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Title

A qualitative study of key stakeholders' perspectives on compassion in healthcare and the development of a framework for compassionate interpersonal relations.

Short title

Compassion in Health Care

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STRUCTURED ABSRACT

Aims of paper: To report findings from a qualitative study of key stakeholders' perspectives on 'compassion' in the healthcare context. To present the 'Framework for Compassionate Interpersonal Relations'.

Background: Although many research papers, health policies, and healthcare strategies identify compassion as an underpinning value and key component of healthcare quality, identifying a unified definition of compassion is challenging. For Higher Education Institutions implementing 'values-based' recruitment processes, a clearer understanding of this core concept is vital.

Design: Exploratory, qualitative design.

Methods: Academic staff, health care students, clinicians and service users (n=45), participated in nine focus groups where they were asked to define compassion in the context of health care. Data were transcribed verbatim and analysed using thematic analysis.

Results: Four overarching themes were drawn from the data. The first theme centred on participants' definitions of compassion, while the second identified compassionate behaviours. The third theme related to barriers and threats to compassionate practice and the fourth, focused on ways to support compassion in practice. Participants believed that health care staff should be '*consistently compassionate*', and were emphatic that compassion should not be substituted with a '*care without engagement*' approach.

Conclusions: The findings concur with other research, which identifies the link between compassion and empathy and the importance of establishing meaningful connections with others. Whilst participants in this study recognised the pressures of health care work and accepted that the expectation of '*consistent compassion*' was not necessarily realistic, it was still seen as an important goal.

Relevance to Clinical Practice: Participants held clear expectations regarding practitioners' communication skills and used these as a proxy for compassionate practice. The 'Framework for Compassionate Inter-personal Relations' may be used to promote reflection on the implementation of compassionate practice. It may also be used to highlight areas of focus when conducting values based recruitment activities.

SUMMARY BOX: What does this paper contribute to the wider global clinical community?

- Compassion as a concept is a complex phenomenon that is difficult to explain. However, all participants in this study expressed the hope that clinical staff would be compassionate, all of the time, whilst also recognising that this expectation was unrealistic.
- Participants decided whether practitioners were compassionate (or not) by judging their style of communication, whether they invested time in developing a positive interpersonal relationship with them and their levels of personal engagement. Care given without personal engagement was viewed as non-compassionate.
- The 'Framework for Compassionate Inter-Personal Relations' sets out key stages in developing and maintaining compassionate relationships, identifiable from participants' accounts. This Framework may be used as a stimulus for personal learning or as guide to values based recruitment activities.

KEYWORDS

Compassion, healthcare, values, clinical practice, focus groups, qualitative research, empathy, thematic analysis

INTRODUCTION

The concept of compassion has become a key area of concern in the context of western healthcare systems where questions have been raised about the lack of 'care' evident within increasingly sophisticated healthcare systems (Youngson, 2011, Shaller 2007). In the UK in recent years, a litany of investigations and reviews have revealed systemic failures to provide care to ill and vulnerable people in institutional health care settings, culminating in patient neglect and abuse (Department of Health, 2013a; Francis, 2013). As a consequence, some have concluded that compassionate values have been eroded by market forces and economic constraints (Bradshaw, 2009), leaving the UK National Health Service (NHS) in the midst of a 'crisis of compassion' (Parish, 2007).

In response, the UK Department of Health implemented numerous strategies to maintain a policy focus on compassion in health care, through its 'Compassion in Practice Strategy' (Department of Health 2012) and the Education Outcomes Framework (Department of Health 2014). Practical initiatives have also been introduced to improve the patient experience, such as the 'Family and Friends Test' to measure care quality (Department of Health 2013b) and the 'Care Makers' Programme (NHS Employers 2014) to support the development of compassionate cultures. Within the NHS Constitution, the Department of Health (2013) sets out six values that healthcare staff are expected to meet and identifies 'compassion' as one of these. Most recently, the NHS 'Values-Based Recruitment' (VBR) Strategy has become a prominent feature of the compassion agenda and one with which Higher Education Institutions are urged to engage (Health Education England 2014).

