Towards promoting and assessing clinical compassion

How compassionate are you, and how compassionate should you be? Is it possible to measure compassion and compare it to a standard? Can compassion be developed and remediated as if it were a skill? Would assessment of clinical competence in compassion be useful, and how could it be achieved?

In 2010, Robert Francis eloquently stated: 'People must always come before numbers. Individual patients and their treatment are what really matters. Statistics, benchmarks and action plans are tools not ends in themselves. They should not come before patients and their experiences' (Francis, 2010). Thus the investigation of failings at Mid Staffordshire NHS Trust suddenly brought into sharp focus the need to ensure that the most basic elements of health care are not neglected. There followed a re-emphasis on care, compassion, competence, communication, courage, and commitment (the 6Cs) by the nursing profession (Cummings and Bennett, 2012).

The report into criminal abuse at Winterbourne View Hospital reaffirmed the need to refocus on developing systems to support appropriate care for those patients who are most vulnerable and challenging (Nicholson et al, 2012). Policy makers have since elevated the importance of treating people with respect, dignity and compassion, by stressing the need to give more emphasis to the views of patients and other service users (Department of Health, 2013). Then Bruce Keogh delivered a report on hospitals which advocated an ongoing transparent review of accountability for safety, clinical effectiveness and positive patient experience, without recrimination (Keogh, 2013). At the same time the Secretary of State for Health in the UK stated: 'The NHS must hire and train for compassion as well as competence' (Hunt, 2013).

One of the cornerstones of the report which followed from Don Berwick is that staff should be developed and supported, because: 'in the end, culture will trump rules' (Berwick, 2013). The quality of health care fundamentally depends on the qualities of the people delivering it. How can we measure only that which is important? How can the compassion of health-care staff be routinely assessed and ensured within the increasing bureaucracy of the NHS? Recent reforms have damaged morale:

> **'The processes of appraisal and revalidation are intended to be positive and constructive. When they become negative and destructive, the system fails, and fails the applicants. People will just learn how to "game the system" or withdraw from it, squandering valuable resources' (Grieve, 2013).**

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Thus a renewed emphasis on assessing care could be difficult to achieve when clinicians feel despondent that the sins of a minority have led to increased bureaucracy and thus reduced time available for patient care.

Professional context, individual qualities for compassion and empathy

Compassion is more than a passion to relieve suffering, and has a variety of subtly different definitions depending on the context (Halifax, 2012). The authors consider that compassion is a selfless concern to actively improve the wellbeing of others, and to treat others as you would wish others to treat you. The drive and empathy to help those in need is tempered by the emotional (clinical) detachment needed to ensure maximum effectiveness to relieve suffering. Therefore, a compassionate professional is a dependable advocate for a sufferer's best interests regardless of how stressful the situation is or who is suffering.

Effective expression of compassion involves acting on genuine feelings of needing to help (Peus, 2011). This ensures that actions are appropriately motivated and that interactions are sincere (*Table 1*). Compassion requires the emotional capacity to communicate in a way acceptable to the sufferer. Emotional capacity is the ability to recognize and articulate beliefs, desires, concerns and physical feelings, and can be developed through experience (Helmich et al, 2013). Acceptable communication uses cues from tone of voice, body movements and facial expressions, and requires a proportional tolerance to distress. The practice of compassion can be further supported by having a predictable daily routine, undertaking random acts of kindness, and learning to understand the needs of others (Dalai Lama, 2003), although there appears to be little empirical evidence to substantiate this. It is also useful to establish the other person's feelings, ideas, function and expectations (Weston et al, 1989). Thus, compassionate behaviour can be taught, learned

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and developed (Helmich et al, 2012), but individuals can choose whether or not to exhibit these behaviours. Different individuals harbour different degrees of compassion which are ever present. Altering this core value depends on life experiences (e.g. parenthood, bereavement). Thus exercises which enable an individual to relate to the values of others by seeing or experiencing the circumstances of another from a similar perspective to theirs should help them to be more compassionate.

Empathy is an affinity for mutual feeling which enables one to relate to others as individuals through shared experience. The degree of engagement, judgement and obligation can be distorted by one's own experiences and life events, and is proportional to temporal and physical distance in separation between individuals. Social consequences of publicly observed mutually recognized emotions, synchronous communication and intimacy, potentially increase vulnerability of both parties and may not be desirable (*Table 1*). Over-investing in empathic accuracy may limit effective support. There is a need to exhibit empathic concern without becoming personally distressed and while retaining impartiality (Preston and de Waal, 2002; Gutsell and Inzlicht, 2010).

