

Compassionate care: the theory and the reality

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Summary

This paper outlines the development of an emerging new approach to compassion based on aspects of human evolution and neuroscience and a review of some of the evidence for the compassionate approach. The authors also acknowledge some of the current barriers to delivering compassionate care and highlight the importance of identifying and minimising such barriers in order to enhance patient outcomes and promote clinicians as facilitators of healing.

I am interested in the science of compassion, and how organisations can best support their workforce to facilitate compassionate care. I believe practitioners secure better outcomes if they collaborate with patients and their families/carers as co-facilitators of healing. I developed the Connecting with People training to reduce stigma, promote compassion and develop a common language and understanding between those experiencing suicidal thoughts and those trying to help them. I believe that we all have a role in the paradigm shift of suicide mitigation.

Alys Cole-King

I have had a long interest in building inner compassionate capacities for people with high shame and self-critical problems. With, and for, these patients I developed compassion-focused therapy that integrates western insights on the role of attachment and affiliative behaviour with western and eastern meditation and image practices. This has led to a specific model of compassion that articulates the core attributes needed to engage with, and become attentive to, 'suffering' and the skills associated with the alleviation of suffering. This model is now applicable to a wide range of settings including personal therapy, relationship-building and organisational process. The model can help to identify where compassion can become problematic particularly when systems think about how to move from a threat-focused to a compassion-focused organisation.

Paul Gilbert

Introduction

The NHS Ombudsman's report *Care and Compassion* which gives an account of ten investigations into NHS care of older people makes difficult reading. For example 'Hospital staff at Ealing Hospital NHS Trust left Mr J forgotten in a waiting room, denying him the chance to be with his wife as she died'. We suggest that improving clinical governance will not improve patient care unless systemic and widespread changes enable compassionate care to be delivered. The recent Care Quality Commission Report *Dignity and Nutrition* reviewing care in some of the hospitals identified in *Care and Compassion* found that some of the problems still remained.

*The Point of care: Enabling compassionate care in acute hospital settings*¹ suggests actions that could promote compassionate care in acute medical settings. We suggest that they are also relevant in primary care. *Nothing personal: Disturbing undercurrents in cancer care* by Mitzi Blennerhasset² outlines her cancer treatment and her experience, at times, of a lack of compassion. Compassionate care can enhance staff efficiency, help elicit better patient information, and so inform treatment plans which lead to better recovery and increased satisfaction.^{3, 4, 5}

A science of compassion?

Compassion is commonly misunderstood as being only about traits such as warmth, kindness and gentleness. These are important of course, but compassion is much more than that. Paul Gilbert's 'compassionate mind' approach integrates the scientific study of compassion and affiliative behaviour with the use of compassion in health and mental health fields.⁶ This approach suggests that compassion is an aspect of the same abilities that primates evolved for parenting and for developing the affiliative and co-operative relationships that enable group survival. These abilities are evident in many species: all mammalian mothers are sensitive to distress in their infant and will try to reduce that distress. Bowlby's model of attachment developed out of his animal studies and infant observations, and led to important insights into how we form (and break) affiliative relationships. More recently, the neurobiological substrates of affiliative relating and empathy have been revealed.^{7, 8}

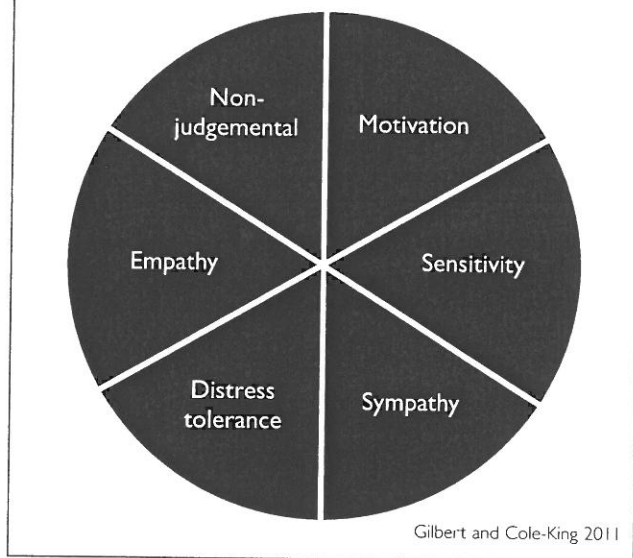
Today we might define compassion as 'a sensitivity to the distress of self and others with a commitment to try to do something about it and prevent it'. This sensitivity implies that awareness, attention and motivation are all involved. 'Doing something about it' would require commitment, courage and wisdom; indeed it is difficult to think of compassion without these qualities. Compassion is not synonymous with pity: it does not depict one person as being weak, inferior or lesser in comparison with another. Compassion is an important aspect of the Institute of Medicine's definition of patient-centred care.⁹

