Should compassionate practice be incentivised?

In this article...

- Definitions of compassion
- The effect a focus on compassion can have on healthcare
- Suggestions for shifting this focus

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Abstract
A lack of compassion is often seen as the root of problems within the NHS. However, this assumption is open to question. It is not always clear what is meant by compassion, and it is not evident that compassion is the best way of motivating healthcare workers. Addressing organisational issues by attempting to enhance compassion may therefore mask the real cause of the problems the NHS currently faces.

Compassion is often assumed to be a prerequisite for healthcare (Leget and Olthuis, 2007). Accordingly, when things go wrong in the NHS, it is tempting to assume that a lack of compassion must somehow be to blame. Often, nurses in particular bear the brunt of that blame. However, in rushing to ascribe the situation to lack of compassion, perhaps we fail to identify all contributory factors. And, in attempting to remedy the situation by enforcing greater compassion, perhaps we are focusing on the wrong targets.

These questions are not simply academic – they have a direct bearing on how we respond to catastrophes in the health service, and affect the basis on which healthcare staff are hired and promoted, and the ways in which their performance is monitored. If we could be certain that focusing on compassion would solve the problems in the NHS, perhaps this should not be a cause for concern. However, we cannot be certain. I would suggest that lack of compassion is unlikely to be a primary cause of problems in modern healthcare and institutions, and attempting to increase compassion will therefore fail to prevent problems and may even cause or exacerbate difficulties.

Nevertheless, in response to the report on care failings at Mid Staffordshire Foundation Trust (Francis, 2013), prime minister David Cameron suggested nurses should be hired on the basis of their compassion, and that those who were more compassionate should be paid more. In short, compassion should be incentivised (Campbell, 2013). As Mr Cameron and many others know, merely uttering the word compassion can be seen as a kind of rhetorical short cut to the moral high ground; surely no one could argue against compassion and, if compassion can never be bad, those who argue for it must be right.

In order to determine whether Mr Cameron’s plan is likely to work, it is necessary to address several preliminary questions:
- What do we understand by compassion, and what work do we expect it to do? We need to be clear on this if we are to be fair to nurses who are paid less than their peers due to their lack of compassion;
- How do we measure compassion? This would be the means by which compassion was reinforced in the NHS, and must be reliable;
- Can we be certain – once we have defined, measured and incentivised compassion effectively – that problems such as those at Mid Stafford will be prevented? Or, to put it more bluntly, will it improve things?

Compassion can be understood in a number of ways. This article considers two interpretations: compassion as a deep, loving concern between individuals; and compassion as a response to urgent need.
Compassion as concern between individuals

Bradshaw (2009) sees compassion as a deep and powerful loving relationship – an emotion that causes us to respond to others and to suffer when they suffer. She regards this kind of compassion as being essential to good nursing. However, her view seems extremely – perhaps excessively – demanding. Ordinarily, we feel compassion for a limited group of people: those whom we love, or who are “part of my circle of concern... whose happiness is an element in my conception of a flourishing life” (Nussbaum, 2008).

When we see a loved one thirsty, hungry, in pain or lying in soiled bedding, our compassion may be the primary cause for our intervention. This is at least in part because our relationship with that person makes us suffer when they are in distress. The link between love and suffering, as encompassed in compassion, is often associated with religious belief, as Bradshaw (2009) notes, especially Christianity. The “passion” in compassion derives from the Latin “pati” – to suffer. Love and suffering go together. Christ on the cross is an illustration of compassion – an embodiment of both love and suffering. The idea of compassion as being associated with love feeds into the idea that it is intrinsically valuable – a virtue in its own right.

This view of compassion is associated with an expectation that it cannot easily be controlled, measured or manipulated (Bradshaw, 2009). Buber (2002) writes of empathy as being intrinsically personal, and subjective; it cannot be enforced or systematised but it springs from intimacy – the “I/thou” rather than the “I/you” relationship. Pence (1983) suggests that trust and intimacy are necessary for compassion to flourish, and that compassion is a response to the particular rather than the general; it is based on personal relationships, rather than abstract ideals or generalised roles.