However, it has largely been assumed that a shared understanding of the concept of compassion exists across the NHS, between Higher Education Institutions and across the UK service user populations. Yet, engagement with the VBR agenda and the literature reveals that greater understanding of the concept of compassion is needed, resulting in this qualitative study to explore academic, clinical and lay perspectives on ‘compassion in healthcare.’

BACKGROUND

Although many research papers and healthcare policies identify compassion as a core underpinning value and component of healthcare quality, identifying a unified definition of compassion continues to pose a challenge (Schantz 2007). This is largely due to the complex and subjective meanings attached to term. For example, the term compassion may refer to a range of acts, not only a single one (Sturgeon, 2010) and compassion may be defined simultaneously as both virtue and value. Compassion may also come to light in a range of contexts, meaning different things to different people at different times (Dewar 2011).

Indeed, each individual may possess a personal understanding of the word compassion and as a construct it may be indistinguishable from others such as sympathy, altruism and pity (der Cingel 2009). Compassion may also include kindness, empathy, respect, building relationships with others, and ‘being with’ another person at a time of suffering (Firth-Cozens and Cornwell, 2009). The Compassion in Practice strategy exemplifies this linguistic range, defining compassionate practice as: ‘...how care is given through relationships based on empathy, respect and dignity’ and defining compassion as ‘intelligent kindness’ (Department of Health 2012 p.13).

Although many descriptions of compassion have been offered, little agreement has been achieved regarding its identification, nor its measurement (Volpintesta 2011). For example, Bradshaw (2009) argues that to define compassion for the purpose of measurement, constitutes a misguided and dehumanising enterprise. In contrast, Dewar (2011) identifies the benefits of examining and understanding how compassion is implemented and experienced in clinical settings. Yet other authors (Paley 2014, Traynor 2014, Reeves et al. 2014) refute the claim that widespread compassion deficit exists, attributing poor care to a matrix of organisational, social, political and economic factors, rather than to a collapse of compassion.

Despite this complex and contradictory backdrop, it has been argued that Universities responsible for health professional education should now adopt a 'values-based' approach to recruitment, taking particular care to select candidates with compassionate values (Willis Commission 2012, Health Education England 2014). One suggested strategy is to screen or test for compassion at the admissions selection point to nursing degree programmes (Francis 2013, Hehir 2013, Johnson 2008). To support University engagement with the VBR agenda and to enhance our understanding, an exploratory qualitative study was undertaken to gain an in-depth understanding of key stakeholders' conceptions of the term compassion. In this paper, we report these findings laying the foundation for a shared understanding of compassion in health care settings.

THE STUDY

A qualitative approach for the study was selected as a detailed understanding of explanations and perceptions was required. The objective was to gain an understanding of the term compassion and the meanings ascribed to it by a range of stakeholders: health and social care students; health and social care University staff; health care clinical staff; and members of the public in the role as receivers of health and social care.

METHODOLOGY AND DESIGN

A 'pragmatic' qualitative approach, sometimes known as 'basic qualitative research', was adopted. This is a practical method of answering research questions by seeking understanding of people's descriptions and interpretations of a given phenomenon, but without being wedded to either an ethnographic, phenomenological or grounded theory approach (Savin-Baden & Major 2013). A broadly essentialist/realist approach was employed as it enabled meaning, experiences and perspectives to be theorised in a straightforward way. Braun and Clarke (2006 p. 85) argued that within this framework "a simple, largely unidirectional relationship is assumed between meaning and experience and language".

DATA COLLECTION

Focus groups were led by a Research Assistant (author XX – ANONYMISED FOR REVIEW) employed for the study, based on his knowledge of health psychology, and previous research experience on projects involving patients and staff in health care settings. One of the project co-PIs (ANONYMISED FOR REVIEW) attended the first focus groups to ensure these kept to the research aims and to provide feedback on the approach to facilitation.

Two researchers were present in each group, with the research assistant leading the discussion each time and another team member team taking notes regarding order of speaker and key points, to assist with later transcription.

A semi-structured interview schedule was developed specifically for the project. This was written following a review of the literature and determined the core questions that were appropriate to understand compassion in a health and social care context. The interview schedule was discussed with and approved by the project advisory board that consisted of the research team, University health and social care staff, and lay members of the Research Support Volunteer Panel. Two questions formed the main core of the discussion: the first asked participants how they would define compassion; the second asked what behaviours would indicate that a health care professional was compassionate.