There is now a large and growing literature on the psychology and neurophysiology of affiliative relating.¹⁰ For example oxytocin and opiates are known to be biological mediators of care affiliation, with oxytocin linked particularly with feelings of affiliation, trust, soothing and calmness.^{6, 11} Oxytocin receptors in the amygdala influence threat-processing and important modifications of sympathetic and parasympathetic activity which have enabled mammals to engage in close personal relationships and soothe each other.¹² Therefore it would be a serious misunderstanding of science to dismiss compassion as too 'woolly' a concept for serious study or application.

Of course there is more to compassion than hormones and mammalian affiliation. Humans are unique to the extent that our compassion depends on a number of other abilities such as empathy and the ability to stand back, think and reflect. Compassion is more than just caring: we can care for the family car or a beautiful painting but we can't have compassion for inanimate objects: the only object of compassion is another sentient being. In fact it seems the skilful use of compassion fundamentally depends on humans having evolved to interact and understand the minds of others.

Paul Gilbert's 'compassionate mind' approach builds on this basic idea, namely that specific abilities and skills go into developing compassion; that it is not something as simple as an emotion or motivation, but rather a complex combination of attributes and qualities. Gilbert suggests

Diagram 1



that in the light of current research, the human capacity for compassion appears to involve two 'different' psychologies: on the one hand for awareness and engagement, on the other for skilled intervention in action. Hence the inner ring of attributes in the diagram below are the core attributes necessary for the sensitivity to engage with, and understand suffering. The outer ring relates to the skills required to (skilfully) do something about that suffering.

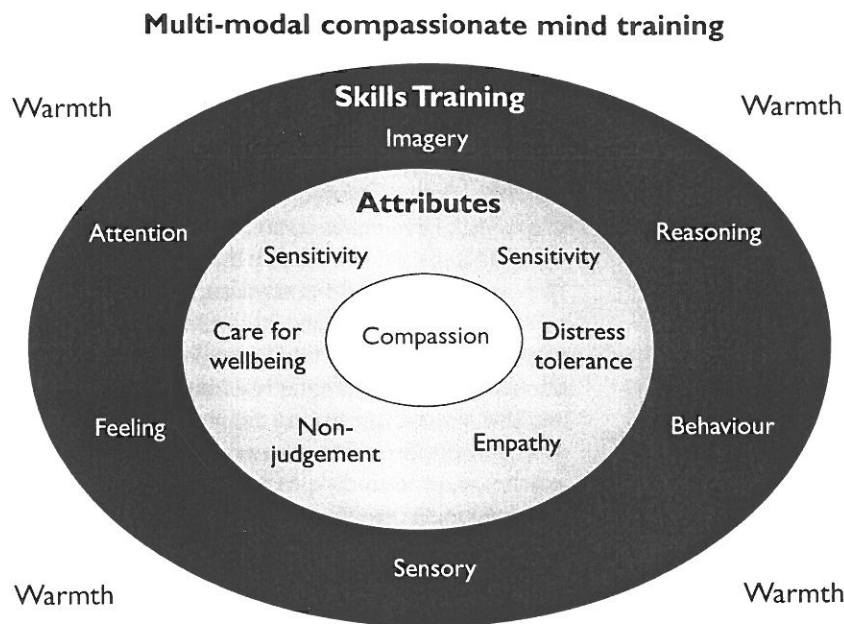
We can look at the key attributes in more detail.

Motivation The initial stage requires the motivation to be caring, supportive and helpful to others. This is the '*commitment to try to do something about it*' aspect of compassion which can operate at particular points of time, but also represent a set of values which define how we would like to be in our roles and also as human beings. Motivation is the fundamental component that shapes compassion's other attributes. For example, empathy without motivation to help could be exploitative – the advertising industry uses a certain kind of empathic insight to manipulate our desires. The motivational system is what provides the focus, the purpose and point of all the other abilities. (Motivation is referred to as 'care for wellbeing' in diagram 2). Individuals who are motivated to help others rather than having ego-focused goals have better social relationships, less conflict and greater wellbeing.

Sensitivity is the capacity to be sensitive and to maintain open attention, enabling us to notice when others need help. It is the opposite of 'turning a blind eye, or being too preoccupied to be able to notice – or too aware that one 'doesn't have time to notice' and so gradually one doesn't notice.

