Chapter 2

Background to Compassionate Healthcare

Compassion in Healthcare: The Heart of Medicine

In light of the definition of compassion discussed in the previous chapter, it might seem inevitable that compassion would lie at the heart of all healthcare. After all, healthcare is focused on 'health' and 'care', and one would imagine that any system which is centred on such concepts would hold compassion as a central value. But while this is true in theory, and sometimes in practice, compassion often gets lost in healthcare delivery systems that are over-stretched, poorly structured, increasingly computerised, and often neglectful of the perspectives of patients, families, and staff alike.

There are many reasons for this erosion of compassion. Increased demand on health services, coupled with limited resources, means that clinical staff are often stretched thin, managing large caseloads with insufficient time to spend with each person. This can develop into a transactional rather than relational approach to each individual patient, with a focus on efficiency and throughput rather than compassion, understanding, and addressing the individual needs and concerns of each patient and their family. This is a regrettable consequence of health systems that value throughput and efficiency to a degree that impairs the opportunity to cultivate other values, such as compassion and empathy.

Growing reliance on technology and electronic health records can also depersonalise patient-doctor interactions. Despite the many benefits of technology for information management and diagnostic precision, it is increasingly easy to spend much of the patient-doctor consultation looking at a screen in search of test results, prescribing guidelines, treatment algorithms, or appointment times. Technology is seductive. Often, test results and biometric data promise a degree of certainty in situations of great unclearness, medical ambiguity, and personal distress. This apparent certainty is, however, often illusory, and can command considerable opportunity cost. An overreliance on technology changes the nature of personal interactions with patients and diminishes quality of care.

These problems are commonly compounded by workplace cultures that prioritise measurable 'outcomes' or numbers of patients seen, rather than person-centred values such as compassion, empathy, relationship, and understanding. This emphasis on quantitative 'outcome' measures can discourage doctors and other professionals from spending time building relationships with patients and families, and deepening compassion. It is difficult to prioritise such efforts when they are routinely ignored or, at best, rarely recognised or valued in the workplace.

Finally, and perhaps most urgently, working in healthcare can command a severe emotional toll on staff and can diminish capacity for compassion owing to emotional and physical exhaustion. Healthcare is fundamentally focused on helping others, but healthcare

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workers can become detached, burnt out, and despondent over time. Empathy is eroded. Compassion declines. Patient care suffers.

Often, the expectation is that we, as healthcare staff, should detach emotionally from our patients in order to provide care that is based entirely on logic or on certain kinds of evidence, rather than care that is *also* informed by compassion and relationship-building. This continues to be the case despite growing evidence that patients do not like this approach. When asked, patients usually express a desire for personalised and humane clinical care (Bensing et al., 2013). They emphasise the value of fostering the patient-doctor relationship and providing personal attention, empathy, and warmth.

Baguley and colleagues agree that 'compassion is important to patients and their families, predicts positive patient and practitioner outcomes, and is a professional requirement of physicians around the globe' (Baguley et al., 2022; p. 1691). In an especially interesting study, this group used 'topic modelling analysis [to] identify empirical commonalities in the text responses of 767 patients describing physician behaviours that led to their feeling cared for':

> Descriptively, seven meaningful groupings of physician actions experienced as compassion emerged: listening and paying attention (71% of responses), following-up and running tests (11%), continuity and holistic care (8%), respecting preferences (4%), genuine understanding (2%), body language and empathy (2%) and counselling and advocacy (1%).

This research group concluded that 'these early data may provide clinicians with useful information to enhance their ability to customize care, strengthen patient–physician relationships and, ultimately, *practice medicine in a way that is experienced as compassionate by patients*' (italics in the original).

These, then, are key components of compassion in clinical care: listening, continuity of relationship, holism, respect, understanding, empathy, and advocacy. These are also key components of good medicine, and many patient complaints result from a failure to observe these values. Given their centrality and clear significance, can these values be learned by trainee professionals? Can these values be taught?

Compassion in Medical Education: Back to Basics

Medical education tends to value compassion in theory, but less so in practice. Not only do contemporary health systems seem to work against compassionate care much of the time, but medical students are expected to learn from the behaviour of clinicians working in these environments. So, while compassion is written into our professional identity as healthcare professionals, students might not consistently see compassion in practice, and therefore tend not to learn it as a practical value or a useful skill.

Teaching compassion in medical schools requires a comprehensive approach that combines knowledge acquisition with skill development and reflective practice that supports self-awareness. Most of all, teaching compassion means sustaining an educational environment that values and practices compassion itself, supports future healthcare professionals in their personal development, and prioritises the delivery of compassionate, person-centred care at all stages of the patient experience.

