



Review Article

Let us start an epidemic by giving away kindness

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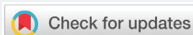
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‘Patients were left in soiled sheets or sitting on commodes for hours. Some patients needing pain relief got it late or not at all.’ These were a sample of the findings in the Francis Report which revealed severe failings in patient care in the Mid Staffordshire NHS Foundation Trust in the UK. Recommendations in the Francis Report included the need to recruit compassionate staff and having compassion training for clinicians [1]. Whether telling a young man that he has cancer or comforting an elderly woman who is feeling anxious, the health professional needs to be skilled in understanding what the other person is going through and respond appropriately.. The crisis of compassion in medicine is multifaceted in origin and some factors identified in the Francis Report were compassion fatigue, overwork, excess demand, lack of continuity and the failure to see the patient as a fellow human being [1]. Unfortunately modern medical practice prioritises technical progress, evidence-based medicine, meeting targets set by bureaucrats and efficiency at the expense of the ‘soul of medicine and medical practice’. Meeting key performance indicators (KPIs) has become the priority rather than the patient. Couple of other factors include increasing commercialisation of healthcare and the overemphasis of the biomedical model in medicine.

There is much ignorance about compassion, as to what it is, where it comes from, what might influence compassion in our practice and whether it can be taught. There is also confusion of the terms sympathy, empathy and compassion. Often these terms are used inter-changeably but they are not the same. What do these terms actually mean?

Sympathy is an emotion caused by the realisation that something bad has happened to the other person, concern for the welfare of others and experiencing another’s emotions [2].

Empathy is a complex, multifaceted, dynamic concept [3]. Affective empathy is the ability to subjectively experience and share in another’s psychological state or feelings. Cognitive empathy is the ability to identify and understand another person’s feelings and perspective from an objective stance [4]. Carl Rogers, the founder of humanistic psychology, placed empathy at the heart of his patient-centred psychotherapy [5]. Irving’s three-dimensional model of empathy proposed that the doctor has to understand the patient’s world (cognitive), feel with the patient (affective) and communicate this understanding with the patient (behavioural) [6].

Compassion comes from the Latin roots *com*, which means ‘together with’, and *pati*, ‘to bear or suffer’. The Greek word for compassion is *splagchnizomai* which means ‘to be moved as to one’s bowels’. In the ancient world the bowels were thought to be the seat of one’s emotions. In the Cambridge English Dictionary compassion is explained as ‘a strong feeling of sympathy and sadness for the suffering of others and a wish to help

them'. Compassion is built on the capacity to empathise but involves the additional step of wanting to alleviate suffering. This is an important distinction. It is not only the feeling but being moved sufficiently to act.

Compassion is the core of the therapeutic alliance and central to all elements of patient care delivery. The Health Care Practitioner is part of the healing process and this relationship helps healing. We can improve health and longevity, heal quicker, reduce pain, inflammation and anxiety and recover faster. There is scientific evidence that compassionate care from health care practitioners helps in reducing post-operative pain, improve the survival rate of cancer patients, lower the mortality rate in high risk cardiac patients and boost the immune system of patients [7]. Compassion is the core of the therapeutic alliance and central to all elements of patient care delivery. The healthcare practitioner is part of the healing process and it's this relationship that helps to heal. According to Carl Rogers the main ingredients for a positive healthcare practitioner and patient relationship should include empathy, honesty and genuineness [8].

In health care settings studies have suggested that healthcare practitioners who approach patients with compassion have a significantly greater effect on delivering positive and improved health outcomes. This matters to patients and shows interest in their well-being and is a positive way of expressing concern. Research has shown that patients adherence to recommendation made by healthcare professionals increase when care is delivered in a compassionate way [9]. Healthcare professionals tend to feel more engaged and valued when working within this type of environment and patients report they feel "cared for" which is crucial to better health outcome and the well-being of teams. Compassion makes people more resilient to stress and strengthens the immune response. Compassionate people are more likely to be socially connected and as a consequence making them less vulnerable to the effects of loneliness.