Sympathy is our emotional response to distress. Compassion requires an ability to be moved emotionally by another's distress. Sympathy is the sort of 'emotional connectedness' that happens when we see a child who is playing happily falling over and hurting themselves. The spontaneous feeling of being moved to help would be

Diagram 2: The compassion circle: key attributes of compassion (inner ring) and the skills needed to develop them (outer ring)



From Gilbert (2009) reprinted with permission from Constable & Robinson Ltd

Empathy allows us to understand and respect the importance of a patient's dignity and, even though their body is decaying, deformed, disfigured or malodorous, to honour it.

The nature of empathy and its importance in social relationships now has a substantial grounding in neurobiological research which has shown that it depends on distinct pathways in and between certain distinct areas of the brain. It has become clear too that when these areas are damaged the capacity for empathy may be greatly reduced and certain states of mind can block or disrupt empathic processing. Some neuroscientists are beginning to suspect that a lack of empathy may underpin poor caring or even cruelty.^{8, 14}

Non-judgement means not

judging a person's pain or distress, but simply accepting and validating their experience. Compassion also involves being non-judgemental in the sense of not condemning. Some clinical encounters may make us feel frustration (or anger, fear, disgust, sadness and so on), but if we don't find ways to work these feelings out and deal with them, they will hinder empathy. Feeling angry about a situation we cannot influence or control undermines compassion, lowers morale and makes us more vulnerable to burnout.

familiar to most of us. So sympathy is linked to sensitivity plus an urge to relieve suffering.

Distress tolerance is our ability to bear difficult emotions both within ourselves and in others. People who feel overwhelmed by another's distress may feel psychologically unable to face it and so have to turn away. Alternatively because the suffering feels too distressing, they have to act as rescuers under compulsion to turn off the other's distress as fast as possible. Being able to bear distress and cope with it allows us to *be with* distress: actively remaining present to listen and feel able to work out with the other person what might be helpful for them.

Empathy has both emotional (affective) and cognitive (thinking) aspects. It requires not simply an ability to recognise another human being's feelings, motivations and intentions, but also to make sense of their feelings and our own emotional responses. For example when we see somebody who looks tearful we register this at an emotional level, and we also try and understand that they may have experienced some kind of loss. The process is less automatic than sympathy, and requires the effort and time to imagine what it might be like to be that person in their predicament: 'to be in their shoes'. Empathy also enables us to predict the effects of our actions on others. For example an empathic nurse sees that a patient needs their water to be moved within reach, or that one patient needs a lot of information while another may not want it. Empathy can allow us to understand another's needs even when they may be unaware of them or in denial: the shy or proud person who doesn't want to ask for help may be left alone because they never 'cause a fuss', although they have important needs they feel unwilling to express.

Empathy also enables us to predict the effects of our actions on others

The compassionate skills shown in the outer circle in diagram 2 are the ways in which we go about helping. For example *sensitivity* in the inner circle is to do with openness to suffering, whereas *attention* in the outer circle means paying attention to what can be helpful. Using compassionate imagery and sensory focusing can be especially valuable when we stop and just imagine what a person is going through, or what might be genuinely helpful to them emotionally and physically. Or we might try imagining the relief somebody could experience if we were able to help them. Hence the feelings of the outer circle tend to be more positive – taking pleasure in our ability to be helpful and share a moment with our patient.

These interconnected elements enhance one another, and all are infused with an underlying warmth towards others, rather than detachment. For example, think what

might happen to your compassion if any one of these inner ring attributes were missing: you might be motivated but lack empathy; you might want to help but find it difficult to understand other people well enough; or you might work on (say) a children's cancer ward but get so upset that you lose sleep and become depressed; such compassion fatigue is well-recognised.

Becoming compassionate

The evolution of attachment and affiliative behaviour helps explain how it is possible to be emotionally invested in others, motivated to care for them and moved by their distress, yet be able to maintain empathy and make sense of it.¹⁵ Based on this understanding, we propose that there may be ways to maximise health professionals' ability to access and operate from a compassionate-mind position whatever their personal situation.

Seager suggests that having secure attachments and relationships is one of the most important contributors to empathy, but that some people (or that people in certain situations) will have a greater capacity for empathy. A personal quality that influences this capacity is self-compassion, a concept which Kristin Neff – using a Buddhist model of self-compassion – has been at the forefront of developing (www.self-compassion.org).¹⁶ Her model focuses on three major dimensions:

- *kindness* – understanding one's difficulties and being kind and warm in the face of failure or setbacks rather than harshly judgemental and self-critical
- *common humanity* – seeing one's experiences as part of the human condition rather than as personal, isolating and shaming
- *mindful acceptance* – awareness and acceptance of painful thoughts and feelings rather than over-identifying with them.