Focus group participants were purposively sampled from the University health and social care staff and students, two NHS Hospitals, and from members of the public within the city where the University is located. Participants were recruited through posters in public locations (including university buildings, two local community libraries, and two primary schools), email announcements (at the University, local Council, one community centre and in the two hospitals) and by word of mouth. Participants included University staff, University students, healthcare professionals (HCPs), and members of the public (referred to hence forth as lay people). Each focus group contained individuals from only one of these four groups.

In total, nine focus groups with 45 participants were conducted. Table 1 shows the mean age, age range, and gender of each group, plus the represented ethnicities and professions. Focus groups with staff and students took place at the University; focus groups with HCPs at two NHS Hospital sites in the West Midlands; and with lay people at the office of a charity organisation and at the University.

TABLE 1 HERE

Ethical approval for the study was obtained from the University Ethics Committee. In addition, study approval and permission to access clinical staff was gained from the Research and Development Department at each Hospital. Informed written and verbal consent was ensured throughout the study. Individuals were not obliged to participate and had chance to ask questions before focus groups took place. Individuals were told the following about the purpose of the study.

The recent inquiry into the failings of the Mid-Staffordshire NHS Foundation Trust (Francis Report 2013) highlighted the way in which negative values, culture and behaviour resulted in poor patient experiences and outcomes. It is now recognised that it is essential to recruit staff to the NHS with the right values and commitment to compassionate healthcare practice. We therefore need to review existing recruitment processes to include assessing applicants' values, attitudes and compassion. The aim of this project is to investigate the concept of compassion in detail so that it can be clearly described and defined. This understanding will then be used to develop and test a formalised 'measure of

compassion' that can be used in the recruitment and development of health and social care students and professionals.

The focus groups took between 30 and 90 minutes. All participants were thanked for their contribution.

DATA ANALYSIS

All focus groups were digitally recorded and transcribed verbatim. Data were analysed by the research team, using NVivo and Braun and Clarke's (2006) six-stage method of thematic analysis. In the first stage, the researchers became familiarised with the data corpus through repeated reading. This was followed by the generation of coding nodes where interesting features of the data were coded across all the transcriptions. In stage three initial codes were loosely grouped together, which allowed the explanations of compassion to be identified. In this phase the themes were cross-checked by all researchers for agreement. Over-arching themes that grouped the initial codes were developed to create a framework for writing up the analysis in stage five. Stage six involved writing up the analysis and selecting extracts to illustrate themes.

RESULTS

Four overall themes were identified from the data (see Table 2). The first centred on participants' definitions of compassion and was captured by the *in vivo* code '*A big word that you can't summarise in one.*' The second theme related to the identification of compassionate behaviours and was entitled *Positive Communication and Consistency*. The third theme, '*Losing compassion: when the system takes over*', concerned the barriers to compassionate practice and arose when participants shared personal experiences of illness

and health care provision. This led on to the final theme, '*Supporting compassionate practice*', where participants identified solutions to the difficulties they identified within healthcare environments. Each theme and its 'sub-themes' (denoted by italics) are described in turn and illustrated through verbatim representative extracts. The extracts are labelled according to the type of participant: student, lay person, clinician (for health care staff) and lecturer.

TABLE 2 HERE

Compassion: 'A big word that you can't summarise in one'

Participants were first asked to describe compassion and to define the term. Although all participants found it difficult to do this, a number of similar views could be identified. Some participants felt compassion was an *innate emotion* and part of someone's personality, that one was first born with. There was a consensus that people entering healthcare needed a certain (undefinable) amount of innate compassion, which some participants felt could be developed further through education and personal development. The following extract is illustrative, "You can increase it yeah. You have to have the basis of it when you're born with it and if you haven't got in then you can't learn it." (Student). Participants talked about compassion in abstract terms, using vague phrases that were difficult to understand without interpretation: "...it's just that feeling, yeah, yeah." (Lay person); "It's difficult to define compassion. However, we all know that it's an innate element in that even if we cannot define it, it is a virtue." (Clinician).

As the discussions developed, participants described compassion as a 'gut feeling' that arose out of interactions with others, or in response to a sound, an image or an observed event.