The motto of the Royal College of General Practitioners is "Cum Scientia Caritas" which means compassion with knowledge [10]. Compassion is a virtuous response that addresses the needs of another through understanding and action [11]. It is the hallmark of quality care and yet the core elements of compassionate care remain poorly understood. Studies done among medical and nursing students show that there is lack of awareness of what compassion actually means and whether it can be taught or is a natural virtue. This has been an age old argument even from the time of Socrates. It cannot be taught by creating departments or by theoretical knowledge being imparted to students [12]. Healthcare students are growing up in a culture where we say "have empathy but what we value is science".

In a very practical article in the British Journal of General Practice, the authors mention a number of factors that can have an impact on our compassionate practice of medicine [13]. They include doctor factors, patient factors, clinical factors, environmental and system factors. Under doctor factors, the authors suggest that simple self-reminders may reinforce the motivation to be compassionate. Rather than the neutral maxim '*primum non nocere*' or 'First do no harm', silently repeating 'May I be of benefit' when hand sanitising, touching a patient, or auscultating is a more proactive approach to daily professional practice. In many contexts, a significant proportion of our patients will be nearing the limits of what conventional treatment can accomplish and the most important thing we have to offer is our presence and compassion. Under patient factors the authors suggest that compassion flows when we like our patients and the flipside is true as well. Patients who are rude, demanding and difficult suck the oxygen from our compassion. There are several approaches to this difficulty, most of which involve a simple shift in perspective. First, we might strive to remember that the experience of a patient as 'difficult' is partly a function of our own conditioning. Patients we find difficult are seen as 'OK' by other team members. Second,

we should remind ourselves that the most difficult of patients are suffering. Viewing such patients as persons who are suffering can change our defensive and threatened stance to one of wanting to care. At the very least, acknowledging patient distress may reduce our tendency to personalise any insults. Under clinical factors, the authors mention that doctors when confronted by challenging clinical scenarios, patients who are not improving or complicated side effects, compassion likely suffers. We shift from wanting to connect with patients to an analytical mode. We sometimes even blame our patients for not improving. When doctors are cognitively or emotionally threatened by clinical situations, our minds can shift into a tunnel vision mode in which decisions like a quick pharmacological fix or unnecessary investigations are made. Under environmental factors the authors mention distractions during consultations including interruptions (for example, phone calls, nurses, and students), noise and paperwork diminish compassion. Feeling threatened by workplace issues or worries regarding patient complaints may shift the caring mind to a defensive or aggressive approach to patients and colleagues.

We are not born with compassion and it is a skill that can be learned and strengthened by specific exercises and with practice. Through this we can understand how to increase feeling of connection and feelings of compassion within ourselves. We can then begin to introduce more compassion into our daily lives and transfer this into our working environment. Simple changes can make a difference and here are seven steps that are achievable by all of us working in the healthcare space to make us more compassionate.

1. Find similarities – seeing ourselves as being similar to others increases feelings of compassion. All of us are frail human beings vulnerable to disease and suffering.
2. Believe in your power to do well – when we believe we are able to make a difference we are less likely to suppress our feelings of compassion.
3. Notice how good compassion feels- studies show that compassion and compassionate action activate the brains reward centre.
4. Lead by example – research and feedback from healthcare students suggests that compassion is contagious. Most students learn by modelling what they see in their teachers and seniors. If we are to help teach and cultivate compassion then lead by example.
5. Meditating – a compassionate approach to others shifts resting brain activation to the left hemisphere, a region associated with happiness and boosting immune functions
6. Talking about what we are thankful for – in classrooms, at team meetings or even at the dinner table – boosts happiness, social well-being and health outcomes.
7. The ‘3Ts’ technique for showing compassion – talk, time and therapeutic touch. These are fundamental to good healthcare but have been increasingly sidelined by bureaucratic expectations.

In conclusion, in our modern day healthcare with all the differing expectations of healthcare professionals, it is easy to forget the main reason why many of us became healthcare professionals is to care for our patients. Compassion has long been considered the cornerstone of the patient-healthcare professional relationship. However we are struggling to deliver compassionate care to our patients. Our medical and nursing students are leaving training with less empathy and compassion than when they enter training. Sustaining compassionate medicine is not simple but it can be understood and trained for. It is imperative that we re-discover compassion in healthcare.



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