

What do we need to do to sustain compassionate medical care?

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Abstract

The term 'compassion' is widely used, but what it requires is rarely analysed. It has been defined as understanding another's suffering, combined with commitment to doing something to relieve this. It involves an emotional component – a personal reaction to the plight of another – and sensitivity to the personal meaning a condition may hold for the individual. An emotional response to tragic circumstance is by nature spontaneous. But compassion also requires deliberate responses – respect, courtesy and attentive listening.

The human brain is hard-wired with the capacity to share the experience of others, including their emotions. So the potential for empathy and compassion is innate. However, this can be limited by repeated exposure to suffering, when the neural networks involved become down-regulated. In addition, an organisational culture geared to performance targets with diminishing resources can lead to exhaustion and burnout. This results in reduced capacity to attend to the needs of patients.

The traditional solutions of education and further research may not be sufficient. A framework is proposed for doctors to contribute to compassionate medical care, taking account of organisational factors. The key elements are: awareness; self-care; attentive listening to patients; collaboration; and support for colleagues.

Key words

compassion; empathy.

Key points

- Responsibility for providing compassionate care is both individual and collective
- For the individual doctor, compassion involves not only an emotional response to suffering, but also commitment to treating all patients with respect, courtesy and kindness
- Sustaining compassionate care - in the face of organisational and other barriers - requires moral and ethical commitment to upholding the values of the medical profession

What is compassion?

Compassion is now invoked freely in specifications of healthcare. It is clearly desirable, and apparently the solution to many ills. It commonly enters public awareness as a deficiency - lack of compassion was a salient theme in the Francis Report on failings in the Mid Staffordshire Trust, and specific training in compassionate care figures in the Report's recommendations.

There is an assumption that we all know what compassion involves, but its meaning is rarely analysed. Attempts to define it indicate more than a single dimension - for example:

“recognising and understanding another’s concerns, distress, pain or suffering, coupled with....taking action to ameliorate them.” ¹

It is characterised by an emotional response to suffering, which requires the ability to enter imaginatively into another’s situation; and commitment to doing something about it. But there is also a rational element, including an evaluation of the seriousness of the condition. We may feel compassion for a life-changing disease or injury; in the case of a cut finger sympathy may often be more appropriate. But a note of caution. We need to be sensitive to the personal meaning a condition holds for the individual – which may not be obvious. One of us (BAL) recalls treating a patient with a cold sore on her lip, who was emotionally distressed. She was a flautist and feared the swelling and discomfort would mar her performance at an important concert. .

To the extent that compassion involves an emotional response, it is by nature spontaneous - it cannot be mandated. If it is to be part of the doctor's daily work (and within the ambit of duty), compassion needs to consist of more than a personal emotional reaction. Doctors have to deal with a wide range of conditions varying in clinical severity – and also varying in emotional valence. What they all require is respect, attentive listening, simple courtesy and kindness.

Where does responsibility lie?

Individual doctors are of course responsible for the way in which they treat their patients. It is easy to assume that the matter ends there, but a powerful case can also be made for collective responsibility resting with the organisation. From this perspective, there needs to be a balance of responsibilities between the individual and the system as a whole.² This matters in terms of both accountability – how and from whom to learn about individual and systems errors, and responsibility - where and with whom to locate the focus for getting things *right*. Where a lack of compassion is identified as underlying a significant failure in healthcare, as recently in the Francis Report, this needs to be seen as both an individual and a collective responsibility .¹ Compassionate medical care is dependent not only on the individual clinician, but also on his or her team, and the organisational context within which he or she practises. All are responsible and all must be engaged if compassionate care is to be sustained.

What does the science tell us?

What do we know so far about the nature of compassion? First, advances in neuroscience have demonstrated that the human brain has neural networks which are hard-wired with the ability to share the experiences of others, including their emotions and sensations.³ At least two neural networks are involved: one activated during empathy for pain and another activated by compassion.⁴ So the human capacity for empathy and compassion is innate.