The emotional response was described as a *feeling of empathy* towards another. As one participant noted, the feeling of empathy stimulated a desire to understand someone's situation, feelings or needs. While some participants felt that 'empathy' was part of 'compassion', others felt that the two were distinct constructs, as 'compassion' went 'deeper.' Some equated the term 'compassion' with giving and showing 'care.'

"[Compassion is] a value. It's feeling empathetic and concerned for those who are in need." (Clinical).

"[Compassion is] caring for your fellow person. Offering care, particularly if someone's ill. A good Samaritan, whatever you want to call it, that's what you are, I think that's compassion. Someone's down ill, you show compassion." (Lecturer).

Compassion was also viewed as an *altruistic quality*, where energy was expended not for personal gain, but to help another.

"Compassion is not about you, it's about the person that you're with and what they need from you. So as you said, it's a give, but it's not a give on your terms, it's on what that person needs." (Lecturer)

Indeed, compassion was described as a *force for action*, whereby a feeling of compassion led an individual to 'take action' or to take responsibility for trying to help another person or situation in some way.

"I would see compassion as having a number of components and I think the ability to see the other person's emotions-to understand to some degree where they may be coming from, even if it's tentatively but then I would see compassion as also making some response – so there being an action component to it as well as the feeling component. Because you can see something but not respond to it, whereas I

think if you gonna be compassionate, you've got to see it -and do something about it." (Lecturer)

When talking about compassionate staff they had met, participants described staff who had "delivered on promises" (lay), or had "gone the extra mile" (lay) to meet a patient's needs. Examples were given of health care staff who had empowered others or "walked alongside" (lay) their patients, rather than "mollycoddling" (lay) them, or those who advocated for patients and their needs. A number of participants also identified that staff who were compassionate tended to be those who spoke up against poor practice or were whistleblowers, and those who had the 'courage' to 'speak up' for others.

"Well maybe what I'm saying is you needed to have the courage to be compassionate sometimes within the sort of stressful context of working within the hospital." (Lecturer 1)

In this way, it was possible to define compassion as the combination of underpinning emotions (such as sympathy and empathy), with altruistic values, (particularly a desire to help others), which together motivated an individual to take action that would ultimately be experienced as 'care' by the recipient.

Recognising Compassion: Positive Communication and Consistency

Participants were asked how they would recognise whether someone was compassionate and which behaviours were important in relation to compassionate health care. Almost all participants judged whether a practitioner was compassionate or not through an assessment of the manner, style and extent of their communication skills. In this way, an individual's

communication skills were used as a proxy for recognising compassion. For example, when participants talked about compassion, they typically recounted periods of illness they had experienced and the way staff had spoken to them. Within these discussions, they identified that they had felt most cared about when a staff member 'connected' with them or had 'given his/her full attention.' In this way, the importance of *positive interpersonal interactions* and *personal engagement* was highlighted.

"Yeah. And like building that relationship and wanting to get to know you. And it's just being a person that you could ask for help." (Student)

"if you look at the practical component, you know when somebody has responded to you and you know when somebody has ignored your needs [...] and I think that's the emotional response that that creates, it's the thing that sticks with you long after the original act [...] is finished." (Lecturer)

Indeed, taking time to build relationships with patients and relatives was viewed as fundamental to compassionate practice. Practitioners who were perceived to be genuine, kind, had good listening skills and used appropriate tone of voice were highly praised and were identified as 'compassionate'.

Most participants agreed that a set of *core communication skills and behaviours* could be identified that typified compassionate care. These behaviours included smiling, appropriate touch, and eye contact and were identified as crucial in building an initial rapport and developing the potential for a compassionate relationship through personal engagement. These short-term behaviours formed the first impressions of the healthcare professional and could be extremely positive or negative. One participant recalled her negative experience from reception staff at one General Practice surgery: "nobody looked at you, no receptionist

looked at you, it was awful.” (Lay person). Indeed, a number of respondents believed it was possible to identify who was compassionate by looking at their eyes.

“If you could watch somebody and them not know, then I think you would be able to tell if they’re compassionate. You’d just be able to see it in their eyes...” (Student).