Table 1. Warning signs
Indifference to patient feelings, desensitized to suffering or 'pathologising' patients as conditions
Expressing insincere sympathy (as pity has connotations of superiority and disables others)
Personal distress as a result of expressing excessive empathy (as suffering with others disables oneself)
Perceiving the patient as a threat to achieving a goal
Blaming or stigmatizing others for not acting when you were aware of a problem
Reluctance to report poor practice because 'there for the grace of God go I'
Preoccupation with past or future, more than here and now
Not enough time, or otherwise 'powerless' to act

Table 2. Values promoting compassion in individuals
Has insight into own health and ensures own needs are met (to maximize emotional capacity and efficiency of actions)
Avoids thoughts of superiority, self-aggrandisement and idolatry
Identifies patients as coherent individuals
Listens to patients and carers
Believes patient suffering is serious, not trivial
Attributes proportionate values to patient needs
Is non-judgemental and independent of discrimination
Exhibits authentic unconditional positive regard for others
Improvises to maintain standards under suboptimal conditions
Retains capacity for reflection on practice
Embraces the institutional values which promote compassion (*Table 3*)

Psychological testing and selection for compassion

Psychological testing combines several standardized tests into an overall assessment of mental tendencies. Behavioural assessment can be achieved with objective observations of performance. Emotional or cognitive functioning can then be evaluated by comparison with a normative reference of equivalent time and place. Thus objective occupational personality questionnaires reveal the relative influence of the big five factors of normal personality (conscientiousness, agreeableness, neuroticism, openness, and extraversion; Barrick and Mount, 1991). Compassion corresponds to agreeableness, concern for others and seeking to achieve social harmony. Associated traits include being considerate and a willingness to compromise (Rothmann and Coetzer, 2003), as opposed to self-interested scepticism, malevolence and competitiveness.

Within health-care staffing, individuals with desired values (*Table 2*) and skills should be recruited and promoted. The potential for compassion is often deduced by conducting personality tests. These aim to elicit a reaction which is rated using a Likert scale, Thurstone scale, Script Concordance Test or Situational Judgement Test to determine an individual's feelings about an event, person or object. All personality tests are based on the premise that the findings can be generalized to different contexts.

The questions typically involve making repeated choices between equally desirable personality descriptors to correlate preferences with professional role models. A common criticism is the potential for self-reporting bias to give a false impression of ability. To counter this, initial tests can be used to develop rapport and create inferences for follow up with other methods, such as direct observation (to explore relationships between internal psychological processes and target behaviours), peer reports (although these can be influenced by vested interests, gossip and peer pressure), and collateral information (from personal, occupational and medical histories). It is important to ensure that there is no discrimination as a result of differential item functioning between groups (e.g. specific knowledge or degree of divergence in identification between those involved, as a result of status, age, gender, culture, or language). It is also important that the tests are not transparent in their intention to assess compassion, to minimize the scope for preparation and coaching and thus not compromise reliability or validity (Morel, 2009).

Assessment of compassion and the workplace

Extensive literature exists for assessing empathy, but not for compassion. An individual's desire to act is easier to discern than determining that he/she will act. Various tests exist to test empathy (e.g. the Empathy Quotient advocated by Baron-Cohen and Wheelwright, 2004).

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More comprehensive measures rate the degree of both positive and negative verbal responses to scenarios, by self and others (Truax, 1967), and by self of others (Mehrabian and Epstein, 1972). These verbal responses can further be correlated with the physiological responses and immediate unconscious reflex reactions of nonverbal expression (Levenson and Ruef, 1992; Leslie et al, 2004).

Equivalent questions are also often used to determine the degree of internal consistency. However, these tests are only able to assess the potential to demonstrate empathy (Geher et al, 2001) and their interpretation is based on the perspective of the empathizer, recipient or third party (Gladstein, 1987; Duan and Hill, 1996).

It is also crucial to control for gender effects. Until recently, studies suggested that women are not more empathic than men, although there are some differences in motivation (Ickes, 1997; Klein and Hodges, 2001). However, the selection of medical students with empathy has found that both female and older students are more empathic (Chen et al, 2007; Boyle et al, 2010). Functional magnetic resonance imaging has since confirmed that empathy-related neural responses to observing unfair suffering are significantly higher in females than males (Singer et al, 2006), and that the capacity to relate to another (cognitive empathy) is localized in the ventromedial prefrontal gyrus, while the capacity to respond to another (emotional empathy) is localized in the inferior frontal gyrus (Fan et al, 2011).

Training (supported by supervision, peer engagement, simulation and regular review) can develop the skill of empathy (O'Malley, 1999; Gilbert, 2010). By integrating empathy into professional development, appraisal and revalidation, compassion can be monitored and modified via the use of portfolio reflections, interviews and 360-degree feedback from staff and patients. Triangulating multiple forms of evidence increases the confidence that performance is independent of format. At a personal development review, self and assessors judge the consensus of both good and bad to determine a grade (e.g. Exceptional/Excellent/Satisfactory/Improving/Inconsistent) according to whether predetermined key performance indicators have been achieved. These include:

- Demonstrating core values (*Table 2*)
- Enhancing performance of self and others
- Making any unanticipated contributions.

