Compassion in nursing 2: factors that influence compassionate care in clinical practice

Exploring the professional, personal, cultural and educational factors that influence compassionate care, and how nurse educators can encourage it

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FACTORS THAT INFLUENCE COMPASSION
Caring for others is a fundamental part of nursing practice (Corbin, 2008).

It is difficult to imagine that nurses would not want to be compassionate to patients, but some factors interfere with good intentions and prevent them from being translated into actions.

Issues that may inhibit compassion in everyday nursing practice can be classified as professional, cultural and personal.

Professional factors
The availability and use of time can influence compassionate care. Pearcey (2007) studied third year student nurses’ perceptions of clinical practice and, unsurprisingly, lack of time was seen to equate with lack of care.

There are suggestions that newly qualified graduate nurses acquire knowledge from textbooks, which ill equips them for clinical practice (Tweddell, 2007), limiting their ability to provide compassionate care. This criticism fails to acknowledge that, on pre-registration courses, half the education takes place in clinical practice.

Torjuul et al (2007) found experienced surgical nurses questioned the ability of newly qualified practitioners to be as compassionate as more experienced colleagues, but this view was based on their lack of experience in challenging clinical situations. Tweddell (2007) suggested that compassion develops with experience. More experienced surgical nurses reported that being close to patients and relatives and witnessing their suffering allowed practitioners to see in a compassionate way (Torjuul et al, 2007).

Knowelden (1998) suggested that experience influences nurses’ ability to be caring, as student nurses said they were often overwhelmed by the working environment. Therefore, it could be not the amount of clinical experience but the length of time it takes nurses to acclimatise which is important. Support mechanisms such as preceptorship and clinical supervision may have a role in facilitating compassionate care. Wright (2004) argued that “personal, professional and healthcare agendas seem to draw us ever further away from the heart of nursing”. He suggested that activities considered to be intellectually demanding, such as managerial and technical aspects of care, are perceived as more important than “hands-on” care. Managerial and technical functions are more likely to be carried out by more senior or experienced nurses, drawing them away from direct care, whereas newly qualified nurses will have comparatively fewer of these responsibilities.

Pearcey’s (2007) study offers some support for Wright’s views. Student nurses said that qualified nurses mainly cared for patients’ medical needs, with the core element of nursing delegated to junior practitioners.

Many years ago, a “task-centred” approach to organising care was proposed as a possible defence mechanism against the anxiety that a more interpersonal style of working creates (Menzies, 1970). This may offer some insight into the behaviour of nurses who seek refuge in form filling and other activities not directly related to care.

Factors that inhibit compassionate care cannot be considered in isolation. As one student nurse explained: “A lot of the time, staff would probably like to spend more time ‘caring’ for patients, however with staffing levels as they are, nursing priorities are more to ensure that patients’ medical needs are met first, then if there is time the nurse can work on going beyond what is expected” (Pearcey, 2007).

This indicates a belief that, at a basic level, nurses’ role is to attend to medical needs, with additional care viewed as optional.

Caring for others may have a personal cost for nurses, and the effect of helping or wanting to help others who are traumatised or suffering can result in compassion fatigue (Absolon and Krueger, 2009).

Nurses need to be aware of strategies, both individual and organisational, that can limit the impact of working with suffering. A supportive and caring working environment (Stewart, 2009) and access to supervision are examples of organisational provision, with rest, diet, exercise, personal relationships and spiritual support as aspects that individuals can focus on (Absolon and Krueger, 2009).

Cultural factors
Exactly why society expects nurses to be compassionate is not clear, although this may be related to the profession’s religious origins and because most care is usually provided by family or friends with whom we have emotional attachments (Woodward, 1997).

Patients assume that nurses will provide compassionate care. However, once this becomes the norm, there may be a danger that it will become devalued or hidden. Compassion is an individual and natural response to the suffering of a fellow human. Attempts by nurses to overtly display this quality could mean it becomes institutionalised, lacking any real feeling and ultimately worth less (Salvage, 2006).

Cultural changes can influence nursing, or
nursing may mirror cultural changes. The view of the profession as a calling or vocation is now somewhat outdated and likely to be associated with Nightingale’s idea of service. Today, the word “vocation” is frequently used to mean career, yet originally it meant calling, particularly to a religious way of life. As religious values have become more marginalised in society, so too caring may have moved to a more peripheral position in nursing culture (Woodward, 1997).

The decline in the original vocational nature of nursing might be related to the development of a scientific basis for healthcare (Salvage, 2004). This change may also be reflected by the vocabulary used in nursing, where compassion has been superseded by the use of words such as caring and empathy. Early nurse leaders viewed compassion as a fundamental quality of a nurse (Schantz, 2007).

Science and technology have both been linked to the decline in the caring nature of some nurses. There are concerns that some nurses apply their skills to machines and systems, rather than provide care for patients (Knowelden, 1998).

A great deal of nursing is practised in hospitals, which have their own culture. There have been substantial changes in hospitals over recent years and the resulting increase in pressures may have had a negative effect on the compassion shown by some nurses (Tweddel, 2007).

Personal factors

Koerner (2007) felt the personal philosophy of nurses forms the root of compassion, arguing that an ability to see how living beings are related and involved with each other is the foundation for compassionate care. She saw compassion for others as an essential to develop in student nurses. Assuming these sentiments are truthful, nurse educators have a responsibility to nurture and develop these individuals, enabling them to become compassionate registered nurses. This might be achieved by exploring how students are assessed, both theoretically and clinically. The NMC clearly indicates that compassion is an attribute required of nurses, but it is left to educators to determine how and where it is developed and assessed.

It is possible that educators have focused on preparing highly skilled nurses, but have not allowed enough time to help them to develop fundamental caring skills. The increased focus on academic preparation for nurses may have resulted in the academic level of assignments taking centre stage. It is also easier to assess academic skills.

Increasing these assessments that measure ability to analyse the wholesomeness and complexities of practice presents challenges, and simply may not be academic enough in some eyes.

Mentors are in a good position to decide whether a student is compassionate in practice, but they are likely to need considerable support and guidance from nurse educators about how to detect the presence of compassion.

One solution could be to allow student nurses to appreciate the realities of receiving care by recording a journal or log of a patient’s feelings and emotions – in effect, using the patient and her or his experience to identify compassion in nurses.

Mentor assessment of student nurses could be guided by Kralik et al’s (1997) research, which explored patient perceptions of pre-operative care. In this study, patients categorised nurses as “engaged nurses” or “detached nurses”, identifying the qualities of the former as friendly and warm, gentle, and compassionate and kind, all attributes essential to develop in student nurses.

CONCLUSION

It is vital that nurses, whether in practice, education or leadership positions, engage in the debate about defining and communicating the role of compassion in nursing.

Without involvement from frontline nurses facing the daily challenge of providing compassionate care, nursing may have a target-driven view of this concept placed on it. This will mean that nurses and educators will have to continue to tolerate “the current focus on achievement of competencies, and a ‘tick box’ approach to measuring performance” (Hunter, 2004).

REFERENCES


