“Blaming disadvantaged patients has no place in care”

Most nurses provide a high level of care to most patients – but not all. It appears acceptable not to offer some groups of people compassionate care and for health services to discriminate against them.

There has been a lot of discussion around Compassion in Practice, which sets out the 6Cs – a set of values and behaviours that aim collectively to improve nursing at every level. It has probably generated much informal debate between nurses nationwide; some will welcome it but others will view it less positively, seeing it almost as an insult to them and the profession, maybe thinking: “If this needs to be taught, are we training and employing the right people?”

As a community matron in the health inclusion team, I work with some of the most discriminated-against groups, namely homeless people, sex workers, substance misusers and ex-offenders. These people experience multiple and enduring disadvantages and are cut off from the opportunities most of us take for granted. As a result, they are doubly disadvantaged by experiencing difficulty in accessing health services in general, and primary care in particular.

One explanation for this is stigma, which, in my experience, is common. I often hear comments about our clients – “dirty”, “smelly” or “it’s their own fault because they drink” – from my colleagues. Refusing to operate on patients who are obese has resulted in public outrage as this is viewed as discriminating against overweight people; this refusal, however, is based on sound scientific evidence that obesity is a risk factor for surgery. I am convinced no one would consider being disrespectful to a patient in the terminal stages of lung cancer through smoking. Yet it remains acceptable to use the “self-inflicted” label for people who experience cellulitis through drug use or frequent falls when under the influence of alcohol.

There is a high did-not-attend rate for these clients, which can lead to their gaining a reputation as “time wasters”. When a person is hearing or visually impaired, legislation demands the NHS takes specific measures to help them access healthcare, yet there is no such consideration for those with no permanent address who cannot be sent an appointment letter. Access could be improved for these patient groups by considering how their lifestyle affects their likelihood to attend, such as timing an appointment for a person with an addiction issue for when they are neither too heavily under the influence nor experiencing withdrawal.

Many users of the health inclusion service have mental health issues and often resort to drug or alcohol use as a form of self-medication. We may be quick to judge, but how many of us self-medicate, for example, by having a glass of wine at the end of a hard week?

During winter, many hard-to-reach groups experience significant emotional, mental and physical hardship. Surely a true test of compassion would be to consider their needs and ensure they are met?

Jane Morton is community matron for the homeless, Shelton Primary Care Centre, Stoke on Trent

We’ve heard an awful lot about compassion in healthcare over the past year. There has been much debate, and calls to recruit and reward nurses on the basis of compassion. Can nurses really be expected to treat all patients with compassion? Patients should receive respectful, dignified and high-quality nursing care – is it too much to demand compassion for all?

Compassion is an emotional response, and our Discussion on page 18 questions whether it is reasonable to expect nurses to put so much of themselves into each and every patient. The author warns against incentivising it, and adds that focusing too much on compassion may distract from other factors that may contribute to poor care, such as a lack of resources.

Nurses already undertake more emotional labour than most professionals, and are, in the end, only human.

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