Grading should avoid normative comparisons (where the individual is benchmarked against others) as this encourages competition (as someone will always be at the bottom no matter how good everyone is), and affects self-esteem. Instead, as with all high-stakes assessments, formal grading should be criterion-referenced and ipsative (i.e. accumulating with own previous performance). Only evidence of the individual's attitude which is transparent, focused on achievement and independently corroborated should be recorded.

Finally, the concept of a professional workplace is a misnomer in a health-care context. Many would like to behave differently outside of their employment setting, where they feel that they are entitled to a private life equivalent to any other member of the public. However, there is a public expectation for doctors to represent their profession at all times wherever they are, and to behave accordingly. The person should exhibit compassion at all times and in all places, not just the workplace. Indeed, one can only be certain that compassion is genuine when it manifests itself independently of external scrutiny. However, the workplace is the only place where compassion can be formally measured.

Competent compassion and emotional intelligence

Compassion needs to be continuously expressed at a standard appropriate to the circumstances. Competence requires an ability to interpret a situation, identify options and be able to act appropriately. Ability should grow through experience depending on the individual's aptitude to reflect and adapt. Ability progresses from being capable through to being proficient, skilled, expert, and finally mastery. This progression maps onto initially acting in accordance with rules, then situation, goals, conviction, and finally acting with intuitive understanding (Dreyfus and Dreyfus, 1980). Progression in compassion depends on developing emotional intelligence. This comprises the ability to assess and influence the perception, use, understanding and management of one's own emotions (Mayer et al, 2001). However, being too sensitive to emotional states can decrease the ability to make effective decisions, particularly when outcomes could be emotive or transformational.

Fostering a compassionate culture in the workplace

As end users of health care everyone wants a compassionate culture. Why are some staff more compassionate than others, and why are some people compassionate some of the time? The high cost of health care with an ethos of financially driven targets and enhanced bureaucracy diverts efforts from patient care. The ease with which an outcome can be measured does not necessarily correlate with its importance, and such targets can appear blind to the immediate real needs of patients. Establishing cultural change through hospital organizational development programmes is challenging (Benning et al, 2011).

Compassion takes time, time requires money, investment requires evidence of output, and compassion cannot easily be assessed. Thus compassion is often neglected altogether, especially when staff are under pressure to prioritize and deliver other more easily measured outcomes. In short, the value placed on other outcomes places staff under threat, which undermines their ability

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to exhibit compassion. Staff can become inhibited by the need to obey rules. Staff attempting to continue to practice compassionately will exceed their capacity to respond to suffering, leading into a spiral of burnout, fatigue, desensitization and damage. Compassion has to begin in the workplace before it can effectively manifest in clinical practice. Inappropriate criticism of individuals in their absence occurs frequently (McDaniel et al, 2013), and often leads to formal complaints. Gossip promotes suspicion of motives, reduces confidence in ability, and biases perception of actions. When individuals hear of this they become demoralized, distrusting and defensive. Support is needed to retain and augment appropriate values while in service. For any individual to exhibit compassion as a social action (Parsons, 1937) they must first feel safe and be able to act naturally, have a personality predisposed to identifying with the suffering of others, have an individual role and status where they are able to help, and be supported by appropriate institutional values (*Table 3*).

Table 3. Values promoting compassion in institutions
Nurtures the personal values which promote compassion (*Table 2*)
Empowers staff to be able to contribute to the alleviation of suffering
Allocates time for compassion and plans for unexpected needs
Minimizes fear of job insecurity (eliminates fines and predatory competitors, protects whistleblowers)
Minimizes fear of litigation
Provides staff opportunity to be reminded of why they joined their profession
Provides supportive interdisciplinary simulation training (providing insight into personal performance to refine improvement)
Facilitates and trains disseminated teams to make shared decisions flexibly
Facilitates challenges to other staff at all levels of seniority
Feeds back effects of contributions (closes loop so that individuals feel listened to)
Fosters transparent ownership of decisions and actions without punishment of mistakes
Shares learning to benefit from mistakes
Facilitates staff forum to regularly discuss non-clinical aspects of patient care (Schwartz, 1995)
Minimizes tension between agendas of professions, politicians, providers and patients
Ensures targets are integrated and do not conflict with each other
Humanizes both staff and patients so that they do not appear anonymous

KEY POINTS

- Compassion should be prioritized in health care.
- Compassion can be measured, and thus selected for and monitored.
- Compassion can be improved by training.
- Compassion can be promoted by appropriate institutional values.

Conclusions

Focusing on compassion at the centre of your thoughts, and as the motivation for your actions, is a path to maximize the wellbeing and fulfilment of both oneself and others (Dalai Lama, 2001). It is clear that there are many ways in which clinical compassion can be measured and developed. A culture of continuous monitoring, training and reflection needs to be promoted. This requires the identification of warning signs and remediation based around enlightening individual values within an empowering institutional context. **BJHM**

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