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Considerations for the measurement of compassionate care: views of healthcare staff

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Review

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There are no conflicts of interest associated with this publication.

Abstract

Background: Compassion in health services has received increasing attention recently due to concerns about a perceived decline. Subsequently, there has been much debate about the measurement of compassionate care, but little is known about this subject from the perspective of staff.

Aim: To explore healthcare professionals' views of measuring compassionate care.

Method: As part of a grounded theory study, using semi-structured interviews and focus groups with healthcare professionals involved in the care of patients with type 2 diabetes, participants were invited to discuss this topic of measurement.

Results: Measuring compassion was regarded as problematic due to its complex nature. Categories identified in the data reflecting this difficulty included: *distinguishing compassionate care from other concepts; relying on informal indicators; making the subjective objective; incorporating external influences; putting it to use.*

Conclusion: Findings outlined the complexity associated with measuring compassionate care and how attempts to do this by managers could be a problematic endeavour.

Key words: compassionate care, focus groups, healthcare professionals, interviews, measurement, qualitative research

Introduction

Compassion in healthcare has come under scrutiny in recent years, due to concerns about its perceived decline. This is encapsulated by the Francis Report (2013), which documented and reflected on poor examples of care received by patients and their families. Failures outlined in the report include trust leaders not listening to staff or patients, and concentration on finances and attainment of foundation trust status.

The report contains a section on nursing, which states there should be a culture that engenders compassion through recruitment, training and education. It also suggests that nurse managers take on a supervisory capacity, that is not office-bound, to support a culture of compassion. However, there is little empirical work exploring the meaning of compassionate care for health professionals. As part of a grounded theory study on the topic aiming to understand the meaning of compassionate care for healthcare professionals (Tierney et al 2017), the authors asked research participants for their views and perspectives on its measurement. Findings on this specific aspect of the study are reported below.

Literature review

Compassion is defined by Brown (2014) as ‘... a soft, gentle word that has a deep strength and richness... a feeling that rises up in response to another’s difficulty and urges one to act to alleviate their discomfort’. It is associated strongly with nursing, portrayed as a core component of the profession (McCaffrey and McConnell 2015), and described as ‘its most effective strength’ (Schantz 2007). The link between compassion and nursing has a long legacy; Florence Nightingale depicted it as a ‘moral virtue’ to be possessed by all nurses (Papadopoulos and Ali 2016). This has continued to the current day, with compassion forming part of the Nursing and Midwifery Council Code of Conduct (2015).

It also takes centre stage in the Department of Health and NHS England strategy, Compassion in Practice (2012), which outlines a national vision of values and behaviours for nurses, midwives and care staff. Despite this however, accounts of poor care, in the UK and elsewhere (Stenhouse et al 2016), where compassionate care appeared to be absent, have resulted in a raft of opinion pieces and policy documents on the subject, including debate about its measurement (Bradshaw 2008, Sturgeon 2010). Yet, there is a lack of knowledge about how those who deliver patient care feel about the issue; therefore, the authors enquired about measurement of compassionate care as part of a larger grounded theory study.

Aim

The aim of the study was to explore the meaning of compassionate care from the perspective of staff who work with patients with type 2 diabetes (Tierney et al 2016). As part of this study, the researchers asked participants for their views on measuring compassionate care; is it possible and is it desirable? Type 2 diabetes was selected as a critical case for the research because, as a long-term condition, it involves regular contact between patients and a range of healthcare staff. The University of Warwick's Biomedical and Scientific Research Ethics Committee reviewed and approved the study (Ref: REGO-2015-1424).

Method

A qualitative methodology was adopted to explore the topic in depth. Purposive and theoretical sampling were used to recruit staff from two NHS trusts and relevant professional networks, such as Diabetes UK. The researchers strove for maximum variation in the sample in terms of experience and role in healthcare, gender, and location of work, for example community/primary care or secondary care.

Participants were invited to contribute through an individual interview, which lasted between 40 and 75 minutes, or a focus group, which lasted between 40 and 80 minutes. All participants gave informed consent to their involvement, and use of their anonymised quotations. The data, which were collected between May and October 2015, were audio-recorded and transcribed verbatim. All interviews and focus groups were conducted by the first author.

Principles of grounded theory (Charmaz 2014), including writing memos about codes and categories, and constant comparison of data, codes and categories, were applied during analysis. The first author, who has no clinical background, led on initial and focused coding, which was shared and discussed with other members of the research team, who have a mix of clinical and academic experience. The computer programme NVIVO assisted with data management. Quotations on the measurement of compassion were extracted from the overall dataset, to which 58 codes were applied. These codes were then clustered into the five themes presented below. Verbatim quotations from focus groups (FGs) and interviews (Ints) are included to support the arguments presented.

