Throughout 2011, and for much of this year, the national and professional press have been dominated by reports of failures in health and social care. Stories have focussed on the avoidable harm and disturbing cruelty suffered by individuals and the distress of distraught families seeking answers in the light of systemic organisational failure on an incredible scale (Francis 2010, CQC 2011a, CQC 2011b).

Respect, compassion and dignity: the foundations of ethical and professional caring

by Jane Reid

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Investigations have revealed (see Box 1) that at the heart of shortfalls in care, lay lack of respect, lack of compassion and failure to uphold the dignity of patients. The ‘disasters’ were shocking and quite rightly concentrated minds on how and why such things could happen in a system that is supposed to be in the business of ‘caring’.

It couldn’t happen where I work! Could it?
The publicised ‘failures’, given the overall scale and provision of health and social care, represent a small minority, but their occurrence and devastating impact nevertheless cannot be trivialised or condoned. The system and individuals failed in their duty of care to safeguard the vulnerable and dependent. Harrowing accounts were summarised and described during the Mid Staffordshire Public Inquiry, ‘as an admission of collective shame’ (Smith 2011). Although some may believe that nothing similar could happen elsewhere in the NHS, the stark reality is that it probably will, not least because, amidst the failures, there were many good staff giving great care. These accounts remind us all that variation occurs between and within environments of care, between professions and professionals within organisations and across health communities. Smith (2011) in her closing remarks to the inquiry volunteered, on the basis of the evidence heard, that the tragedy of Mid Staffs, could and would occur somewhere else in the NHS at sometime, if it were not already doing so.

Icebergs and waterlines
Media attention has quite rightly highlighted the devastating consequences of the shortcomings. Yet the risk of relentless focus on a few organisations is that it nurtures the illusion that Mid Staffs was an isolated ‘blip’, something that happened ‘over there’ and ‘would not happen here’. The attention on a few organisations has certainly masked the sizeable scale of avoidable harm experienced by patients across the wider NHS on a daily basis. The scale of variation in care remains a continuous challenge (Gray & DaSilva 2010). Using the analogy of the iceberg, we need to pay attention to what is below the waterline as well as to what is obviously above it.

The timeframes of investigation and reporting the public inquiry of Mid Staffs have been delayed, (Calkin 2012) yet the great wheel of the NHS continues to turn; people and organisations are busy navigating the impact of the NHS reforms (Kings Fund 2012) whilst striving to compensate the £20 billion shortfall in NHS funding, creating the perfect storm for further systemic failure (Cowley 2012). The conditions for this are powerfully illustrated by the 2012 Annual Staff Survey in which 40% of respondents reported that they would not recommend where they work to a relative in need of the NHS (Ramesh 2012). Measures that provide assurance regarding compassion, respect and dignity, will undoubtedly feature in the recommendations of Francis. How the NHS will be tasked to respond and provide that assurance will need to take account of the significant burden of data capture, reporting and inspection that already exists. Foresight on the part of those charged with designing the response will be required if unintended consequences are to be minimised.

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KEYWORDS Compassion / Commitment / Care / Conscience

Independent inquiry of Mid Staffordshire (Francis 2010)
Care and compassion (Health Service Ombudsman 2011)
We’ve been listening: Have you been learning (Patients’ Association 2011)
Care Quality Commission report on Winterbourne View (2011a)

Box 1 Investigations of failures in health and social care
The NHS touches our lives at times of basic human need, when care and compassion are what matter most

‘Primum non nocere: First, do no harm’ (Hippocrates) Creating the conditions for compassionate care

Going forward, the collective task must be to shift mindsets at all levels of the NHS, from the centre to the frontline, ‘board to the ward’, and at all points of direct care, including the operating theatre. Crucially we must stop normalising the abnormal or accepting the unacceptable. Collectively and individually we must practice and promote professional values that safeguard patients and ensure that variation is properly owned, investigated and tackled (Gray & DaSilva 2010). Delivering improvements in surgery, whether reducing surgical never events, enhancing productivity, increasing clinical effectiveness, safeguarding patient safety or assuring compassionate care, is dependent upon positive attitudes, professional and ethical behaviour, and harnessed commitment across all levels of the NHS, through robust leadership and effective performance management.

