than simple human kindness: it also requires courage, competence and that mysterious quality which some call 'bottom' – meaning a combination of personal substance and integrity. The medical profession in Britain appears to be going through a crisis of bottom. Doctors publicly proclaim their love of the job, but the statistics tell a different story. Burnout among doctors, which used to be endemic, is now an epidemic. I have noticed a Gadarene rush to retirement among my former NHS consultant colleagues.

Sir Thomas Legge (1863–1932) was the first Medical Inspector of Factories in Britain. He is famous for his four axioms on the prevention of occupational lead poisoning, which appeared in his posthumous book, *Industrial Maladies*.[6] The first two axioms are: (i) 'Unless and until the employer has done everything – and everything means a good deal – the workman can do next to nothing to protect himself although he is naturally willing enough to do his bit', and (ii) 'If you can bring an influence external to the workman, you will be successful; and if you can't, or don't, you won't.' In other words, institutional and organisational change is far more likely to succeed than attempts to change the behaviour of individuals. Compassion will not be regenerated by educational workshops, or by regulation of doctors and nurses; if anything, this approach only exacerbates the problem. The average doctor and nurse is, to use Legge's phrase, 'naturally willing enough to do his bit'. We should instead remove the institutional and organisational perverse incentives which act as barriers to compassionate care. And we should treasure those nurses and doctors with bottom.

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