Buddhist approaches and Gilbert's compassionate mind training can provide techniques for developing self-compassion and for working through various forms of personal resistance to it.

The inescapable facts of life are that we are born, flourish for a while and must then decline, decay and die. Medicine and nursing are confronted by the darkness of the human condition, but the reality that life entails suffering and limitation is not an easy one to embrace. So although these professions will always be intimately linked with compassion, it is understandable that many of those who work on medicine's front line find it easier to focus on the objective mechanics of healthcare, than to engage with the anguish that will sometimes surround them.

It seems that the capacity for compassion is associated with certain psychological and social factors. Hope and especially feeling cared for and cared about are among the more prominent. For instance in one study of an emergency room compassion-intervention, 133 consecutive homeless individuals received a hot drink and a caring conversation. Perhaps surprisingly, this

significantly reduced the likelihood of their repeatedly returning.¹⁷ Men have a death rate 40% higher than normal in the year after they have been widowed.¹⁸ Self-compassion can be effective in protecting against and relieving concomitant depression, as one RCT of an online intervention supporting optimism and self-compassion exercises has shown.¹⁹ And, because patients are more likely to disclose concerns, symptoms and health behaviours to compassionate healthcare professionals, empathic staff could ultimately be more effective at delivering care.²⁰

There is growing evidence that compassionate clinical relationships have significant physiological effects, including prevention of health problems and faster recovery from various conditions.²¹ Cortisol and oxytocin for instance, which have far-reaching impacts on the immune system, are among the many hormonal determinants of resilience and recovery, that stress and attachment profoundly affect.²² Furthermore compassionate care also plays an important part in creating satisfying physician-caregiver relationships and better patient-and doctor-experiences.²³ Patients appreciate consistently compassionate physicians and rarely forget their 'spontaneous acts of kindness and generosity'.²⁴ A scientific understanding of such relationships and their profound physiological (or conversely, patho-physiological) effects ought to make compassionate care a more central concern in medical training and practice.

There is a relatively small subset of medical practices and procedures where 'fixing' is the most appropriate approach to take. For example, we can fix broken bones or remove cataracts and replace joints; immunisation and anaesthetics are undeniably great gifts to humankind. Moynihan however, suggests that we have 'over-medicalised' patients, and that doctors who focus only on treating and 'fixing' are in fact scientifically and clinically limited.²⁵ People with chronic long-term disease, or relapsing illnesses, or 'medically unexplained symptoms', or whose lives are ending, are all definitively 'unfixable' if approached only from a mechanical point of view rather than an emotional and personal perspective. In our fascination and deserved admiration with medical 'magic' it is all too easy to lose sight of the Hippocratic tradition that we should attend not just to the disease, but also to the person who has it. If medical science is to be wisely employed we must use it in context. Therefore, since the context is the whole person, our ever-present question should be 'how do we create the conditions for healing to happen?'

What gets in the way?

Organisations shape the way health services are delivered, in as much as they either support or militate against certain styles of working. Many kinds of constraint on compassionate care have been cited: reward systems, time demands, bureaucratic (often defensive) paperwork and various aspects of organisational culture are among

them.²³ Others have blamed 'shackles of routines and ritual', which hinder flexible, individualised and creative delivery of patient-centred care.²⁶ More specific barriers such as autonomy clashes and end-of-life values and preferences have also been implicated.²⁷

It is widely believed that nurses who are empathic and caring are more prone to absorb the traumatic stress of those they help.²⁸ Eventually this 'compassion fatigue' is said to impair such nurses' performance and make them prone to burnout. On the other hand Graber noted, after interviewing highly praised compassionate physicians, that their compassion or empathy appeared to sustain and support, rather than tire or weaken them.²⁴ In our model empathy is one of the attributes of compassion. But without the motivation to be helpful and the skills to do it, empathy can become far less benign: an empathic torturer is worse than a non-empathic one; the ultimately cold and calculating psychopath may in fact score extremely high for empathy; and empathy is very important in marketing for working out how to attract or manipulate people and 'push their buttons'. So what may be sustaining these individuals is the effective combination of empathy plus their commitment (motivation) and their skills for helping. Whether their compassion ultimately helps or harms the carer may also depend on whether the organisation they work in encourages compassionate action or stifles it. Burnout is more likely when people feel constrained from acting compassionately, because of work-culture constraints. An exploratory study of emergency care physicians and nurses found three barriers to quality improvement and compassionate care: the patient being looked at as an object; physicians and nurses belonging to different organisational cultures; and hospital internal organisation, if it hinders optimal working with patients and improvements in quality.²⁹