It would be all too easy for example, to label performance management. through robust leadership and effective commitment across all levels of the NHS, the system, other environments of care divorced from the domain of the operating theatre (see Case Study). But rather than dismiss them as irrelevant, we should embrace them and distil the relevant learning. First and foremost we should hold a mirror up to our own practice, and critique accountability and patient advocacy in the patient experience positively.

Case study: Where was the compassion?

Mr N, 68 years old, was described by his daughter, Mrs L, as mentally active and creative – he was in the process of tracing the family’s ancestry and was writing a book.

Mr N, an otherwise fit and healthy gentleman, suddenly presented as acutely unwell with a strangulated intestinal obstruction. He was listed for a laparotomy, an operation which started at midday and was expected to last for three hours. Mr N’s wife and daughter remained alone in the waiting room for five hours. Reflecting on their experience they describe trying unsuccessfully and with increasing desperation to find someone to give them some information. They eventually found the consultant, who reported that the surgery had gone ‘reasonably well all things considered’, and that as far as he was aware, Mr N was in the recovery room.

Sadly, 20 minutes after admission to recovery, Mr N’s condition deteriorated significantly, he presented with abdominal distension, tachycardia and respiratory distress. He was returned to theatre for repeat laparotomy, mid procedure he suffered cardiac arrest.

Meanwhile his wife and daughter waited nearby for news, oblivious to events ‘wander[ing] the corridors looking for someone to tell us what was happening’. A ‘dazed’ registrar spoke to Mrs L, but his English was ‘very poor and broken’. The exchange left Mr N’s wife and daughter unclear as to whether Mr N had died: ‘my question asking if he was alive kept getting sidestepped, yet the question – is he dead – also got a no. The confusion was terribly distressing’. They asked to see Mr N and did so eventually at around 9.30pm. Invited to attend the holding bay of the main operating theatre suite, they were informed by the senior clinical lead for theatres that Mr N had been pronounced dead and they could ‘visit with him in the recovery room’, before he was ‘laid out’ and available for presentation in the chapel.

Mrs L complained first to the trust, and then to the ombudsman that the family had been left with no clear understanding of her father’s condition during his final hours, which was deeply distressing. As she observed in one letter to the trust ‘This is just one of many such events in the working life of your staff but it has lifelong repercussions for us’.

The NHS touches our lives at times of basic human need, when care and compassion are what matter most (DH 2009). It is therefore vitally important that individuals, teams and boards explore what caring, compassion, respect and dignity mean and how they are demonstrated. Staff need to verbalise what ‘good’ care looks and feels like and how it can be assured. Building shared mental models of compassionate care will require staff to articulate their values and to describe the expectations they have of themselves, their peers and the organisation as a whole. Around these commitments can be nurtured, for assurance is dependent on shared goals and the energy to deliver them. Thereafter staff need to work collegiately to create climates in which peer support, challenge, critique and speaking out are the norm when things fall short of what should be provided to patients.

Accountability and patient advocacy in the form of speaking up to promote patients’ interests or with regard to escalating concerns about unacceptable practice, conditions or variation which impacts quality, must be at the heart of professional, managerial and board practice. Dignity, safety and compassion are the tenants of caring, the foundations to safeguarding the vulnerable, and are the first line of self, team and operational scrutiny which is so vital to organisational regulation (Wikipedia 2012).

Compassion and caring: what patients want

Attree (2001) when researching patient and relatives’ perceptions of high quality care, identified the components of compassionate care as including: respect, dignity, privacy and opportunity to exercise choice about care and treatment. Loeb (2006) observed additionally, that patients value the opportunity to discuss their emotions, to be addressed by their preferred name, to receive appropriate touch and eye contact.