However, the practice of medicine brings exposure to a high level of distress and fear, associated with disease and mortality - combined with inevitable uncertainty around clinical decision-making. These conditions are anxiety provoking to some degree for the majority of clinicians (whether or not openly acknowledged) and can lead to feelings of being overwhelmed requiring some form of defence or coping strategy (Ballatt & Campling, 2011). Most such defences involve some separation or distancing from emotional responses. The parallel evidence from the field of neuroscience indicates that neural networks responsible for empathizing with the pain of others become “down-regulated” after repetitive exposure to observing others' pain.

What happens in clinical practice?

In addition to the inherent stress of the work, it is increasingly common for clinicians to experience pressure to achieve service efficiencies, by meeting performance targets even when resources (finance, staffing) are reduced. Along with nursing and other healthcare colleagues, they are faced with the challenge of doing more with less. In this context, it is all too easy for the organisational culture to shift and emphasise the attainment of targets and the maintenance of marginal returns as the priority - perhaps to the detriment of the core purpose of the service.

As a result, clinicians are likely to experience a loss of professional autonomy, in that they are no longer able to practise freely as they judge best. In emotional terms, the effects of this include a heightened state of anxiety; feelings of anger; and what can only be described as moral distress. The result of these states is increasingly one of burnout – emotional exhaustion, treating people as objects and a low sense of accomplishment. This inevitably serves to distract from a proper focus on the needs and concerns of individual patients and their families and has been associated with medical errors.

Traditional solutions may not be the answer

There are consequently obstacles to the expression of compassionate care at all service levels - individual clinicians, their teams and the wider organisation. One potential solution to this might be to provide more education. And to a degree, there are grounds for believing that education can help, at least under the right circumstances. Human beings are born with the capacity for compassion - but can still learn to deepen their potential to provide compassionate care.¹ Sensitive teaching about communication skills and attentive listening will result in patients who are more satisfied with their care and *may* also lead to improved outcomes.⁵ But there is little lasting value unless compassion also has reality within the culture of the organisation. Where this is not the case, we might be better served by asking how we can at least mitigate the organisational factors which suppress the innate compassion of healthcare professionals.

A further solution might be to recommend more research. And again, there is reason to hope that gathering additional data would be useful - provided that certain conditions are satisfied. It would be helpful to know more about the impact of care experienced as compassionate on patient well-being; and to understand whether and how this mediates the outcome of treatment. But it matters crucially how any such findings are *applied*. In their book *Intelligent Kindness* Ballatt and Campling (2011) make an important point:

“Research of this kind can only be helpful - with the proviso...that the learning would be at risk of being applied in a ‘technological’ manner that misses the point, or indeed works against promoting kindness.” (p43).

How to enact compassion in health care

In this complex situation, where individual and collective responsibilities are interdependent, what should be the priorities for the medical trainee and their teachers? The following suggestions are offered, not in order of importance, as a guide which takes realistic account of the challenges of providing compassionate care:

Action	Descriptor
1 Awareness	A high degree of awareness - both of one’s emotions, thoughts and reactions, and of the impact of the organisational and educational context in which care is provided
2 Self-care	A conscious approach to self-care - taking account of emotional as well as physical needs, and seeking opportunities for support and emotional expression - through mentoring, supervision, peer discussion and other opportunities for reflection
3 Attentive listening	Commitment to giving priority to the needs of patients and their families, through attentive listening beneath the surface for their concerns, and by remaining open to new perceptions and experience.
4 Collaboration	Commitment to working collaboratively with colleagues, patients and families to change systems of education and care delivery that create barriers to compassion
5 Support for colleagues	Continual attention to the needs of students, trainees, and colleagues - fellow doctors and staff from other disciplines - noticing when they are under pressure, acknowledging this and where possible and appropriate offering support.
6 Commitment	Maintaining a moral and ethical commitment to upholding the values of the medical profession; and to acting with and advocating for compassion despite existing barriers.

Table 1 - Actions required to sustain compassionate care

In a given set of circumstances, it is only ever possible for any of us to do our best. But we have a responsibility to consider what this best may be. We have multiple responsibilities - to patients, to colleagues, to the wider organisation - and in addition to ourselves, to resist burnout and sustain our own well-being so that we can care for others. In this way, whatever the context, it is always possible to contribute to the capacity for compassion in medical care.

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Suggestions for further reading

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