

Compassion: hard to define, impossible to mandate

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."¹

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,"² an e-learning programme called *Compassion in Practice*,³ and the "6 Cs"—care, compassion, competence, communication, courage, and commitment—as a vision for nurses, midwives, and care staff.⁴

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."⁵ 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



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?

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 had lung cancer, and they 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.

Raymond Chadwick is consultant clinical psychologist, Teesside University, School of Health and Social Care, Middlesbrough TS1 3BA, UK R.Chadwick@tees.ac.uk

Cite this as: *BMJ* 2015;351:h3991

NO HOLDS BARRED Margaret McCartney

Patient safety means minimum staffing

What is essential care? Being clean, washed, dressed. Being helped to eat, drink, use the toilet. Receiving appropriate drugs on time. Being able to rest. Being treated humanely and with kindness. Being monitored properly. Being noticed when in pain or distressed, if blood pressure falls, if agitated, or if the bathroom door has been locked for so long that something may be seriously wrong.

Basic healthcare is far beyond “basic”; it is everything. Without it, patients are not safe.

The evidence that having more staff is associated with longer survival has been accumulating and should be difficult to ignore.¹⁻³ Strikingly, a nurse looking after one extra patient is associated with a 7% increase in the likelihood of patient death within 30 days of admission (the overall death rate in this study was 1.3%). In English stroke units, having 1.5 rather than three nurses for each 10 beds is associated with one extra death within a month, in every 25 patients admitted.⁴

It comes as no surprise to anyone who has been rushing around like a proverbial blue arsed fly that understaffing is associated with mistakes

and near misses.^{5,6} But poor staffing doesn't just risk poor care for patients; it also risks chronic stress and burnout among staff.⁷

And our politicians seem not to have understood. The former health secretary, Andrew Lansley, said in 2011 that understaffing “is no excuse. We're talking about the incorrect administration of insulin, putting someone in a boiling hot bath, or failing to identify a patient using their name.

“That isn't because you're understaffed, that is because you are doing it wrong and because there is no process by which that is properly checked.”⁸ Yet the best people can make the worst mistakes, when the environment allows.⁹

This is also about quality. To promote good deaths, for example, we need the stalwarts of its delivery—our district nurses—to help us. In 2013 England had 5739 district nurses, half as many as in 2002, when the number was 10 446.^{4,5} With their numbers so depleted, how can we deliver good, hands-on care?

The truth is that we are not taking patient safety seriously enough to implement safe staffing levels. The current health secretary, Jeremy



Poor staffing doesn't just risk poor care for patients; it also risks chronic stress and burnout among staff

Hunt, said in 2013 that he would reject calls for minimum staffing levels,¹⁰ even though a report by the healthcare safety guru Donald Berwick stated, “Staffing levels should be consistent with the scientific evidence on safe staffing, adjusted to patient acuity and the local context.”¹¹

The National Institute for Health and Care Excellence has ruled on safe staffing in acute, emergency, and maternity care but has been told by NHS England to abandon further analysis.¹² Bravo to them for publishing it anyway. If staffing were a drug, doctors would be ordered to prescribe more of it. The lack of evidence on implementing safe staffing levels is a scandal.

Margaret McCartney is a general practitioner, Glasgow
margaret@margaretmccartney.com

Follow Margaret on Twitter, @mgmtmccartney

Cite this as: *BMJ* 2015;351:h3903

BLOG Samir Dawlatly

Will general practice survive?

Just before I completed my training as a GP the 2012 Health and Social Care Act was passed. I had a sinking feeling that general practice wasn't quite going to be what I thought it was.

Until that time I had been concentrating on passing my exams and assessments and had not really taken much of an interest in medicopolitics. At times I felt as though there was little hope of stability and security in primary care.

Perhaps now, with the emergence of GP Survival, a group that aims to support and represent grassroots GPs working in NHS primary care (*BMJ* 2015;351:h4070), there is a reason to be hopeful. The group was conceived initially as a social media group, set up out of frustration at the apparent failure of organisations that claim

to represent GPs and defend us from the threats of systematic underinvestment, ill conceived policy, and over-regulation.

Members of the group, acting independently as it was forming, organised a petition to the health secretary, Jeremy Hunt, about his “New Deal.” (Remember that?) The thousands of people contributing to that petition have since been dwarfed by subsequent petitions, organised by others, calling for a vote of no confidence in Hunt. Both these initiatives show how well social media can be harnessed to try to effect change. We are all more connected these days, if we choose to be.

As I write there are over 3000 members of the GP Survival online group. The numbers grow daily. But the Facebook group is not the be all and end all: the intention has always been to

These initiatives show how well social media can be harnessed to try to effect change

create a not for profit, democratic organisation representing GPs, to consistently promote general practice and challenge the media and politicians when they deride GPs, while supporting members working on the frontline.

The group hopes to draw attention to the current crisis in general practice in the UK, to identify the causes of this crisis, and to campaign for realistic solutions. It also aims to deal with the areas of workload, funding, appropriate use of general practice, promotion of general practice, and support for a skilled GP workforce.

Once the transitional team has developed the constitution and set



up GP Survival as an organisation in its own right, I'll be joining to take part in electing its first committee proper. I think its aims might have an outside chance of ensuring the survival of British general practice and perhaps help GPs survive in their jobs.

If general practice is to avoid its own migrant crisis and hold on to GPs who are retiring early, then groups such as GP Survival are essential in providing hope for the future.

Samir Dawlatly is a GP partner at Jiggins Lane Surgery in Birmingham and a member and moderator of the GP Survival Facebook group.

Find him on twitter @sdawlatly

Find out more at thebmj.co/gpsurvival