Richard Vincent wonders if we are losing the intuitive ingredient of healthcare

ARE WE LOSING OUR COMPASSION?

key points

- The key elements of compassion are attentiveness, empathy and action.
- The loss of compassion in healthcare has resulted chiefly from a pre-occupation with the physical sciences, poor role modelling and a mismatch between demand and resources at both personal and institutional levels.
- Strategies for restoring compassion are gaining momentum based on a variety of different worldviews and methodologies.
- A timely opportunity exists for us to promote compassion and spiritual awareness in medical education and practice from a Christian perspective.

Even before the Francis Reports[1,2] in the UK brought the failure of compassionate care into sharp public focus, observations across the world were growing that compassion as an essential ingredient of care was draining away. In the period since then 17,000 scholarly publications have appeared[3] exploring compassion in three main areas: understanding its nature and role in health, determining the causes of its loss, and investigating how it might be restored in both personal practice and in healthcare institutions. This article looks at these themes in the light of our Christian calling to show compassion in all that we do, not least in our service to patients and colleagues.

The shape of compassion

The parable of the Good Samaritan[4] paints a picture of compassionate care, exemplifying its main components: attentiveness, empathy and action.

1. Attentiveness

Choosing to give someone your undivided attention is the first step of a compassionate approach. In Jesus' parable it seems unlikely that those who passed by were unaware of the injured man, but they chose a strategy that placed the needs of their world higher than his – perhaps because of their workload, their reputation or their status.

2. Empathy

Empathy may best be defined as having an inner sense of what it is like to be in the position of others, particularly in their suffering. This requires both cognitive and emotional intelligence informed by our professional training and experience of illness and its effects – and perhaps also by our personal memories of pain, fear or isolation. Imaginative reflection will help, and need not take long. But Christians have the additional privilege of prayerful access to God's wisdom[5] to help us identify and engage with our patients and their immediate concerns – whether they arise from body, mind or spirit.

Jesus identified with the harassed and helpless condition of the people he ministered to, prompting him to weep.[6,7] Our emotional response to patients and their relatives will vary, but it should never be absent. Empathy establishes a connection with a patient and is quickly appreciated. It also provides important steps toward their recovery.[8]

3. Action

Compassion takes tailored, practical steps to address the suffering of the person in view. This will take time and the energy of *our* body, mind and spirit. We use our knowledge, skills and available resources to their best effect while we continue, at least for a while, alongside our patients in their uncharted journey.

Compassion invites us to address our patients' *human* needs:

- To be properly **H**eard, their words not just being noted down for the record
- To be **U**nderstood in their dis-ease, anxiety and uncertainty even if they present an appearance of calm
- To explore the **M**eaning of their illness – more important to them than our scientific explanation of their diagnostic label and management plan
- To be able, without feeling silly, to **A**sk any question at all expecting a truthful, respectful and accessible answer
- To be **N**urtured, not just treated or referred.

Expressing compassion in a medical context means recognising the patient before us as a person made in God's image, already loved by him far more than ever we could. And compassion's enthusiasm

for restorative action will outweigh the dangers envisaged by those worried that emphasising the importance of an emotional response to suffering might eclipse our necessary skilled scientific response to our patients.[9 10]

The loss of compassion

If compassion seems an intuitive ingredient of healthcare, why have we been losing it? The side box shows an interesting selection of suggestions from a recent medical discussion in Zimbabwe involving 24 medical students and ten faculty members of Bulawayo's National University Medical School. Many of these will sound familiar.

The focus on materialistic science is strong in both medical education and clinical practice. An interest in mechanisms, measurements and data predominates leading to patients being seen as cases rather than persons, an attitude that may be reinforced by clinical teachers. Demands that constantly outstrip our resources of energy or time have a seriously detrimental effect. This leads to exhaustion or burnout that suppresses our ability to show compassion – even though we know this is a critical component of our practice. Working in systems where we receive a little or no appreciation or are driven toward goals that are neither realistic nor compassionate further dampens our motivation to care. Out of such pressures stress and hopelessness grow readily. These remarks are far from theoretical; nearly half of young doctors in the UK report that their stress levels rose last year,[11] and over 40% of doctors are considering early retirement – with 25% thinking of leaving the profession entirely for similar reasons.[12]

The return of compassion

How can compassion – and hope – be regained?

1. Look around

A combination of rising patient expectations and predominantly negative reports about healthcare can subtly drag us down, making compassion harder to maintain. But it is uplifting to note other data that present a more balanced and encouraging profile. For example, in the UK, patient satisfaction with the NHS is nearly as high as it has ever been.[13] Also in a recent study[14] across eleven first-world countries, including the US, the UK came top in 85 areas of measurement for the quality of its healthcare; and it achieved this at second to the lowest cost.

Note, too, that compassion and the spiritual dimension of our patients are receiving increasing attention with regional and national initiatives[15] to incorporate them into routine clinical practice. The worldview of those involved varies widely, but the 'marketplace' now holds a clear and welcome legitimacy to engage with this activity. Herein lies a wonderful opportunity for us to develop schemes in medical schools and clinical settings that explore, model and teach these topics centred on Christ – the One who is the true source of compassion, spiritual life and hope.

Looking around should also encompass seeking fellow Christians with whom we can enjoy mutual encouragement, share our challenges and blessings, and support one another in prayer. Sadly, service pressures, fragmenting staff rotas and frequent relocations pose serious threats to achieving this in practice. And for those in more settled posts such pressures are often compounded by additional professional demands for teaching, research and administration and by important family commitments. Responsibilities within a local church may also take additional time. But supportive fellowship is an important ingredient of life to pursue wherever possible.

Finally, many in healthcare are compassionate in their service. Looking around to notice even small acts of compassion at work can be encouraging if not inspiring, and giving positive feedback to the carer concerned has been shown to stimulate institutional cultures of compassion.[16]

2. Look in

As battle fatigue threatens our reserves of compassion, engineering at least occasional quiet pauses in the whirl of life is essential. Ideally these will allow us to reflect on our main drivers and supports, our fears and our deepest unspoken needs. Bringing these to our ever-listening Father will always prove restorative.

3. Look up

Looking up draws us closer to our saviour, healer and example, Jesus. No one has had greater compassion. He placed himself entirely in our position and made the greatest sacrifice of all for our restoration. He was pressed on every side by the needs of the people he came to serve yet was not overwhelmed because of his continual and deliberate closeness to his Father.

Jesus also gave us amazing promises on which to draw as we struggle with the demands of life. In John 14–15, we are offered his personal presence and power, in obedience to seek from him whatever we need, guidance into truth and generous experiences of peace and joy. By refilling our hearts with compassion from above we can become models of outstanding care as well as agents of hope. The resources we need rest not in us but in the truth that 'We love because he first loved us'.[17] Our role is joyfully to receive God's love and channel it to others – to our patients through empathy with their physical, mental or spiritual suffering and the delivery of expert scientific care; to our clinical and administrative colleagues under pressure; and particularly to all who have yet to find Jesus.

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Reasons for loss of compassion

- Not compassionate to start with ➪ concern for prestige, top courses
- Trained to be scientists
- Dealing with dead bodies – body ➪ object
- Persons become 'specimens' in pathology labs
- We become adapted to illness ➪ hardened ➪ people become 'interesting cases'
- Clinical role models do not value the emotional world
- Negative attitudes from lecturers, patients and team
- Lack of gratitude and appreciation
- Insufficient resources
- Economic hardship prevents action on needs
- Cannot change the world ➪ can't change anything of the patient
- Loss of social aspects of life
- Too much demand
- Despair becomes part of you

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