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Continued

contact, and to be given time to share a personal story. Personalisation and emotional care are described by patients as going a long way to making intolerable or distressing situations bearable. Staff who appear friendly, warm, sociable, approachable and who engage with patients in a way that builds rapport are perceived as ‘good’ practitioners (Van der Elst et al 2011).

While there is no one definition of caring, there is consensus that patients’ experience of quality care owes much to the motives and intention of the carers, primarily that they want to care, intend to care and will commit to actions that are caring in nature (Watson 1988). Swanson (1991) suggests that knowing, being with, doing for, enabling and maintaining belief in the other, are the hallmarks of a caring disposition. Kim-Goodwin et al (2001) add involving, interest in, concern for, compassion and commitment, to that list.

While compassion and care are distinct entities, it is clear from the literature that they are inextricably linked in the assurance of quality patient experiences.

Caring for colleagues?
Compassion for the carer as well as the cared for is equally important, for caring invokes feelings and can be demanding and painful (Rappaport et al 2006). Giving of oneself can be incredibly hard to do, due to all manner of competing and constraining forces, not least the pressures of repeated demand. Compassion fatigue is well recognised in the literature, most notably in relation to cancer care (Ulrich & Fitzgerald 1990, Welsh 1999). Although sometimes difficult to differentiate from other similar conditions (burnout and post traumatic stress disorder), compassion fatigue can develop in anyone, irrespective of environment or speciality (Wee & Myers 2003). Schwam (1998) describes it as a unique form of burnout in the care giving professions and identifies perioperative staff as being vulnerable to it, due to overexposure to traumatic events, complex surgery, patient distress and the emotional labour of meeting the needs of anxious patients.

Our practice should also demonstrate compassion for other members of the team who are experiencing problems in their personal or professional lives
Staff vulnerable to compassion fatigue, are often overly conscientious and self-giving, and are at particular risk when they cannot deliver care to the standard or desired outcome that they believe patients should receive/achieve. Staff with compassion fatigue may feel chronically tired and irritable, dread going to work, lack joy in life, feel trapped, drink more alcohol or overeat, they may also become cynical and bored. Over time compassion fatigue can compromise empathy and practitioners may become less emotionally connected to their patients than might be desirable. This can impact the relationship with and the response to the patient, affecting the quality of care provided and the compassion shown. If unresolved it can lead to an increased number of patient and family complaints, sickness/absence and higher staff turnover (Simon et al 2005). Schwam (1998) cautions that perioperative staff are at particular risk when they practice in high pressure environments, face repeated or unreasonable demands, or work in organisations in which their emotional resilience and well being is given insufficient attention.

Reflecting on the reports of poor standards and the absence of compassion at Mid Staffordshire invites the question, were staff as much the victims of the systemic failures as the patients?

Orolovsky (2006) encourages healthcare professionals to learn to care for themselves and one another and to try to replenish their energy during the workday through peer support, and activities outside work. A professional support system of peers can do much to remind health staff of realistic limits and unrealistic expectations. It certainly encourages care of one another (Canfield 2005).

Promoting compassion and dignity
There is an extensive focus on compassion in the nursing literature and it is described as central to many nursing theories (Morse et al 1990, 2007). However, compassion is not the prerogative of nursing as it concerns human connection, respect for humanity, and treating another in a manner in which one would expect to be treated. This is the business of all staff. Compassion is about kindness, consideration, empathy, feeling and identification with ‘the other’, at times of vulnerability, pain and distress (Tweddle 2007).

Compassion is more than acting in a consistent manner as it is culturally and spiritually framed, and is context dependent (Attree 2001, Tweddle 2007). Compassion is also more than just doing for others, or giving technical clinical interventions of high quality; compassionate care involves creating space to listen, giving voice to the expression of emotion, and providing opportunity for discussion of feelings (Loeb 2006). In short, compassion and dignified care are about seeing the person in the patient (the other), and responding accordingly (Goodrich & Cornwell 2008).