Results

A range of healthcare professionals, including doctors, nurses, dieticians, podiatrists, healthcare assistants and administrators, took part in an interview ($n=13$) or focus group ($n=23$). Most of the participants reported having reflected little on the meaning of compassion as a discrete concept within their caring work, before the data collection. Participants defined it as something expected in health services, a collective value that had come to the fore after high profile instances of poor care (for example at the Mid-Staffordshire trust). Comments included the following: 'It's a commonality we have as human beings... to understand the patient you cannot but enter the arena of understanding human values... You're respecting not excluding and it's to do with dignity... it's about having that right attitude...' (FG1 P2), and 'Compassion is a hard one to, to quantify what it is, but we're all of the opinion that when you're with a patient that compassion is part of your job, it's part of how you should be presenting yourself and how you should be interacting and responding to patients' (FG3 P1).

Despite their lack of previous contemplation on the meaning of compassionate care, participants expressed clear views about its measurement, which are represented in the following five themes:

- Distinguishing compassionate care from other concepts.
- Relying on informal indicators.
- Making the subjective objective.
- Incorporating external influences.
- Putting it to use.

Theme 1: Distinguishing compassionate care from other concepts

During discussions about its meaning, participants often equated compassionate care with good communication skills, and showing an interest in patients. They regarded it as more than patient satisfaction, which could be connected to issues like cleanliness and hospital food, and tended to relate it to other fundamental concepts, such as patient-centredness and empathy: 'I mean compassionate, in a way means allowing the patient into their care and... thinking if you had that particular disease, and being in their shoes... that is also part of empathy and compassion, and letting the patient into the centre of care' (FG1 P5).

A lack of distinction can make measuring compassionate care problematic, and reflects the heterogeneity found in how it is defined within the existing literature (Papadopoulos and Ali 2016). Data collected for our study implied that staff develop their own ways of assessing whether they had given compassionate care, which is explored in the next theme.

Theme 2: Relying on informal indicators The absence of a standard or agreed tool to measure compassionate care meant that participants looked for signs of having acted in this way as a normal part of their working day, for example patients making changes to their behaviour and thus improving their blood glucose levels, or patients coming back and thanking them: ‘... if you’re showing compassionate care and the patient feels they’re being supported, I think the outcome... would be a positive one because if they feel that they’re being supported and they’ve got a network there, I think that motivates them to self-manage their condition...’ (Int 9).

Participants’ informal indicators appear to be based on their judgment of what compassionate care entails, however there might be a gap between what clinicians and patients regard as compassionate care (Easter and Beach 2004, Friele et al 2008). As McCaffrey and McConnell (2015) state, ‘compassion is partly in the eye of the beholder or recipient of care.’ Patients have identified professionals who are respectful, try to understand them as individuals, and engage them in care planning and decision-making, as compassionate (Lown et al 2011). Data collected by the authors implied that healthcare professionals might focus more on outcomes, for example behavioural or biomedical indicators.

Theme 3: Making the subjective objective Participants suggested that the meaning of compassionate care is not static, and often varies from person to person and situation to situation. It can be exhibited in a range of ways in a single appointment/consultation, for example by helping patients from the waiting room, listening to them vent their frustration, or making them a cup of tea. Individuals’ understanding of compassion, according to some participants, is shaped by their upbringing and background: ‘... it stems from my, from religious understanding and also ethical and moral learning and what I’m trying, how I’m trying to improve myself as a person’ (Int 5).

The participants noted how their understanding of compassionate care had changed as they became more experienced. Several recalled regarding it initially as a wish to help people, but linked this to clinical goals rather than the wishes and needs of patients. They suggested that they learned over time that compassionate care involves connecting with patients, listening to them, and understanding things from their perspective, so they could respond in an appropriate manner: ‘You come in bright-eyed and bushy tailed and think you can change everything, all I need to do is let people know what they need to do and of course they’ll do it... I’ve come to recognise we can make small strides and where we make them we should celebrate them...’ (Int 2).

Yet, as indicated in theme 2, there may be a tendency to focus on clinical indicators and, as seen in theme 4, professionals can struggle to understand patients’ perspectives because of the circumstances in which care is delivered.

Theme 4: Incorporating external influences A recurrent refrain was the importance of recognising external factors that can affect compassionate care. For example, participants described how working conditions, such as being short staffed, lacking time, feeling overwhelmed by paperwork, or having to meet targets, can affect compassionate care, and that these would need to be acknowledged if measuring it: ‘... we have sort of 10 minute appointments and... sometimes you’re running late and you’re under pressure... the compassionate side of me sometimes gets, gets very sort of, not completely lost but gets hurried up and in a big rush...’ (Int 13).