If we accept this idea of compassion and expect to rely on this as the mechanism by which nurses are impelled to do their jobs, we expect each of them to be able to describe each of their patients as “one of those whose happiness is an element in my conception of a flourishing life”. However, nurses are not usually caring for loved ones. They are responsible for many people, working to fulfil many tasks as efficiently as possible, often in situations where time is limited.

Nussbaum’s (2008) conception of compassion relies on the idea that the individuals in question have formed relationships of a more or less loving type. However, no one expects to form this kind of relationship with every person they meet – the individual, human aspect of compassion militates against this. Yet, if every patient has a claim to compassion, it is not good enough to await the natural human response – each patient must be treated equally, so each must receive a regular quantity of compassion. Any patients who fail to elicit compassion could complain justifiably of discrimination regardless of the standard of care they receive. This might seem ludicrous, but it is an inescapable result of incentivising compassion.

We all find some people pleasant and appealing and others repellent. Nurses do not usually have the luxury of awaiting their emotional response to patients. Their obligation is to treat all patients, however they feel about them.

The interpretation of compassion above is clearly demanding. It requires nurses to respond to all patients as individuals, form intimate, loving relationships with them and allow themselves to become vulnerable to suffering in forming those relationships. If this is the kind of compassion we expect to incentivise, it is going to cost in terms of measuring something commonly thought to be immeasurable and in terms of the demands made on nurses’ emotions, in addition to the other demands they face. This is simply not feasible.

Compassion as response to urgent need

The second way of thinking about compassion may be relevant to Mid Staffordshire. One reason for shock at the events at Mid Staffordshire was that any ordinary person would surely have intervened had they seen someone in the kind of desperate need described (Francis, 2013). Any ordinary person would bring a glass of water, call for help or do something. The people who failed to do this were not just ordinary people but nurses, whose specific job it is to see and respond to patients’ needs.

The kind of compassion that provokes an immediate response to suffering regardless of the relationship between sufferer and responder may be a more realistic aim in healthcare. We may be able to make better sense of the Mid Staffordshire problems as failures of compassion if we interpret it in this way. We do not need to demand nurses form intimate relationships with patients; we need to ensure nurses have the same minimally decent compassionate response as anyone else.

Most of us, as averagely compassionate people, would be moved by the plight of a person in desperate need or suffering terrible pain. If this is true, compassion might be seen as a safety valve – a way of compelling staff to intervene if things are slipping or patients are suffering. Those who do not feel a compulsion to intervene when patients are neglected and dying are – on this interpretation – abnormal, lacking the most basic compassionate responses, and therefore dangerous in the health service.

The problem here is that, unlike most people, nurses frequently witness extreme need or distress; it is part of their everyday lives. Because of this, even with a normal degree of compassion, they may lack the resources to respond to everyone’s needs.

Faced with more suffering than we can hope to alleviate, most of us might hope that at least we would do what we could. Did the nurses at Mid Staffordshire do less than this? Some behaved reprehensibly, but here I am discussing the concern that nurses and other health professionals at Mid Staffordshire collectively brought about problems through the lack of compassion.

Recognising the difference between responding to an individual’s suffering and responding to suffering on a large scale is crucial. The focus on compassion as the source of the problem fails to address a vital concern: resources. If the level of need outweighs the resources required to meet that need, compassion cannot resolve the difficulty, individually or collectively.

Conclusion

The rhetorical and quasi-religious power of compassion is worth thinking about in the healthcare context. The question of how we expect nurses to feel is important but, if it is possible that some of the events at Mid Staffordshire arose through inadequate resource management, we must be very cautious about the prospect of diverting further resources to measuring something many believe to be immeasurable and creating more incentives and targets to occupy nurses and managers.

References