Regrettably, it appears that medical training does not increase empathy amongst medical students, and can even decrease it (Neumann et al., 2011; Hojat et al., 2020). Why is this? How can it be changed?

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In addition to role-modelling empathic interactions and compassionate care, it is necessary to add nuance to two concepts that commonly inform medical training. The first concept is the need for 'equanimity' in clinical practice (which is often mistakenly interpreted as detachment) and the second is the centrality of evidence-based medicine in contemporary clinical practice (which is often mistakenly regarded as the *only* value that should inform clinical decisions). First, equanimity.

Traditionally, medical students are (rightly) taught the value of equanimity. This is the ability to remain calm in the midst of anxiety, uncertainty, and emergency situations. In these settings, the equanimity of the healthcare professional is extremely helpful, highly therapeutic, and can be lifesaving. On the other hand, the idea that equanimity means remaining entirely detached from patients' experiences and emotional states can be deeply unhelpful. Equanimity does not out-rule engagement with the anxieties, fears, hopes, and emotional states of others, provided appropriate boundaries are observed in such interactions.

The benefits of equanimity were famously outlined by Sir William Osler (1849–1919), the Canadian physician and a founding professor of Johns Hopkins Hospital. Osler was one of the first medical teachers to bring students out of the lecture hall and to the patient's bedside for clinical teaching early in their training. He wrote that 'the natural method of teaching the student begins with the patient, continues with the patient, and ends his studies with the patient, using books and lectures as tools, as means to an end' (Osler, 1906; p. 315). Osler was highly patient-centred in his approach to care.

In a well-known speech titled 'Aequanimitas', Osler emphasised the importance of equanimity or 'imperturbability':

> In the physician or surgeon no quality takes rank with imperturbability . . . Imperturbability means coolness and presence of mind under all circumstances, calmness amid storm, clearness of judgement in moments of grave peril, immobility, impassiveness, or, to use an old and expressive word, *phlegm* . . . the physician who has the misfortune to be without it, who betrays indecision and worry, and who shows that he [*sic*.] is flustered and flurried in ordinary emergencies, loses rapidly the confidence of his patients. (Osler, 1906; pp. 3–4)

For Osler, however, equanimity did *not* mean detachment. Quite the opposite: Osler emphasised that 'a clear knowledge of our relation to our fellow-creatures and to the work of life is also indispensable' (Osler, 1906; p. 6). He added, again in the language of the times, that there is a need to appreciate the essential, relational, human essence of medical practice:

> Nothing will sustain you more potently than the power to recognize in your humdrum routine, as perhaps it may be thought, the true poetry of life – the poetry of the commonplace, of the ordinary man, of the plain toil-worn woman, with their loves and their joys, their sorrows and their griefs. (Osler, 1906; pp. 404–5).

For Osler, equanimity did not preclude engagement, empathy, and compassion. Rather, these values lay at the very heart of clinical care, along with some judicious equanimity to maintain them.

Today, the idea of 'evidence-based care' is even more commonly said to lie at the heart of medicine and has, arguably, become the dominant value in medical education, even more than equanimity. This has been an enormously positive development in many ways. Evidence-based care has enhanced human health immeasurably and lengthened lives. It

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would, however, be a mistake to see evidence-based medicine as the only requirement for good clinical care. More is needed, along with equanimity and a firm evidence base.

In a commentary on empathy, Spiro regrets that medical practitioners have risked losing their sense of humanity in a 'crusade for "evidence-based" certainty' (Spiro, 2009; p. 1178). Has this overdue emphasis on evidence-based care led to a loss of empathy or compassion in clinical care? Spiro asks whether empathy can be taught, citing Osler's concept of equanimity as one of the problems in teaching empathy, especially if equanimity is praised as meaning 'detachment', which, if carried to excess, results in the suppression of emotions even when doctors themselves fall sick.

However, going back to the roots of the word equanimity and its use in contemplative traditions, it is clear that equanimity refers to balanced emotion or evenness of mind (Fronsdal and Pandita, 2005). Equanimity arises from observation, the ability to see without being caught up in what we see, and the spaciousness that comes from appreciating the bigger picture or seeing with understanding. Osler, too, did not regard equanimity as a form of detachment, but rather a form of wise engagement and awareness.

The true meaning of equanimity relates to a judicious combination of compassion (as the emotional response to another's suffering), the motivation to relieve that suffering (by calmly applying proven remedies), and a good degree of self-awareness (to balance cognition with emotion in difficult circumstances). This is not always easy to achieve, but an awareness of these values can help to deepen compassion, expand empathy, and improve clinical experiences for all involved: patients, families, staff, and students.