Moving forward

Several professional bodies which have recognised how organisations can inhibit compassion, are now actively working to promote more patient-centred care. They include the RCGP RCPsych Primary Care Mental Health Forum, and the College of Medicine. The college describes itself as a new force bringing together patients, scientists and all healthcare professionals to redefine what good medicine means by promoting 'the traditional values of service, commitment and compassion.' In fact, in many parts of the world our colleagues are exploring ways of developing a compassionate orientation towards oneself and others. (see for example Paul Gilbert's www.compassionmind.co.uk; the Center for Compassion and Altruism Research and Education <http://ccare.stanford.edu>; Hearts in Healthcare www.heartsinhealthcare.com).

Wales Mental Health in Primary Care (www.wamhipc.org.uk), an action group of the RCGP Wales, has developed three 'gold standard' hallmarks – excellent communication, trust and person centeredness – to enable excellent patient care. Managerial approaches

to healthcare reform are very valuable, provided they are informed by a deeper understanding of what influences individual motivation towards compassionate practice, and what facilitates compassionate behaviour. The Schwartz rounds are one such initiative. During an inpatient stay on a palliative care ward in the United States, Kenneth Schwartz observed that staff were experiencing emotional difficulties of their own – perhaps with attachment issues, grief or pain – and that this would sometime interfere with their providing compassionate care. For example a professional looking after a terminally ill man who reminded them of their father might find it reawakening feelings of loss and grief. In the light of his insights Schwartz established the Schwartz Rounds Centre in 1995, his assumption being that compassionate care required a compassionate setting and therefore that staff needed to attend to their own emotional health and the wellbeing of their team. Here once again we see self-compassion in action.²⁹

The Schwartz rounds are a way of encouraging multidisciplinary teams to acknowledge and share the emotional impact of working with very distressed patients, and manage their team dynamics. They are in effect a form of psychological supervision that would be familiar to GPs who have benefitted from membership of Balint groups. The rounds aim to improve relationships between members of the many disciplines involved in high-pressure multidisciplinary palliative care teams. But are they effective? Recent research into Schwartz rounds in acute hospital care suggests that by setting aside time to come together and talk through their feelings about patients, clinical teams can improve morale and provide better patient care (www.theschwartzcenter.org). But how rarely do most clinical teams meet in this way to think about the compassionate care they deliver? A recent evaluation by The King's Fund regarding the impact of team supervision on patient outcomes is awaited. Meanwhile some clinical teams in Betsi Cadwaladr University Health Board in Wales who have been engaging in Schwartz rounds for several years report very positive feedback from the staff involved.

Dr Rita Charon, director and founder of the Program in Narrative Medicine at Columbia's College of Physicians and Surgeons has another approach. She has found that encouraging medical staff to write about their patients' and their own experiences in a 'parallel-chart' enhances staff levels of compassion. In a recent study, 82% of the participating students rated this 'parallel-chart' method as beneficial, both as a therapeutic outlet for the emotional trials of residency and as a more effective way of preparing for conversations with patients and their families (www.columbia.edu/cu/alumni/Magazine/Fall2003/artofhealing.html).

Toxic organisations

We know the nature of compassionate actions and feelings, and we know how we can train staff to develop these capacities within themselves. But the systems and

structures in which health professional have to operate may prove more problematic. Though it would be a great relief to think that the poor care identified in the NHS Ombudsman report *Care and Compassion* applied only to isolated incidents perpetrated by flawed individuals, many of us suspect this is not the case. But if – despite the NHS brimming over with examples of excellent care – there is also widespread failure of care and even outright abuse and bullying, why should this be? Psychological and organisational research tells us that very often it is the organisations themselves and their structures that are the problem, because people who work in negative work cultures will tend in time to adapt to them. Just as individual practitioners can create the conditions for healing, so organisations can create conditions that facilitate compassion, or its opposite.