Similarly, a participant who had interviewed candidates seeking admission to undergraduate health courses felt that what people said could not always be relied upon and as a result, reading the person’s eyes was important.

‘In the end all I was doing was looking into their eyes, because that’s the only place where I would feel confident I would know whether they were faking [compassion] or not. But that’s not science.” (Lecturer)

Participants also identified the need for health professionals to *sustain positive relationships* with patients/families through effective verbal communication, by explaining medical issues in plain language, involving patients and families, and taking particular care when breaking bad or sensitive news. On many occasions, participants identified the importance of tact and sensitivity and for staff to “fight against a production line mentality” (Clinical). One participant described the “dance of reciprocity” (lay), using this phrase to explain how two way interaction was the essential ingredient in effective communication and compassionate practice. A focus on the individual rather than the condition was also important. Some participants identified the need for sensitivity regarding the use of touch, and the showing of emotion.

“...we had the issue of is it or isn’t it professional to cry, and the touching or no touching debate. ...in any compassionate situation, it’s maintaining the focus on the person you are compassionate to and not making it about you.” (Lecturer).

Most participants argued that health professionals should be *consistently compassionate* towards health service users, irrespective of their personal feelings. At the same time, it was recognised by some participants, that this was an unrealistic expectation and occasions would arise where the health care professional did not feel compassionate towards an individual. In this situation, it was suggested that compassion could be 'faked' or replaced by a 'professional' approach to care, although not all participants believed that this was possible.

"That's when you go back to your perspective isn't it where, 'I've not gelled with that person so I'll just be a professional,' but my argument would be that that patient would know that I'm being fake." (Clinician).

Losing Compassion: When the System Takes Over

Many participants talked about the difficulties they had observed or experienced, for health care staff in maintaining a compassionate approach to care delivery. One key aspect was the view that clinical staff *lacked sufficient time* to demonstrate a compassionate approach.

"I trained a long time ago, 30 years ago, and actually used to have probably ten empty beds on a Sunday afternoon. And after you'd done your work and after you'd done your cleaning and stuff, you were actively encouraged to sit and talk to the patients. And I don't think that we have that time built into our days now" (Clinician)

"where I am at placement we have to record the time we've spent with a patient, and if you're spending too much time, sometimes you get criticised for spending too much time with a person. But then, you know, you want to see a person and

treat them properly. But then you can't, because there's like this time restriction." (Student)

Comments about the 'lack of time' typically led onto discussions about the challenging nature of health care work contexts or a 'system' that was constantly "full on capacity pressure" (Clinical) and was described as "a production line of getting patients through" (Clinical). A number of participants described the problem of *burnout* and low morale on the abilities of health care staff to be compassionate:

"I think morale potentially has a lot to do with it as well. When you have things piled and piled and piled and piled, and you can feel yourself sinking into the floor with all of the weight of things you've got to do... I think when morale is low, I think potentially, unfortunately, the compassion and the sitting with the patients and doing those things is perhaps one of the first things to go. It shouldn't be that way at all, but I think... I think staff morale has a lot to do with how that then impacts upon other people." (Clinician)

A general view throughout the focus groups was that if health care professionals had more time with patients, it would be easier to deliver high-quality compassionate care. However, it was generally perceived that increasing patient contact time would be at odds with the drive for a streamlined, cost-effective NHS. In contrast, some participants felt that the 'lack-of-time' argument should not be used to excuse staff from ensuring positive interactions with patients to put them at ease.

"I understand the workload, the workload is huge; we need to do all the paperwork and all that stuff. But it doesn't cost so much to smile, it doesn't cost so much to say 'oh how are you?'" (Clinical).

Indeed, numerous examples of *care without engagement* were recounted by participants where 'care' had been given, but compassion was missing from the staff-patient interaction (see TABLE 3 for personal vignettes). In the stories recounted, it could be argued that it was not necessarily a lack of time that led to poor patient experience, but rather a lack of personal engagement and emotional connection.

