Is compassion possible in a market-led NHS?

In this article...

- Results of a systematic review of core nursing values
- Why politics, policy and organisational culture can damage professional caring values
- How nurses can assert their values and respond to challenges posed by organisational culture

Keywords: Compassionate care/Compassion deficit/Healthcare culture/Healthcare markets

While nurses have been accused by the media of lacking compassion there is little evidence of a compassion deficit in the profession.

The values and behaviours expected of nurses and health and social care professionals are laid out in the NHS Constitution (Department of Heath, 2012a) and the principles of compassion, empathy, dignity and respect are increasingly seen as core elements of high-quality nursing care (DH, 2011; 2010). While the NHS is being radically restructured and core services are being contracted out to private care providers, many reports appearing in the media seem to focus on the supposed shortcomings of nurses and the profession.

Compassion deficit

There have been reports of institutional failings such as the culture and practices at Stafford Hospitals (Francis, 2013; 2010), and sensationalist headlines suggesting graduate nurses are “too posh to wash.”

There has also been considerable professional commentary on the causes and effects of the “compassion deficit” and it has been suggested the supposed decline in care standards and increase in negative patient experiences mean that nurses need to re-establish kindness, caring and compassion as key professional practices (Peate, 2012; McHale, 2012; Blakemore, 2011). In December 2012, the chief nursing officer and director of nursing at the Department of Health published the vision and strategy for compassion in practice (DH, 2012b), emphasising the importance of “The 6Cs” – care, compassion, competence, communication, courage and commitment.

The concepts, which are central to the idea of compassionate care, are not easily defined. The professional literature shows a body of research focused on identifying how key values of compassion, empathy, dignity and respect are understood by both nurses and the public.

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5 key points

1. Research shows compassion, empathy, dignity and respect to be core nursing values
2. Compassionate care results from the interaction between nurses and the organisational and social contexts of nursing
3. Organisational culture, policy and politics can exert a damaging influence on caring values
4. The founding ideals of the NHS have radically changed, with compassion not part of competitive markets
5. Compassion deficit is more likely to be due to political ideology driving health policy than shortcomings in nurses’ caring values
nurses and the public. It has been suggested that human and social dignity are fundamental to humanity itself (Jackson, 2009) and that good healthcare practice is about much more than the sum of knowledge of disease and its treatment (Royal College of Physicians Working Party, 2005).

In the modern NHS, nurses are required to have a range of medico-technical competencies alongside their inherent caring attributes and interpersonal skills (Goethals et al, 2010). It has been proposed that a compassionate health service is one in which nurses (and other health professionals) are responsive to non-medical expectations (Hopkins et al, 2009). This is a service where nurses are able to talk and listen to their patients and attend to the small details that may not be medically important but are of concern to patients and their families.

Can compassion be measured?

Compassionate care needs to be understood as the product of human relationships, professional cultures and healthcare environments (Spandler and Stickley, 2011; Baillie, 2009) and in this context it is easy to see the potential for tensions to arise between nurses seeking to deliver compassionate care and the culture of evidence-based practice (EBP) in the NHS.

It has been suggested that the socialisation of nurses in the “real world” of care delivery creates a tension between the inherent values of practitioners and the environment in which they work (Curtis et al, 2012; McSherry et al, 2012). The evidence-based practice movement has been useful in determining the effectiveness of treatments and interventions, but the nursing practices and kindnesses that actually make care compassionate are not necessarily amenable to research enquiry and cannot therefore be evidence based. Georges (2011) goes so far as to suggest the “euphemism” of evidence-based healthcare masks a depersonalisation of core nursing values, resulting in the compassion deficit.

In a climate of evidence-based healthcare, outcome measures assume great significance, whether these are indices of mortality, morbidity, length of stay, or clinical or economic outcomes. It has even been proposed that NHS trusts and health professional groups will be required to demonstrate the mechanisms by which they measure compassion in care delivery (Jackson and Irwin, 2011), while from April 2013 the government will introduce the friends and families test as a measure of the quality of care. While there may be some consistency in the way patients, families, nurses and other care professionals conceptualise caring values, it is debatable whether compassionate care can be appropriately and reliably measured.

It is perhaps understandable that nurses at the front line of care delivery have become the focus of criticism about declining care standards. However, we know that the great majority are dedicated and compassionate professionals who are driven by a desire to care for people.

It was in this context that we carried out a systematic review of the evidence with the aim of uncovering any factors that influence nurses and other health professionals in delivering compassionate care.

Review method

Literature was eligible for inclusion if it was published between 1 January 2001 and 31 July 2012, was written in English, related to core values and behaviours as defined in the NHS Constitution (DH, 2012a), was reporting a research study or was a professional discussion paper.