‘How many of us, working with patients day after day, get used to not seeing the person in the patient? How easy do we find it to focus on the task in hand or the one we have to do next, rather than pausing for a moment to check that the person we are with is not desperate to share anxieties or ask questions?’ Gadsby 2008, p8

Learning points
Caring can mean different things to different staff groups because it is influenced by environment, curricula and context. Caring needs to be understood and actively promoted. Regrettably, compassion is identified more often by situations in which it is lacking, rather than those where it exists. Negative behaviours including rudeness, confidentiality breaches, humiliation and disregard all indicate a lack of compassion.

Individually and with your peers, make time to think about and discuss how compassion, respect and dignity are demonstrated,
promoted and upheld in the operating room. To address the imbalance of power in the relationship between patients and professional carers, make time to speak with and learn from patients and their families, to explore potential gaps in expectations and understandings, and make the case for supervision and staff development to explore and remedy identified gaps or shortcomings.

In the midst of being busy, we need to be still for long enough so that we can be present ‘in the moment’ to see and hear what is needed. If we are forever focussed on the next task in hand, or somewhere else in our heads, we are unlikely to be sufficiently attentive to our patients and their needs. To be compassionate carers we must strive to see the person in the patient.

References
Attree M 2001 Patients’ and relatives’ experiences and perspectives of good and not so good quality care Journal of Advanced Nursing 33 (4) 456-66
Canfield J 2005 Secondary traumatization, burnout, and vicarious traumatization: A review of the literature as it relates to therapists who treat trauma Smith College Studies in Social Work 75 (2) 81-101
Gaddy A 2008 We need to start seeing the person behind the patient Nursing Times 35 (8)
Hem M, Heggen K 2004 Is compassion central to nursing practice? Contemporary Nurse 17 (1-2) 19-31
Loee S 2006 African American older adults, coping with chronic health conditions Journal of Transcultural Nursing 17 (2) 139-47
Morse JM, Bottoff J, Neander W, Solberg S 2007 A comparative analysis of conceptualizations and theories of caring Journal of Nursing Scholarship 39 (3) 137-44
Morse JM, Bottoff J, Neander W, Solberg S 2007 Comparative analysis of conceptualizations and theories of caring Journal of Nursing Scholarship 23 (2) 119-26
Orlovs-C 2006 Compassion fatigue: Prairie Rose 75 (3) 13
Rappaport J, Belsinger S, Pinoval V et al 2006 Carers and confidentiality in mental healthcare. Considering the role of the carer’s assessment: a study of service users’, carers’ and practitioners’ views Health and Social Care in the Community 14 (4) 357-65
Schwab K 1998 The phenomena of compassion fatigue in preoperative nursing AORN Journal 68 (4) 642-8
Simon C, Pyce J, Roff L, Klimack D 2005 Secondary traumatic stress and oncology social work: Protecting compassion from fatigue and compromising the worker’s worldview Journal of Psychosocial Oncology 23 (4) 1-14
Swanson K 1991 Empirical development of middle range theory of caring Nursing Research 40 (3) 161-6
The Patients’ Association 2011 We’ve been listening; have you been learning? Available from: http://patients-association.com/default.aspx?tabid=80&cid=23 [Accessed May 2012]
Tweddle L 2007 Compassion on the curriculum Nursing Times 103 (30) 18-19
Ullrich A, FitzGerald P 1990 Stress experienced by physicians and nurses in the cancer ward Social Science & Medicine 31 (9) 1013-22
Van der Elst E, Decloë H, Casteleir B, Gastmans C 2012 Elderly patients’ and residents’ perceptions of the good nurse: a literature review Journal of Medical Ethics 38 93-7
Watson J 1988 New dimensions of human caring Nursing Science Quarterly 1 (4) 175-81
Woo D, Myers D 2003 Compassion satisfaction, compassion fatigue, and critical incident stress management International Journal of Emergency Mental Health 5 (1) 33-7
Welsh D 1999 Let’s talk. Care for the caregiver: Strategies for avoiding compassion fatigue Clinical Journal of Oncology Nursing 3 (4) 183-4

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