
REFLECTIVE PIECE

Compassion: Wherefore Art Thou?

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Abstract

Compassion is a health professional value that has received a lot of attention recently. In this paper we consider the nature of compassion, its definition and its expression in practice. We further link compassion to patient-centred care. There is debate about whether compassion can be learned, and therefore assessed. There are similar discussions in relation to 'professionalism' and the effects of the hidden curriculum. We conclude that compassion is everyone's business and that learners require early and sustained patient and client contact with time for reflection to enable the delivery of compassionate care.

Keywords: compassion, care, professionalism, values

Introduction

The Francis report into the conditions prevailing at the Mid Staffordshire Hospital in the UK between 2005 and 2008 mandated that "patients must be the first priority in all of what the NHS does by ensuring that, within available resources, they receive effective care from caring, compassionate and committed staff, working within a common culture. . ." (Francis 2013, p67). Compassion is a recurring theme in the report, particularly in relation to nursing staff, with recommendations that there should be enhanced training in and experience of delivering compassionate care. Compassion is recognised as a professional value for which nurses should be assessed prior to training and subsequently during their careers through a revalidation process.

Nursing staff, whether as individuals or within a team, do not however work in a vacuum; they are an extension of a community of practice and, in the Mid-Staffordshire example, a product of a system compromised by financial imperatives. Assessment may drive and shape what is valued by a student, but for employees charged with the care of the sick, a multifaceted mix of variables influences the way in which they learn to provide care and express compassion in a complex clinical context.

Compassion is not mentioned in the code of the Nursing and Midwifery Council (NMC) of the UK – the standards of conduct, performance and ethics for nurses and midwives (NMC 2010). However, nurses and midwives are expected to treat patients with respect, and be

kind and considerate. The Australian national competency standards for registered nurses likewise do not contain the word 'compassion' (ANMC 2006). The Australian Medical Council requires that medical graduates "demonstrate professional values including commitment to high quality clinical standards, compassion, empathy and respect for all patients" (AMC 2012, p5) whereas the General Medical Council (GMC) in the UK does not stipulate compassion as an outcome of medical training (GMC 2009).

The Francis recommendations and the AMC's standards raise some interesting questions about the conceptualisation of compassion. Is it a value, a skill, or a competence? Is it innate or can it be learned? How should a health professional be assessed for compassion? Is it an all-or-nothing phenomenon or are there grades of compassion from, perhaps, novice to expert? We cannot answer these questions in any depth in this short editorial but wish to consider them in the context of practice-based learning.

Defining compassion

Compassion is often listed as a key principle of (medical) professionalism (see, e.g., ABIM 1995, Arnold & Stern 2006). The term *humanistic medicine* was also developed to remind clinicians of their requirement to provide compassionate, empathetic care (Little 2002). *Patient-centred care*, identified by the Institute of Medicine as one of six goals shaping the US health system in the 21st century (Lown *et al.* 2011), is another phrase used to capture the essence of care as "intervention with a sense of compassion" (Stevenson 2002, p1106). According to Lown *et al.* (2011, p1172), "medical care without compassion cannot be truly patient-centred". Kumagai (2008) refers to medicine as being, at its core, "a form of applied humanism, that is, the application of science in recognition of human values and in the service of human needs" (p653).

However, the underlying emotion of compassion, as expressed through compassionate care in the practice setting, is not easily articulated and it defies easy definition. A simple gesture like a smile, a reassuring look, a touch of the hand, or a silence, may all represent the complex processes that frame compassionate care (Dewar *et al.* 2011). Lown *et al.* (2011), embedding compassionate care within the individual patient's context and perspective, suggest compassionate care 'lies at the intersection' of empathy (understanding) and sympathy (feeling), involving identifying and responding to the distress of others and having a desire to alleviate (act on) that distress. Central to this definition of compassionate care is the 'patient's innate need for connections and relationships' and the care provider's 'desire to understand the patient's context and perspective' (Lown *et al.* 2011, p1172). Taking into account these different viewpoints, we may define compassion as the health professional's ability to recognise patient suffering, an ability embodying the human connection, and their willingness to act on this through the provision of care – as an act of showing they care. Thus compassion is a professional value, a skill to be performed and a competence associated with knowledge of suffering, empathy and willingness to act.

Can compassion be learned?

"There remains a continuous and inconclusive debate about whether compassion is innate or can it be taught?" (Lancet 2007, p630). While the Stanford School of Medicine offers an eight-week course to help participants develop the qualities of compassion and empathy (Stanford, nd), Treadway & Chatterjee (2011) suggest that we are asking the wrong question. They contend that the majority of students come to medicine caring and that through neglect and silence they are taught not to care, concluding that the focus of medical education and training should be on the 'how' of caring (Treadway & Chatterjee 2011).

Similarly, burnout and compassion fatigue are common at the time when nursing students transition to professional practice and are related to the nature of caring work and workload (among other factors), whereas they may be protected from such effects during clinical training to some extent (Michalec *et al.* 2013). However, the effect of the hidden curriculum (Hafferty & Franks 1994) is powerful in medicine. Looking for exemplars of compassion, integrity and patient-centred care, students become dismayed, frustrated and cynical when they are exposed to the unprofessional and unethical behaviour of some of their more senior colleagues (Burack *et al.* 1999, Paice *et al.* 2002). In the UK, nursing students have also been shown to feel vulnerable to the dissonance between their own professional ideals and aspiration to compassionate practice and what they observe in the reality of everyday practice (Curtis *et al.* 2012).

Role models within clinical settings may, of course, be positive as well as negative. The power of the role model in acculturating students and junior health professionals is not to be underestimated as having a central role in their construction of meaning (Cruess *et al.* 2008). Role modelling continues to be a primary method by which clinical supervisors teach (Weissmann *et al.* 2006) and students and junior staff learn to practise the humanistic elements of care. Novice staff require opportunities and guidance in developing reflective strategies to create effective learning opportunities from both positive and negative role models (Kenny *et al.* 2003), which translate into improved care for patients. Without these opportunities 'role models may not be a dependable way to impart professional values, attitudes or behaviours' (Paice *et al.* 2002, p707).

Assessing compassion

Taylor (1997, p521) describes the discomfort caused by discussing compassion in a scientific context, as it has no objective measure, suggesting the "nearest surrogate is the soulless 'continuity of care'". Without a means of measuring it, how then can we assess compassion? Moreover until accreditation bodies stipulate compassion as a learning outcome for health professional qualification we cannot align the curriculum across goals, activities and assessment (Biggs & Tang 2007). We cannot envisage assessing compassion through the ubiquitous OSCE (objective structured clinical examination); there would have to be a validated work-based assessment of some kind, involving patients as well as clinicians. The danger is a reductionist and check-list approach rather than a global one, with the possibility of students receiving 50% for compassion - a meaningless outcome. There would also need to be consideration given to whether students could be remediated through further practice.

Conclusion

Clouder (2005) has argued that it is vital that health professional students accrue a sense of emotional capital, self-awareness and reflective capability during their teaching programmes in order to develop and therefore be able to fulfil their caring responsibilities. This learning in the affective domain is only likely to be achieved through a combination of early and regular patient contact, with facilitated reflection and faculty's recognition and reward of exemplary role models and in practice-based settings. These solutions do not lie in the discourse of a yearly appraisal; they require embedding in the day-to-day delivery of care, where virtues such as compassion are valued as everyone's business. The Mid-Staffordshire report should give us pause for thought; we can all learn from the findings and use them as a catalyst for positive change.

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