A critical analysis of Compassion in Practice

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Abstract

Compassion in Practice is a policy introduced in England to develop a culture of compassionate practice among healthcare staff. There is widespread recognition and agreement of the importance of compassionate practice, and the policy offers a vision underpinned by a desirable set of values. In this article, the significance of a coherent vision is explored and is followed by discussion of the need to anchor the policy vision in values that are important to healthcare staff. The policy’s approach to vision and values may generate tensions, which are also examined and discussed.

Keywords

Care, commitment, communication, compassion, competence, courage, nursing practice, nursing values, quality assurance, quality care

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THIS ARTICLE EXAMINES the vision, values and actions outlined in the policy document Compassion in Practice (Department of Health (DH) 2012). A brief analysis of the terms vision and values is provided, which acts as a useful guide when exploring the vision and values articulated in Compassion in Practice (DH 2012). This exploration reveals several tensions between the policy and the prevailing evidence on compassion and cultural change. These tensions are explored from four key perspectives: individual versus whole system, courage versus fear, communication versus human relating, and commitment to getting it right every time versus aspiring to be the best we can be.

Several reports show that healthcare services are failing to deliver consistently the high-quality compassionate care patients expect and deserve. These reports highlight that those at greatest risk of receiving poor and neglectful care are the most frail and most vulnerable patients (Clarfield et al 2001, Youngson 2008, Care Quality Commission 2011, Parliamentary and Health Service Ombudsman 2011, Tadd et al 2011, Local Government Association et al 2012, Mid Staffordshire NHS Foundation Trust Public Inquiry 2013).

The chief nursing officer in England and the director of nursing at the DH have responded to the issue of poor and neglectful care by developing a three-year policy called Compassion in Practice (DH 2012). The policy outlines a major transformation and provides a vision and strategy for the development of a culture of compassionate practice among healthcare staff. A previous document, Front Line Care (Prime Minister’s Commission on the Future of Nursing and Midwifery in England 2010), set out a vision of high-quality compassionate care, leadership and innovation for nursing and midwifery. Compassion in Practice (DH 2012) appears to build on this publication and incorporates the views of healthcare staff.

In delivering the vision set out in Compassion in Practice (DH 2012), leaders (including senior managers, policymakers and educationalists)

The first author (BD) was part of a three-year action research programme in Scotland that aimed to embed the processes of compassion throughout the NHS for staff, students and academics in education and practice. Learning from this programme has the potential to transform the vision into a reality (Edinburgh Napier University and NHS Lothian 2012, Dewar 2013, Dewar and Nolan 2013). In this article, a range of evidence is used to highlight learning that has the potential to enhance Compassion in Practice (DH 2012).

Compassion in Practice: vision and values
Compassion in Practice (DH 2012) proposes to develop a culture of compassionate practice by articulating a shared vision, values and actions. The assumption underpinning the policy is that openly declaring and following the vision, values and actions will form the basis for compassionate and trusting relationships between patients, staff and managers. This is an ambitious and wide-ranging cultural transformation, requiring the articulation of a clear vision and values. The vision is essential for inspiring, motivating and energising staff to engage in the change process (Kotter 2012). Palmer et al (2004) said that a vision must contain two components: a clear picture of the desired future and the core values that underpin the change process.

Compassion in Practice (DH 2012) recognises the importance of this and dedicates a section to discussing the policy vision. However, rather than explicitly stating the vision, the policy introduces six fundamental values. These values are: care, compassion, competence, communication, courage and commitment – or the 6Cs.

David Foster, deputy director of nursing at the DH, stated that the vision is to develop a culture of compassionate care. He added that to reclaim patients’ trust in the ability of healthcare staff to provide compassionate care, it was necessary to be clear about the values and behaviours that are held in esteem and aspired to (Foster 2013).

To be effective, the vision should contain a compelling and clear set of values. Values cannot be invented simply because an organisation ought to have particular values (Pendleton and King 2002). To serve as the stimulus for change, values have to be real, credible and unchanging over time (Pendleton and King 2002). Values should not be confused with the strategic actions, behaviours or practices associated with the policy. Since values rarely change, they can be identified by imagining their relevance in future decades (Keren and Littlejohns 2012).

Following the publication of Compassion in Practice (DH 2012), a coherent vision of the values that underpin compassionate practice needs to be developed. Compassion is a highly regarded moral virtue among healthcare staff, and basing a wide-ranging cultural change on a vision that lacks clarity risks alienating and disengaging them (Collins and Porras 1996), which in turn may limit the promotion of compassionate practice.