Compassion in Medical Ethical Guidance

Compassion is repeatedly highlighted as an essential attribute by a wide array of professional, regulatory, and educational bodies. This is not surprising, given the natural link between medical practice and providing patient-centred care, but it is useful to highlight just *how* prominent compassion is in such guidance, despite the relatively low weight attached to it in most programmes of undergraduate medical education.

In the United Kingdom, the General Medical Council, in *Good Medical Practice 2024*, states that 'the approach and attitude of a medical practitioner can have a lasting impact on a patient. Treating patients with kindness, compassion and respect can profoundly shape their experience of care' (General Medical Council, 2024; p. 11). The 'core values framework' of the Royal College of Psychiatrists also includes compassion, which it defines as 'paying attention to the quality of care and being sensitive to personal need' (Royal College of Psychiatrists, 2017; pp. 4, 9).

In Ireland, the Medical Council, in its *Guide to Professional Conduct & Ethics for Registered Medical Practitioners (9th Edition)*, states that doctors are required to 'act with honesty, integrity and compassion' (Medical Council, 2024; p. 7). For 'patients [who] are nearing the end of life', the Medical Council emphasises that 'you share responsibility with others to make sure they are comfortable, suffer as little as possible and die with dignity. You should treat them with kindness and compassion' (p. 45).

In the United States, the first principle in the American Medical Association's *Principles of Medical Ethics*, is that 'a physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights' (American Medical Association, 2001). The Canadian Medical Association's *Code of Ethics and Professionalism* lists 'virtues exemplified by the ethical physician' and writes that 'physicians

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enhance trustworthiness in the profession by striving to uphold the following interdependent virtues': 'compassion', 'honesty', 'humility', 'integrity', and 'prudence' (Canadian Medical Association, 2018; p. 2). They add that 'a compassionate physician recognizes suffering and vulnerability, seeks to understand the unique circumstances of each patient and to alleviate the patient's suffering, and accompanies the suffering and vulnerable patient'.

Patients agree with the value accorded to compassion in these documents. Compassion is consistently recognised by health service-users as a hallmark of quality treatment and a key element of person-centred care (Sinclair et al., 2016; Lown et al., 2017). This book seeks to explore the idea of compassion in this context in some depth, noting that it is linked with, but somewhat different from, empathy. Empathy is the quality of experiencing the suffering of another person, whereas compassion includes the motivation to act. Our current understanding of the neuroscience of the two constructs suggests that empathy activates the pain circuits of the brain and compassion activates reward circuits (Goldberg, 2020). This suggests that an excess of empathy can lead to burnout, but compassion can enhance resilience and feelings of fulfilment, with the caveat that the physiology of compassion is undoubtedly complex and in need of further analysis (Di Bello et al., 2021).

Both compassion and empathy are linked with good communication, but both concepts also involve a great deal more than communication alone. At medical school, communication skills are often taught with a view to fostering compassion and empathy. Performed well, such teaching can help with both of these values, because there can be little compassion or empathy without effective communication. But both compassion and empathy require considerably more than simply good communication, as we will explore throughout the rest of this book.

The Elephant in the Room

Nobody who is reading this book, leafing through it in a store, or reviewing it, can help but ask: 'What about the elephant in the room? It's the system, stupid!' Healthcare delivery systems, like all complex structures, can feel disempowering, dysfunctional, and distressing for those within them. Health systems can be paradoxically unhealthy and even harmful. They can feel toxic, broken, lacking resources, and starved of compassion.

Official report after official report decries the state of healthcare in many countries and bemoans the apparent lack of compassion at the heart of various health systems. As a result, many people who hear about strategies to help healthcare staff to cope with stress rightly point out that much of the fault lies within the system itself, rather than the staff. We need to fix the system, not just shore up people who are doing their best in toxic circumstances, or implicitly suggest that they lack 'resilience'. If staff need to don a suit of psychological armour or an emotional hard-hat when they come to work, the fault lies with the workplace, not the workers.