A total of 177 publications were retrieved. Initial screening indicated the literature could be classified into three types:

- Profession-specific discussion;
- International research reports;
- UK research reports.

Study designs and reported methods were evaluated using the Critical Appraisal Skills Programme frameworks, which identified 14 international research reports and 19 UK research reports as eligible for inclusion. A further 30 papers were identified as appropriate discussion pieces, which helped us to interpret the findings of the research. The evidence came from a range of disciplines, including nursing, medicine and dentistry. Some studies attempted to measure compassion, and about half were concerned with the selection, education and training of compassionate nurses and health workers. The remainder explored nurses’ and patients’ experiences of compassion, empathy, respect and dignity, and these papers are discussed here.

Key themes

Tasks and routine

Research in the care settings where poor standards of care were a cause for concern reflected stories reported in the media. It was not surprising to find that the patient groups commonly associated with poor care were older people, those with mental illness and the dying. In a healthcare culture that is focused on targets, outcomes and efficiencies, the care of these vulnerable individuals costs both time and resources, so they cannot be seen to represent economic “value” in a competitive market.

In an NHS organisation under politically driven human resource and financial pressures, it is perhaps inevitable that nurses’ medico-legal responsibilities, such as medicine rounds and completing nursing records, are prioritised. Interpersonal care then becomes task focused and made into routines to meet management targets and deal with staff shortages (Woollhead et al, 2006).

Rules and hierarchy

The research included in the review also showed that where compassion in care was lacking, this was most often in organisations with rigid rules and hierarchical structures (Jackson, 2009).

Walsh and Kowenko (2002) found nurses’ and patients’ understanding of dignity were remarkably similar, and both recognised how organisational factors contributed to compromised care. They also found nurses know when their care practices violated privacy, dignity and respect, yet many refused to surrender their core values in difficult circumstances. Other studies also showed organisational factors, beyond individual nurse attitudes and behaviour, play a significant part in situations of declining care standards (Burhans and Alligood, 2010; Hoy et al, 2007).

Organisation and funding

The political and economic structures that organise – and fund – health services were another key theme in the review. Here, the evidence showed nurses feeling frustration and disillusionment at not being able to do their job properly.

Maben et al (2006) suggested that newly qualified nurses enter the workforce with strong compassionate values and ideals, but these are “sabotaged” by organisational factors that are manifest in bureaucratic working arrangements, and adherence to covert rules to “get the job done”. Woogara (2005) also identified organisational arrangements that left nurses feeling remote from management teams, feeling
they were not being listened to and having their complaints ignored, working to rou-
tines that prioritised efficiency over care, and having to care for challenging “mixes” of patients with assorted conditions and different care needs.

Spandler and Stickley (2011) discussed “compassion fatigue” and “burnout” and that compassionate care is not about the attributes of individual nurses, or a slogan that healthcare organisations can use for a “quick fix”. They said that compassion is a quality or philosophy that should underpin all healthcare policy and practices.

Discussion

NHS care standards are in decline, the evidence suggests. However, in a professional group as large as nurses, there hold compassion, empathy, dignity and maintaining core values and commitment.


Sanderson H, Stickley T, Mchale J (2011) No hope without compassion: the importance of compassion in recovery-focused mental health services. Journal of Mental Health; 20, 6, 555-566.


References


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Research specific to UK nurses

The research specific to nurses in the UK makes up a large part of the international evidence base about compassionate care, and accounted for 10 of the 33 studies.

Some early studies (Faithful and Hunt, 2005; Woogara, 2005) have described nurses’ and patients’ understandings of key values, while other UK research has been influential by highlighting the importance of organisational cultures in delivering compassionate care.

The substantial body of work by Baillie and collaborators (Baillie and Gallagher, 2011; Baillie, 2009; Baillie et al, 2009) has described factors that promote and sustain dignity, and also those that compromise professional values. These factors include some individual attributes of nurses, but also time constraints; the physical environment in which nurses work; high turnover and bed occupancy rates; management pressures; NHS targets; and financial pressures. Baillie et al’s (2009) work is vital in recognising the need for a compassionate ethos and culture at all levels of the NHS and individual NHS organisations.

More recent UK studies (Chadwick, 2012; Curtis et al, 2012) have reinforced the idea that there is a tension between professional nursing ideals and the reality of clinical practice, and that time and an empathetic organisational culture are essential to deliver compassionate nursing care.

Maintaining core values and practices

The research reviewed shows that nurses do hold compassion, empathy, dignity and respect as core professional values; however, in a professional group as large as nursing, there will always be some people who do not deliver compassionate care. This is no different to other professions such as doctors, lawyers or teachers.

While distressing incidents suggest NHS care standards are in decline, the evidence does not support the argument that