

## *Personal View*

### **Compassion: hard to define, impossible to mandate**

Raymond Chadwick

*consultant clinical psychologist, Teesside University, School of Health and Social Care, Middlesbrough TS1 3BA, UK*

[R.Chadwick@tees.ac.uk](mailto:R.Chadwick@tees.ac.uk)

Patients most likely want to interact with the person behind the professional, writes **Raymond Chadwick**, but it's impossible to insist that staff connect emotionally with all patients

Since Robert Francis QC's report of 2013 on the inquiry at Mid Staffordshire NHS Foundation Trust, the word "compassion" has taken on new significance. Its exact meaning may not be obvious, but clearly it's a good thing, and we need more of it. Francis wrote that patients "must receive effective services from caring, compassionate and committed staff working within a common culture."<sup>[1]</sup>

In relation to training nurses he called for "an increased focus . . . on the practical requirements of delivering compassionate care." This, he opined, would require aptitude tests for compassion during selection, training supported by national standards in "fundamental aspects of compassionate care," and "leadership which constantly reinforces . . . standards of compassionate care."

So we now have "values based recruitment,"<sup>[2]</sup> an e-learning programme called *Compassion in Practice*,<sup>[3]</sup> and the "6 Cs"—care, compassion, competence, communication, courage, and commitment—as a vision for nurses, midwives, and care staff.<sup>[4]</sup>

### **What is compassion?**

But what do we understand by compassion? The Francis report did not specify this, which is curious in the light of its legalistic definitions of some other terms, such as transparency and candour. Rather, a lack of compassion is assumed to underlie the breach of what Francis called "fundamental standards"—such as giving prescribed drugs, supplying food and water to sustain life, keeping patients and equipment clean, and providing help to go to the lavatory. But satisfying these standards is hardly sufficient to ensure that care is compassionate: they could all be met mechanistically while taking no account of emotional needs.

A more direct account of compassion from 2011 defined it as "sensitivity to the distress of . . . others with a commitment to try to do something about it."<sup>[5]</sup> Sadly, all too many

accounts exist of patients experiencing a lack of sensitivity from healthcare staff. But what do we know from patients about care they experienced that was truly compassionate?

Powerful testimony is given by Kenneth Schwartz, who instigated the Schwartz Center for Compassionate Healthcare in Boston, USA and was the inspiration for the Schwartz Center Rounds, which encourage discussion of non-clinical, social, and emotional aspects of caring for patients.[6]

Schwartz was a healthcare lawyer who had lung cancer diagnosed at age 40. He was married with a young family and a busy professional life and was confronted with the imminent loss of them all; he survived for just 10 months. Shortly before his death he wrote about his experiences in the *Boston Globe Magazine*. [7]

He wrote, “I was subjected to chemotherapy, radiation, surgery and news of all kinds, most of it bad. It has been a harrowing experience . . . And yet the ordeal has been punctuated by moments of exquisite compassion.

“I have been the recipient of an extraordinary array of human and humane responses to my plight. These acts of kindness—the simple human touch from my caregivers—have made the unbearable bearable.”

The article suggested that what Schwartz experienced as compassion was authenticity—that is, the willingness of doctors and other staff to make contact not only as professionals but also as individuals. One nurse was “cool and brusque” at first but softened when she found out that he had just been told he probably had lung cancer, and talked about his two year old son and her own nephew with the same name. And one anaesthesiologist lived near Schwartz and bought sandwiches from the same shop. She wrote to him in a letter, “We as physicians are taught not to become emotionally involved in our patients because then we would be continually devastated. But . . . your life was one which I could relate to so well . . . your situation really struck a chord in me.”

Later, Schwartz met a nurse who disclosed her experience of cancer in her family. “I cannot emphasize enough how meaningful it was to me when caregivers revealed something about themselves that made a personal connection to my plight,” he wrote. “The rule books, I’m sure, frown on such intimate engagement between caregiver and patient. But maybe it’s time to rewrite them.”

For patients with life threatening illness, it is easy to understand how support of this kind could be invaluable. Certainly, many doctors and other staff go beyond the call of duty in caring for patients—but how would they feel if their organisation expected this of them?

What might be the long term consequences for staff of engaging emotionally with patients regularly?

### **Spontaneous and unexpected**

Should compassionate care be understood as a service aspiration or even as a measurable performance target? Or, by its nature, does it have to be spontaneous and unexpected, if it is to have an effect?

The reality is that no one can dictate what staff members feel towards the patients they meet. We can offer staff opportunities to express their feelings (for example, through Schwartz Center Rounds), trusting that this will enable them to remain in contact with their ordinary human reactions to the people they see. What we can actually expect is more straightforward: that staff should be courteous, in manner and words; that they should show consideration, by taking account of patients being distressed, confused, or frightened and by taking any action within their power; and that they should use their knowledge, skills, and experience in the best interests of each patient.

Compassion? It's a gift freely given by one person to another in the health service — just like anywhere else.

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