TABLE 3 HERE

Supporting Compassionate Practice

While the aim of the focus groups was to gain an understanding of the term compassion from the perspective of a range of different groups, participants invariably began to discuss solutions to the lack of compassion they had experienced in 'some' instances. For example, it was generally agreed that *strong leadership* was required to ensure a consistently compassionate approach from all staff within a healthcare organisation, to set and monitor standards of practice and to promote a reflective approach within the organisation. In one focus group involving academic staff, it was identified that managers should, where needed, act quickly to address poor staff attitudes and behaviours, involving professional regulatory bodies where required. *Positive role modelling* of compassionate practice was also identified as a vital element to enhancing compassion in practice and developing both the current and new healthcare workforces. Across all the focus groups, participants discussed the need for health care students and existing staff to access *education* to support the development of their therapeutic communication skills.

Framework for 'Compassionate Inter-Personal Relations'

Although the initial intention was not to devise a framework for compassionate practice, the experiences shared by participants enabled some key features of effective practice to be identified. From this, it was possible to set out a process that could be recognised as a 'Framework for Compassionate Inter-Personal Relations' (see Figure 1) and can be described as follows.

FIGURE 1 HERE

Stage 1 Connecting: Where the compassionate practitioner engages and connects with the patient by giving his/her full attention, by using active listening skills, positive non-verbal communication skills and appropriate verbal skills. The interaction is used by the health care professional to gain an understanding of the patient's perspective, needs, fears, anxieties and priorities. This is recognised by the patient as someone who 'cares' about them as an individual.

Stage 2 Recognising Feelings: The health professional must recognise the feelings evoked by their interaction with the patient. For genuine compassion to be experienced by the patient, these feelings need to include empathy and concern for the patient, their situation or their difficulties.

Stage 3 Becoming Motivated: Feelings of empathy and concern for the patient are harnessed as a desire to help or a force for action to support the patient. Feelings are used to draw on the personal energy needed to help another and develop a plan of action.

Stage 4 Taking Action to Help: The health care professional implements the plan of action, draws on personal agency and experiences and the support of others to help the patient.

Stage 5 Sustaining Relationships: The health care professional continues to use the skills from stage 1 to sustain the positive relationship with the patient and supplements these by providing the patient and relevant others with information, ongoing explanation and involving the patient.

DISCUSSION

It is currently recommended in the UK that recruitment and selection to health and social care courses should be underpinned by a 'values based' approach and that the identification of candidates with compassionate values should be a focal concern. To this end, the core objective for this study was to gain an understanding of the term compassion in the context of health care, from the perspective of a range of stakeholders. Whilst all participants found it challenging to define the concept, a range of subthemes were evident in the focus groups discussions. For example, all participants explained the need for emotional connection and empathy within healthcare provision. The central importance of communication skills (both verbal and non-verbal) and relationship building, to the provision of compassionate care were also identified. The third distinct component related to the concrete actions that compassionate practitioners implemented which were important in humanising care within a complex health care 'system'.

These findings concur with those of other authors, who identify the link between compassion and empathy (Gustin and Wagner 2013). They are also similar to the components of 'compassion' identified by Burnell and Agan (2013), such as 'the ability to establish meaningful connections', 'meet expectations' and demonstrate 'caring attributes'. What appeared to be unique in our findings was the perception that health care staff should

be '*consistently compassionate*', and that compassion could not and should not be 'faked', nor substituted with a '*care without engagement*' approach. The challenges associated with meeting this elevated expectation were clearly articulated by participants who discussed a number of key barriers to compassionate practice. However, these barriers were not perceived to be unsurmountable nor adequate excuses for uncompassionate practitioners.

Within an education context, it is clear to see how these findings might inform undergraduate education. Since 'good communication' was frequently used as a 'proxy' for compassionate practice, it is essential to maintain focus on interpersonal skills within courses for health care professionals. However, it will be important to guard against simplified, 'mechanistic' approaches to communication, focused on professional, rather than patient needs (Dewar & Christley 2014). Approaches to communication focused on relationship-centred care and 'appreciative caring conversations' may be of value (Dewar and Nolan 2014).

While this research has developed our understanding of the term compassion, there are some limitations. Although the sample size was relatively large overall, the number of participants from each stakeholder group was fairly small. Hence the sample may not be representative of larger stakeholder populations or those groups not included. In addition, the participants volunteered to take part in the study, which was conducted in a small geographical area. The views represented therefore, may not generalise nationally to the UK, or other countries and may also represent a particular type of individual. Having said this, the views expressed by each group of participants were similar, indicating a level of shared understanding across different groups.