Tensions
In a critical analysis of Compassion in Practice (DH 2012), the authors have identified particular messages that seem to be contradictory to current evidence on compassion and cultural change (Firth-Cozens and Cornwell 2009, Patterson et al 2011, Dewar and Nolan 2013). These contradictions create tensions, particularly for healthcare staff, in relation to how best to achieve these aspirations.

Individual versus whole system
The way that the model for creating caring and compassionate cultures is set out in the policy is inherently reductionist, in that it presents the six values as separate entities. Compassion is described as one of six elements when in fact it is at the core of care, competence, communication, courage and commitment. The concern about using a reductionist approach is that people may plan quick fixes for each of the six values and not consider the entire system and context in which care takes place. Environments, organisational structures and processes need to be designed compassionately if staff are to achieve and sustain the aspirations set out in the vision (Crawford and Brown 2011). This requires a whole-system approach led by those in senior management who have the responsibility for developing strategy. In addition, relationships are imperative to delivering dignified care, yet reference to this is sparse in the vision (Local Government Association et al 2012).

The construct of relationships extends beyond the individual receiving care and needs to consider relationships between practitioners, patients and families. More explicit acknowledgement of the wider context is required, together with a whole-system approach based on relationships to achieve a coherent and robust philosophical underpinning that will ground the vision.
Healthcare staff have been struggling to adapt to healthcare environments that are too complex, demanding and fast paced for them to control, cope with or understand (Burns 2001). This has produced a gap between the burdens being placed on nurses to deliver high-quality, patient-centred care and their capacity to achieve this in complex, unpredictable and financially restrained care environments (Pendleton and King 2002).

To realise the ambition of embedding a culture of compassionate care requires the involvement and commitment of all NHS staff not only those involved in direct patient care. This is because modelling compassion is necessary throughout the organisation and should, therefore, include others in the organisation, from staff working in domestic services through to human resources. It is disappointing, therefore, that the vision and strategy are limited to healthcare staff and exclude the wider team and associated collaborative working.

Jocelyn Cornwell, senior fellow at the King’s Fund, said she would like to see ‘a vision for care for patients and their relatives, jointly written by the chief executive, the chief nursing officer, the chief medical officer, the director of patient experience and the chief financial officer and signed off by the whole board’ (Cornwell 2012). Modelling collaborative leadership in this way would be an example of doing things differently rather than doing different things.

*Compassion in Practice* (DH 2012) limits its focus to healthcare staff involved in direct patient care. The policy embraces and includes a wide range of healthcare staff, but the absence of senior NHS leaders is notable. This is of particular relevance in light of the cultural concerns highlighted in the Mid Staffordshire NHS Foundation Trust Inquiry (2013).

The events at Mid Staffordshire NHS Foundation Trust made visible the profound organisational confusion and cultural crisis that came about as a result of NHS leaders prioritising targets and efficiency above safe and effective care. Chief executives, in particular, are essential to cultural transformation and would be expected to communicate and practise the new vision and values (Brown 2013). These important and influential cultural leaders should be integral to implementing *Compassion in Practice* (DH 2012).

There are many examples of failed cultural transformations in the NHS, and some argue that this is in part because NHS leaders impose the visions, values and cultural change on staff without personally committing to the cultural change (Davies and Mannion 2013). If this is the case, attempting to embed a culture of compassionate practice into the NHS that is not led by all of its senior leaders has the potential to create cynicism and make a bad situation worse.

Others have recognised the need for whole-system change. For example, during a trip to Kaiser Permanente, an organisation in San Francisco, United States, that provides an integrated healthcare delivery system, the first author (BD) explored the concept of the compassionate organisation. Kaiser Permanente uses the theory of caring science to underpin its vision and all organisational processes. The caring science model is informed by the values, ethics and moral ideals of human caring, along with the philosophy, theory and sciences that are evident in daily relationships (Watson 2006). Although caring science is a framework to guide professional nursing practice, it extends beyond nursing and had been adopted to frame practice for all staff in the organisation.

The emphasis of caring science is (Kaiser Permanente 2013):

- Being genuine and authentic.
- Being present in the moment.
- Being kind.
- Caring for oneself before being able to care for others.
- Moving from performing the task to connecting with people at the bedside.

All staff including the most senior professionals in the organisation have learned the principles of caring science. It was evident from discussions with these individuals and observations that people try to use the philosophy to underpin all organisational structures and processes. A common vision based on compassionate relationship-centred practice that is named, valued and defended by all staff in any organisation needs to be a priority. This is not a new concept and reports in the UK that have explored what works well in relation to compassionate and dignified care highlight this need (Patterson et al 2011, Local Government Association et al 2012).