The individual skills that enable compassion are increasingly well known

If cost-efficiency and ‘numbers seen and processed’ are the main criteria for quality assessments, it is not difficult for managers to convince themselves that they are creating highly efficient organisations. But these environments can be extremely unpleasant and draining to be in, both for patients and staff. Bowed down and wound up by work pressure and target chasing, we are more likely to experience our more complicated or complaining patients as a source of irritation; pushed for time, it gets easier to overlook the needs of patients who are quiet and uncomplaining, but all the more difficult to behave compassionately towards them. These are not criticisms, simply well-recognised observations of time-pressured working and the complexities of non-compassion-facilitating environments. If we are honest, we may to some extent have already lost control of our workplaces, and allowed target-driven bureaucracy and cost-limitation to take precedence. In a world where healthcare trusts must now become competitive businesses, efficiencies and targets are all too likely to be over-emphasised. Furthermore, in our efforts to squeeze ever greater efficiencies in, and bad practice out, our healthcare systems may be spreading fear and shaming as motivating mechanism for change. Yet though it might be tempting to believe that the more frightened people get the more they will conform, we are playing with fire by catalysing such anxieties, and risk creating cynical, defensive, burned out staff who long only for retirement.

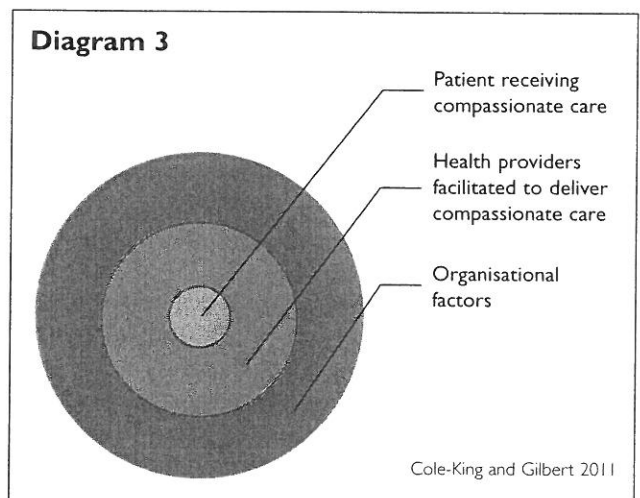
The individual skills that enable compassion are increasingly well known. It is also very clear that social groups and cultures greatly influence practice and values. Therefore in order to grow compassionate patient-centred healthcare we will also have to look beyond the individual. In his forthcoming book *Caregiver stress and staff support in illness, dying and bereavement*³⁰ Robin Youngson describes his cultural and socially-focused

model for enabling compassionate care. It integrates three elements: inner resources (for compassionate caring); a sense of togetherness; and a sense of place. He also shines a light on the powerful forces that are already disintegrating humane and compassionate caring in our modern health services.

- The disease focus, reductionism and super-specialisation can overshadow our humanity and hinder the development of our inner resources for compassion, leaving us feeling powerless and overwhelmed.
- The traumatisation of young professionals in their training and early practice, the widespread bullying in healthcare, and our unresolved emotional responses to human suffering and loss all lead to distancing and isolation rather than to trusting relationships with our patients and colleagues.
- When we create a humane and supportive work environment we can develop the inner resources for compassionate caring.³¹ When we make mistakes we need to have the courage to acknowledge them, apologise, be honest and make amends.

Studies of what facilitates pro-social behaviour in children have shown they need *role models* to guide them, to be *shown skills* that can be practised and developed, *offered rewards* for prosocial behaviour, in the context of *relationships that support* pro-social values. It seems that in developing pathways towards compassionate care in the NHS, these qualities will also prove to be central.³²

Compassion for the patient can be thought of as operating through another series of circles.



In the outer ring are the qualities, values and demands of institutional settings which may facilitate or inhibit compassionate support systems. In the middle ring are health providers who may or may not succeed in achieving genuinely compassionate mindsets, depending on whether their training and work environments support them. And at the centre is the patient who receives the compassionate care.

Conclusions

Clinicians who aspire to the highest medical standards and knowledge must understand that the therapeutic interpersonal relationship has very important effects on physiological regulation. At one level this is straightforward because in the absence of compassionate care people are frightened, upset, stressed, confused and even depressed. In the healthcare setting, all the technical, mechanical tools may be well enacted, yet delivered in such a rush of impersonal interventions, barren of time for kindness, and sensitivity to the fears of disease, injury pain and at times death, that in the outcome is a type of medicine none of us would wish for ourselves, our loved ones or anyone under our care. Yet how often do we find ourselves caught up in exactly such a rush. Consequently, for compassionate clinicians to become facilitators of healing processes rather than simple body mechanics, certain facts need integrating into our science of care: that our brains and bodies evolved to function optimally under conditions of safeness, affiliation and care; that therefore compassion has very powerful neurophysiological effects; that compassion makes our interventions more clinically effective, and therefore competent care must also be compassionate care. But if suffering is our concern then surely all aspects of the person's (and family's) suffering need to be addressed – emotional as well as physical – for clearly these interact. And so we, and the organisations we work in, must aim to provide more than mere 'tick box' technically competent care at an ever faster rate.