CONCLUSION

Participants in this study held clear expectations regarding practitioners' communication skills and used these as a proxy for compassion. That is, participants made an initial assessment of whether practitioners were compassionate (or not) by judging their style of communication, the extent to which they invested time in developing positive interpersonal relationships with them and their level of personal engagement. Care given without personal engagement was viewed as non-compassionate, but had been observed or experienced by most participants.

For service users to feel that they have been treated compassionately, a shared understanding is needed regarding the nature of compassion in health care practice. However, this is an understanding that will forever shift and alter with time and as societal expectations of compassion change. It is therefore important that dialogue is maintained between health care provider organisations, health care staff, educators and service users across a range of ages, cultures and contexts, to explore and understand our beliefs and expectations of 'compassion' in health care and assess for congruence. It is then incumbent on those responsible for the selection of candidates onto health and social care courses to underpin recruitment processes with an assessment of candidates' values, attitudes and understanding of compassion.

RELEVANCE TO CLINICAL PRACTICE

The extent to which compassion is experienced within healthcare is influenced by the communication skills of health care staff. Participants were appreciative when health care

staff invested energy in developing positive inter-personal relations with them. At recruitment and selection to health and social care courses, it is therefore essential to assess candidates' style and manner of communication, and to find ways to explore individuals' level of emotional maturity, motivation and sense of personal agency. Indeed, the 'Framework for Compassionate Inter-Personal Relations' identifies key stages in the development of compassionate inter-personal relationships. It is evident that each stage of the cycle requires the practitioners' concerted effort, energy and the application of a range of skills. It can be assumed that a problem at any point in the cycle might block the development of compassionate inter-personal relations. Health care students and staff therefore require support at all stages of the cycle, lest compassionate relations become damaged or stifled, leading to negative consequences for patients, clinical staff and healthcare students.

TABLE 1: Sample Demographics

Group	Age		Gender		Ethnicity ¹	Profession ²
	Mean	Range	Female	Male		
All groups	47.4	20-76	42	3		
FG1: Students	35.0	27-45	5	0	E, A, P	AN, MHN, D
FG2: Students	40.0	33-50	4	0	E, OBC	AN, MHN
FG3: Students	39.7	20-50	3	0	E, WA	AN, SW, OT
FG4: University staff	49.3	40-55	5	1	B, BB, E, S	MHN, P, C, SW, FA, OT
FG5: University staff	46.3	30-60	6	1	E, B, WA, I	AN, P
FG6: Clinical staff	41.5	28-50	8	0	B, E, NI, RI, I	AN, D
FG7: Clinical staff	55.5	48-63	2	0	E	AN
FG8: Public	64.3	58-76	5	0	B, E	C, R
FG9: Public	55.0	35-69	4	1	E, B, WO	C, A, F, Re, R

¹ Ethnicity: E – English; B – British; A – African; P – Pakistani; BB – Black British; WA – White and Asian; WO – White Other; S – Scottish; OBC – Other Black/Caribbean; I – Indian; NI – Northern Irish, RI – Irish

² Profession: AN – Adult Nursing; MHN – Mental Health Nursing; D – Dietetics; OT – Occupational Therapy; SW – Social Work; P – Physiotherapy; C – Counselling; FA – Fine Art; F – Finance; Re – Researcher; R – Retired

TABLE 2: Themes and Sub-Themes Derived from Focus Groups

Themes	Sub-Themes
Compassion: 'A big word that you can't summarise in one'	Innate emotion Feeling of Empathy Altruistic quality Force for action
Positive Communication and Consistency	Positive interpersonal interactions Personal engagement 'Core' communication skills and behaviours Sustaining positive relationships Consistently compassionate
Losing Compassion: When the System Takes Over	Lacking sufficient time The 'system' Burnout Care without engagement
Supporting Compassionate Practice	Strong leadership Positive role Modelling Education