Relationships between staff and patients, as well as staff with each other, are recognised as central to compassionate care (Sinclair et al 2016), but the environments in which treatments are provided might not allow for such a connection. Hence, structural factors, such as time and resources, might promote or impede the expression of compassionate care (Tierney et al 2016). If external influences are overlooked when measuring compassionate care, this might cause staff, who already feel beleaguered by a range of work demands, to see it as another imposed task rather than integral to their care. Data on how a measure would be used is discussed in theme 5.

Theme 5: Putting it to use Participants perceived a measure as potentially useful for confirming that they were working in a compassionate way, and for emphasising the importance of relational aspects of care to colleagues and managers. Some mentioned that a measure would be welcomed as a way of improving practice, and helping individuals or teams to reflect on what was going well and where progress could be made: ‘... we’re very good at being negative, nurses, we’re really good at going home and thinking “oh goodness, we did a really bad job today”. I don’t very often think about whether I’ve done a good job... it’s probably not a question I’ve ever asked myself “have I given compassionate care today...?”’ (Int 4).

Participants also reported that a measure would be undesirable if it became a tick-box exercise or was used to criticise them. They raised concerns about how it might demotivate staff working in a climate in which they already feel under threat, particularly if it failed to reflect meaningful representations of compassionate care for them and for patients. This echoes Sturgeon’s (2008) warning that measurement of compassionate care should not become another target for staff to meet.

Discussion

Exploring compassion in healthcare is warranted because it is identified as a priority for patients and their relatives, important for recovery and contributing to satisfaction with services (Sinclair et al 2016). This study highlights the complexity of measuring compassionate care, and the potential consequences if it is carried out in a simplistic way. Doubts raised by participants stem from a lack of agreement on the meaning of compassion, and the range of factors that can influence its expression, including the wider working environment. Compassion is defined as 'a sensitivity to distress of self and others, with a commitment to try and do something about it and prevent it' (Cole-King and Gilbert 2014). While clinical and managerial staff want to ensure compassion in practice, it is important to consider compassion for staff as well, and the way the emotional aspect of their work is understood and addressed.

Situational factors can shape professionals' behaviour as much as their individual nature or disposition (Paley 2013, 2014). For example, working in unsupportive settings can result in the development of 'sub-optimal norms', meaning that if poor examples of care are observed, healthcare professionals may develop a lower threshold of what is considered acceptable, in order to cope with the cognitive dissonance they encounter when actual care does not meet standards they regard as optimum (Stenhouse et al 2016). As a result of this, they might focus on tasks rather than finding out what is important to individual patients (Haslam 2015).

Patients are then faced with 'detached caregivers', which might be unrelated to professionals' skills or nature, and has more to do with lack of organisational support to enable staff 'to maintain a receptive state of mind' (Seager 2014). Nurse managers are important in 'fostering organisational cultures on a micro-level in practice areas' (Norman 2015), and could help to sustain compassion in the workplace by offering the following within the workplace (Seager 2014):

- Time - to process emotional aspects of the job.
- Secure attachment - with at least one colleague (to be able to offload).
- Regular backup - feeling part of a cohesive team.
- Regular supervision - that is not just about skills, but also about processing emotions.
- Authentic management culture - where emotional aspects of work are recognised and valued.

A simple measure of compassionate care might seem appealing, but any tool should enable the establishment of a profile that reflects individuals and their needs, and takes into account the importance of conducive environments. Existing measures of compassion, such as the

Compassionate Care Assessment Tool (Burnell and Agan 2013), the Schwartz Center Compassionate Care Scale (Lown et al 2015), and the Compassion Competence Scale (Lee and Seomun 2016), focus on individual characteristics, and overlook the complex infrastructure within which nurses practice.

The rationale for the introduction of a measurement tool must be 'to help people to identify strengths in compassionate practice, so that they can be understood, articulated, shared and made more deliberate in nursing work, and to identify possibilities for development' (Dewar et al 2011). It should also be acknowledged that although compassion may be perceived as a cherished element of nursing, it can be hard to engender during each patient contact (McCaffrey and McConnell 2015), which raises questions about what should be expected realistically from those working in the profession.

Conclusion

Participants did not always regard compassion as distinct from other concepts, such as patient-centred care, and perceived that it varies between people and settings. They relied on informal indicators that their care was viewed as compassionate by patients, and described it as influenced by contextual factors. They reported that a measure could be useful, but were concerned it would become a tick-box exercise or used to criticise them.

Attempts to measure compassion in practice should be undertaken wisely to avoid demotivating staff and treating them without compassion. A compassionate care measure might be useful if used to help teams and organisations celebrate positive examples of care, and to reflect on ways in which work settings, and individual employees, can improve its delivery. Measurement strategies have been proposed that strive to acknowledge and evaluate positive care practices (Dewar et al 2011), however more work is required to ensure that measurements of compassionate care are meaningful to those receiving and providing health services.

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