**Courage versus fear**

The vision identifies courage as one of the six values. Courage is about standing up for one’s innermost values and is essential to the delivery of compassionate, relationship-centred care (Dewar 2013, Dewar and Nolan 2013). In their framework for caring conversations, Dewar and Nolan (2013) suggested that being courageous is a key attribute for initiating such conversations. Courage is about feeling confident to ask questions, being willing to take risks and being able to tell someone he or she has done a great job. Courage might also involve asking a patient...
what matters to him or her in hospital and actively listening to the response, even when the patient’s expectations cannot be met (Dewar and Nolan 2013).

Nurse leaders require courage (Cummings et al 2010). Effective leaders welcome the uncertainty, risk and emotional exposure associated with success or failure and achieve this by having the courage to be vulnerable (Brown 2012). Leaders who avoid vulnerability never allow themselves to be truly seen and from this perspective lack the courage to lead. The result is a leader who prioritises self-protection over self-expression, fear over courage, blame over accountability and risk aversion over innovation (Brown 2012). It should be noted that nurse leaders have been criticised for their poor visibility and have been accused of failing to recognise the interests of others (Storch et al 2013).

Nursing depends on the ability and courage to adjust to changing circumstances and confront the challenge of change (Sherring 2012).

Communication versus human relating

One of the core values in the vision is communication. However, communication is an activity rather than a value. There is a danger that attempts to improve communication lead to mechanistic models of training that focus on enactment of behavioural communication skills, such as listening and questioning aimed at goal-directed communication and problem resolution. This mechanistic approach does not address adequately the relationship that is crucial to the delivery of compassionate care (Doane 2002).

Those responsible for implementing Compassion in Practice (DH 2012) acknowledge the interconnectedness and interdependency among all involved in the delivery and receipt of health care. This would help to promote interactions that enhance the potential for valuing diversity, inter-relating, effective communication, mutual respect and trust, and should be aspired to throughout healthcare organisations (Tresolini and Pew-Fetzer Task Force 1994, Nolan et al 2006, Safran et al 2006).

Dewar and Nolan (2013) developed a framework for caring conversations that supports staff to embrace cultural change and transition to achieve a sense of security, belonging, continuity, purpose, achievement and significance for themselves and for patients and families. Underpinning these conversations are seven essential attributes: being courageous, connecting emotionally, being curious, collaborating, considering other perspectives, compromising and celebrating (Dewar 2013, Dewar and Nolan 2013).

Commitment to getting it right every time versus aspiring to be the best we can be

The vision illustrates the core value of commitment as ‘to be looked after by someone with the courage to make changes to improve people’s health and care, and to ensure that it is delivered on a consistent basis, first time, every time, in the right setting and the right way’ (DH 2012). There is a lack of acknowledgement in the vision of the complexity and reality of achieving this aspiration in practice. This type of commitment might not be possible and might therefore be setting people up to fail. It is not always clear what ‘the right way’ means and who is responsible for defining this. It might be better to consider the concept of caring moments in the care experience that exemplified connectedness and compassion, and the ability to compromise – where people explore differences and work together to agree what might be possible to enhance the care experience.

Freshwater and Cahill (2010) explored the construct of ‘compromise’ and interventions, such as supporting the development of emotional awareness, reflective practice, dialogic relationships and organisational innovation, that can help staff to cope with the dissonance that arises when trying to implement evidence into everyday practice, every time and in the right way.

Healthcare staff need to be supported to develop meaningful relationships with other staff, patients and families. This may allow them to take an active role in shaping care with people that is more realistic, combining people’s philosophies and actual practice, which in turn could result in a better experience for all parties.

Conclusion

Compassion in Practice (DH 2012) aims to develop a culture of compassionate practice among healthcare staff. The desire to develop and follow a shared vision of compassionate practice is admirable and has the potential to enable trusting relationships between staff, patients and managers. Compassion in Practice (DH 2012) is relevant to all and should be at the centre of NHS organisational structures and processes. The policy, however, requires further development to articulate a clear vision of the types of compassionate practice healthcare staff should be aiming towards. The policy does not explicitly state this is the vision and requires healthcare staff to work hard to extract the main messages.

The decision to underpin the vision with a set of values that healthcare staff ought to have risks...
disengaging and alienating them from an essential cultural transformation. There needs to be a more creative and imaginative vision that develops current evidence about compassion and cultural change, as highlighted in this article, and that involves patients, families and staff.

References


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