Figure 1: Framework for Compassionate Inter-Personal Relations

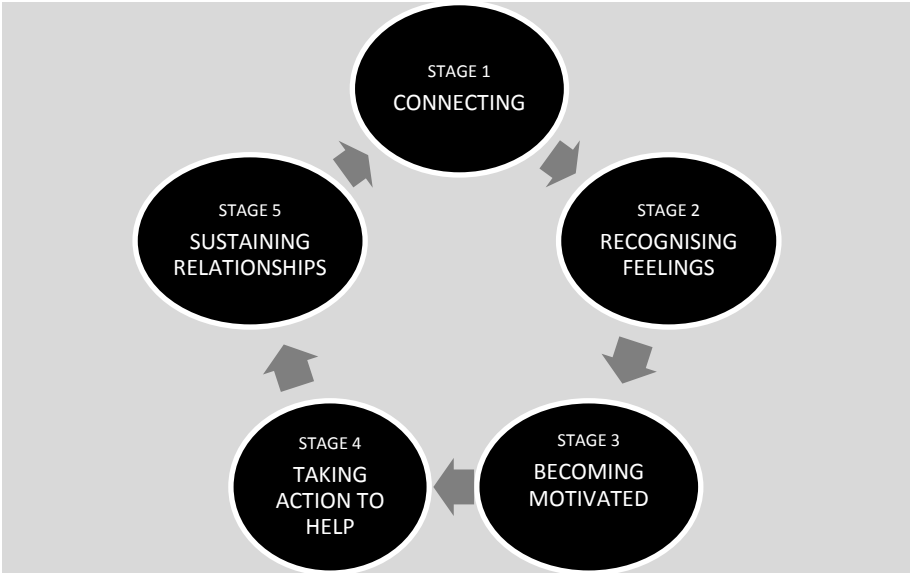


TABLE 3: Care Without Engagement: Participants' Personal Vignettes

Care of the Older Adult: Somewhere where I volunteered, all the staff there ... they did care, but obviously not many of them were compassionate at all. That was definitely a missing piece. But they were doing all the caring things – you know, when they were going to the toilet – but there wasn't the... It is that emotion, isn't it; it's that extra... extra bit. And they wouldn't be intensely focused on that person and making sure that person was, you know, very comfortable when they were eating or comfortable when they were going to the toilet. They were physically doing the feeding or taking to the toilet, and they weren't being horrible or anything, but they weren't taking that extra step to ensure the person was experiencing whatever chore they had to do in the most pleasant way they could....Yeah, so they'd be talking to... you know, while they're feeding their patient, they're chatting to their mate over there. It's that sort of thing, rather than trying to make sure that, you know... are they enjoying the food, is it...You know, am I feeding at the right speed and whatever. They're just having a chit-chat over there about what they did last night. And so it's that lacking. They're doing the caring....but it's not compassionate. (Student 1)

Investigation Unit: 'I had a colonoscopy and the doctor kept telling me it wasn't hurting....And he really didn't want to give me the second lot of Pethidine even though I was in tears. It's like, 'you don't know my pain threshold, I've had three children with no pain relief so'...it really hurt. And he was like, '...surely it's not hurting that much'. Well actually it is. There was one nurse in that room and I wish I'd got her name, she was excellent. She was compassionate, she went 'you have got to get her something', she said 'this is not made up'. She was the only....she was brilliant. She said 'no you need some more, we'll get you this' and she held my hand and said 'come on, stop looking at the screen, I know you're a student but stop looking at it'. She was excellent and at the end she came out and went 'are you alright now', but she was the only one in that room and there were six people in there. She was the only one who I can say was good at her job. For the rest of them I was just another person they had to see that day.' (Student 2)

Acute Medical Setting: 'The nurses were coming in and being very perfunctory about what they were doing, and it was lovely, they would have got good marks for what they were doing. They came in and did what they did and erm- I just said as they were going out, have you met my mother? And they said what do you mean? And I said well I mean do you know who she is? And they said well she's your mother. Yes I said- when you come back next time I'll have a picture of her [laughs] and on the iPad you know you can make it into a frame? And I put a picture of her two weeks beforehand at my niece's and I stuck it up there and next time they came they said oh is that your mother? Oh isn't she lovely looking, a lovely looking face, really cheerful and bright and things. Erm- yes that was her two weeks ago. And from that moment onwards when they were doing a procedure, the handling was a second longer and they squeezed her hand when they held it up to do things and it, - suddenly she was a person rather than a procedure that needed to be gone through (Lecturer)

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