Many of these problems became more apparent during the Covid-19 pandemic in the early 2020s. In 2023, Garnett and colleagues published a 'scoping review' of 'compassion fatigue in healthcare providers' during this time, and wrote that 'the elevated and persistent mental stress associated with the COVID-19 pandemic predisposed healthcare providers (HCP) to various psychological conditions such as compassion fatigue':

> Declines in health providers' mental health has been observed to negatively impact their professional performance and the quality of patient care ... The main risk factors for

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> compassion fatigue include younger age, female sex, being either a physician or a nurse, high workload, extensive work hours, and limited access to personal protective equipment (PPE). Negative behavioral intention towards patients has been identified to be a consequence of compassion fatigue. Interventions such as the provision of emotional support, increased monitoring for conditions such as stress and burnout, and increasing available personnel helped to minimize the occurrence of compassion fatigue.
>
> (Garnett et al., 2023; p. 1)

In many ways, the pandemic reminded us that certain health systems are capable of extraordinary emergency responses when they are required, but also that healthcare systems need to evolve considerably, especially in terms of day-to-day impact on healthcare workers and mainstreaming compassion as a value at all levels.

In rich countries with relatively more resources, health systems need to become more heart-centred and align with the core values of the professionals who seek to deliver care within them. These core values include autonomy, belonging, compassion, empathy, being valued, and a sense of making a competent contribution. In poor countries, systemic problems relate more to lack of resources and there is a different set of problems, but core values still need protecting: healthcare systems must be designed to care and be compassionate.

Heart-centred, compassionate care *is* possible. In Zimbabwe, for example, the Friendship Bench project offers mental health support and creates a sense of belonging in communities where formal mental healthcare is not always readily available.[1] In 2017, the *Guardian* reported on how the project operates:

> The therapy room is a patch of waste ground, and the therapist's couch a wooden bench under a tree. The therapist is an elderly Zimbabwean woman . . . Her patients call her 'Grandmother' . . . Outside a clinic in Highfield . . . just south of Zimbabwe's capital Harare, there are lots of grandmothers – trained but unqualified health workers – who take turns on the park bench to hear stories. They listen to the battered wife who has attempted suicide twice, the man who hates women after he became infected with HIV, the unemployed single mother driven to despair by the struggle of raising four children. (Mberi, 2017)

Compassionate care works. Ten years ago, one research group outlined the possibilities presented by initiatives such as the Friendship Bench:

> In Zimbabwe, where prevalence above 20% for CMD [common mental disorders] has been reported amongst adult primary care attendees, we recently piloted a task-shifting programme called The Friendship Bench and showed evidence of the feasibility and acceptability of using LHWs [lay health workers] to deliver a psychological intervention for CMD. The Friendship Bench programme consists of a cognitive behaviour therapy (CBT) based intervention that emphasises the use of problem solving therapy (PST) for the treatment of CMD. It is delivered by trained LHWs who are employed by the city health authorities in the city of Harare, Zimbabwe. The intervention consists of six sessions of 30–45 min of structured PST, delivered in a discrete area outside of the clinic building on a bench (The Friendship Bench). The PST components consist of problem listing and identification, problem exploration, developing an action plan, implementation, and follow up. We have found preliminary evidence of a clinically meaningful improvement in CMD using this locally adapted PST approach. (Chibanda et al., 2015; p. 2) (citations omitted)

[1] www.friendshipbenchzimbabwe.org/ (accessed 1 March 2024).

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Subsequent work confirms the benefits of this intervention, with this model of therapy showing improved outcomes compared with standard care (Chibanda et al., 2016). Other initiatives elsewhere focus on compassion in order to deliver better, more appropriate care in various healthcare settings, including end-of-life care.[2]

For many projects, patient and carer involvement support the emergence of compassion as a care priority. When patients are truly engaged as active partners, outcomes are better, and care is more empathic and compassionate. The fragmented structure of many healthcare systems does not always facilitate this. Operating in silos means that the manager thinks they know what is best for the frontline person, the frontline person thinks they know what is best for the patient, and the patient thinks that no one is helping or listening to them. Working together in partnership, with compassion and empathy, can help to address this.

To face the Elephant in the Room firmly in the eye before it charges at us, it is useful to recognise people who are already working to transform healthcare through compassionate leadership, embedding core values centred around compassion into the system from the top down, with clearly designed roadmaps and practical steps.[3] We explore some of these in the coming chapters.

Against this background, the remainder of this book focuses on supporting each person to be as compassionate as possible within whatever context they are working, in the knowledge that having compassion for one's self and others will lead to a sense of resilience and thriving in the workplace. After all, to bring this back to the start of our journeys, at the heart of our reasons to become healthcare professionals was the desire to help.

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[2] See, for example: https://projectecho.unm.edu/news/promoting-palliative-medicine/ (accessed 1 March 2024).

[3] See, for example: www.globalcompassioncoalition.org/topics/healthcare/ (accessed 1 March 2024).

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