There is science enough to prove that compassion is not some woolly add-on we can afford to dispense with in our frenetic resource limited times: it is the creator and hallmark of quality care. It helps heal us, both in body and mind, and to come to terms with disability and impairment, or die in peace. By developing health care systems that facilitate compassionate care, our patients' experiences and clinical outcomes will be better, our own risks of burnout or litigation will be less, and our job satisfaction will be considerably greater. Above all, the presence of compassion and its primacy as an organisational value would give us confidence that when we or our loved ones fall sick or are dying, we and they will be well cared for physically and emotionally.

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Three perspectives from the real world

'The very nature of being a doctor attracts students for many reasons; some because of the academic challenges, others through a family tradition or the promise of status and control, some because of experiences of suffering they feel they must relieve. Whatever draws people into medical career, it is to be hoped that some of their motivation grows out of a genuine desire to be a healer'. Paul Gilbert (personal communication)

The following perspectives are from three different viewpoints but with the common thread of the authors having been Cardiff University fifth year medical students undertaking their senior clinical project in compassionate care under the supervision of Alys Cole-King and the senior lecturer, Philip Banfield, North Wales Clinical School. Their reflections clearly demonstrate a desire to deliver compassionate care but also some of the 'real world' challenges of doing so. They are very grateful to the support and assistance that made their projects possible including from the North Wales Clinical School, Jill Newman, Yvonne Williams and the modernisation team, Professor Matt Makin, Jilly Wilcox-Jones and colleagues, Carol Price-Jones, Jenny Jones and colleagues in the emergency department and the Betsi Cadwaladr University Health Board Library Services and the audit department.

Mo Hu, Doctor, Royal Gwent Hospital, Newport: I am a foundation year doctor working in paediatrics, with a special interest in cognitive neuroscience. I have studied the importance of compassion in determining healthcare outcomes, and its practical delivery in NHS settings. The interplay between mind and body has always interested me, and I firmly believe that providing holistic healthcare is an integral part of the healing process. Although there are barriers to providing compassionate care, I have been struck by some of the negative attitudes of healthcare professionals to such a vital component of care.

Compassion is a vital component of responsible medical practice. It can be pivotal in determining patient outcome and can shape patient experience. Working as a junior doctor I feel that the medical model often sidesteps compassionate care. On reflection, I have been struck by the lack of awareness among my peers regarding the benefits of providing compassionate care. Our reward systems are too heavily focused on quantifiable academic achievements rather than the qualitative aspects of treating patients holistically. Without support, I have found it difficult to strike a balance in providing the appropriate level of compassionate care that is consistent with my developing professional identity and individual values. I believe that more teaching and peer reflection on the quantifiable benefits of compassionate care, as well as staff reward systems, may increase the effortful practice of compassionate care. While I am finding it difficult to temper a professional relationship with a compassionate one, I believe that with experience and reflection I will become a better clinician. It would be foolish not to recognise that long hours, pressure and challenging patients can impact whether compassionate care is provided. I think it may be time for clinicians and managers to actively question their priorities.

Alexandra Lloyd, fifth year medical student, Cardiff

University: I decided to contribute to this article due to personal experiences throughout my life where I have witnessed and received both good and bad care, in many situations. One particular moment was in Malawi, where out of hundreds of people, a Malawian woman who spoke no English was the one who reached out to me in a time of distress, showing me that you can do so much for people with small gestures, and that being a doctor extends far beyond the medical knowledge we have. Having seen people in both medical and non-medical situations gaining huge benefit from just one person reaching out and going that one step further, I strive to be compassionate and caring from every angle in my personal life, and throughout my medical career.

As medical students we are trained from very early on how to be compassionate with our patients; we are taught communication skills, go through role plays, analysing everything from the words we use, to our body language, and the importance of giving patients time to talk, no matter what their ailment is. The General Medical Council provides medical students with the guide *Tomorrow's doctors* which has a section devoted solely to communication with patients, stating we should be able to: *'Communicate clearly, sensitively and effectively with individuals and groups regardless of their age, social, cultural or ethnic backgrounds or their disabilities, including when English is not the patient's first language'*.

I wanted to be a doctor for many reasons, but one key element was wanting to be able to care for others with new skills and competencies, along with providing these people with someone to turn to, talk to and trust, and to care for them in a holistic manner, providing each and

every one of them with a high level of compassion. To me compassion means treating patients with respect, hearing and understanding situations from their perspective, and acting appropriately, and never making anybody feel they are wasting my time, no matter how busy I am. This, combined with medical schools teaching on compassionate care throughout the course, means it is difficult for me and other fifth year medical students to be able to see how these seemingly basic qualities can fall below par, and in particular become a huge issue within the media. The reality of being a doctor will soon be with me and while I can see how endless patient lists, shortages of staff and a feeling of being overwhelmed with the new responsibility will all have an impact, I hope to never lose my caring attitude and desire to give patients the empathetic care they deserve.

Yvonne Honstvet, junior foundation year one doctor:

I became interested in compassionate care as fourth year Cardiff medical student following attending both the Connecting with People compassionate care and suicide awareness training modules as part of my undergraduate psychiatry placement at the North Wales Clinical School. I work as a junior foundation year one doctor in a London teaching hospital and now have hands-on experience of the day to day challenges and rewards of delivering compassionate care.

The wisdom goes that the longer the time spent in service, the less compassionate doctors become. As a medical student I empathised closely with patients. I felt like a bridge between lay person and doctor; not yet confident enough in my medical knowledge, I found that providing an encouraging nod, listening ear, or a hand to squeeze came naturally. I admired compassion when demonstrated by my seniors, I silently promised myself to do better when I encountered less than compassionate care. I am now one of the newest members of the profession – a foundation year one doctor on a busy firm, having undergone transition from idealistic student to the reality of 90-hour weeks. I endeavour to be compassionate, but am very aware of the obstacles faced in everyday practice: time pressure, an incessant beep, 40 patients to investigate, cannulate and prescribe for daily, with no time to eat/drink/or even visit the loo on duty. However, I remain optimistic that compassionate care is achievable. I have tried to build compassion into my style of work; that way it becomes the norm. As juniors we see our patients every day, and we have the benefit of building a rapport with them. I recently stayed back from a morning round to question why a patient did not seem his usual self. He announced he was contemplating suicide. I was able to get him the help he needed. This emphasised to me the importance of a compassionate interaction, no matter how brief. I cannot categorically state that every single one of my encounters with a patient or relative has been empathic. Yet neither can I recall one that I look back on and regret showing a lack of compassion. I hope that day does not come. My attitude has changed from my medical school days but for the better: I can now practice with compassion in my own right.

EVENTS



JANUARY 2012

- 12 **End of life care and the GP.** A St Christopher's Hospice half-day course. Details at www.stchristophers.org.uk.
- 21 **Embracing death and dying.** A one-day course open to all, 10 am–5pm, The Subud Centre, 26a Station Street, Lewes, with Hermione Elliott and Brian Graham. £75. Information at www.livingwelldyingwell.net/livingwell-3sem-hp.html.

MARCH 2012

- 9 **Global health alerts: Why mental health matters to global health.** An RCM free evening event. Royal Society of Medicine, 1 Wimpole Street, London. Information at <http://www.rsm.ac.uk/academ/index.php>.
- 12 **Celebrating spiritual care in NHS Scotland.** An opportunity to engage with the innovative work developed in the field of spiritual care and healthcare chaplaincy NHS Scotland since the development of national guidelines in 2002. Details/booking anne.richardson@nes.scot.nhs.uk.
- 13/14 **Spiritual care and health: Improving outcome and enhancing wellbeing.** Glasgow. A conference for healthcare researchers, educationalists and practitioners with an interest in spiritual care to explore how its delivery may enhance patient outcome and the well being of patients, their carers, staff and organisations. Details/booking anne.richardson@nes.scot.nhs.uk.
- 29 Mar –1 Apr **Two three-day courses in Somerset: Working with death and dying,** a professional development course for counsellors and psychotherapists, with Hermione Elliott and Brian Graham; **All about life and living,** an extended personal development course open to all with Louise Anderson and Osanna Whitehouse. Early bird booking by 17 January £255, £285 thereafter. Information at www.livingwelldyingwell.net/livingwell-3sem-hp.html.

MAY 2012

- 3 College of Medicine annual conference **Healthy Ageing.** More information at www.collegeofmedicine.org.uk/annual-conference-2012.

To publicise your event email Edwina Rowling at edwina.rowling@gmail.com