

Debate & Analysis

William Pickles Lecture 2014:

Cum Scientia Caritas — compassion with knowledge



INTRODUCTION

I take *caritas* to mean compassion; we could also consider it to mean charity, one of the three theological virtues. Through compassion, I would like to consider the virtues and values by which we live and practise. Events would have us believe that somehow in the NHS compassion has been lost. I suggest that it is not but that it needs to be supported.

DEFINING THE PROBLEM

There are numerous reports of where compassion has been lacking in health care, with many recommendations for action. The Health Service Ombudsman commented that 'these accounts present a picture of NHS provision that is failing to respond to the needs of older people with care and compassion'.¹ To this we must sadly add the events at Mid Staffordshire as outlined by Robert Francis QC.² Consider the patient narratives found within the Francis reports³ and Julie Bailey's book⁴ through the lens of compassionate care. The inquiry found that the culture of the trust was not conducive to providing good care for patients or providing a supportive working environment for staff; problems included bullying and low morale. To which we could add many other cases: Winterbourne View, NHS Lanarkshire, Vale of Leven, Princess of Wales, Abertawe Bro Morgannwg, and so on.

When the Mid Staffordshire scandal broke it was asked, 'How could clinicians pass on by on the other side of the ward?' But can we all honestly say that we would have been the ward equivalent of the Good Samaritan? As professionals we must be the Samaritans; we must stand up for what is right.

COMPASSION OVERWHELMED

Do doctors lack compassion? I am not convinced that they do, but an accumulation of factors creates an environment in which compassionate care is overwhelmed.

Re-disorganisation

The NHS exists in a constant state of flux with energy being invested in change of state, with loss of skills, memory, and grip. The continual reorganisation gets in the way of the delivery of care. Donald Berwick observed that '*the leaders of the NHS and government have sorted and resorted local, regional, and national structures into a continual parade of new aggregates and agencies. Each change made sense, but the parade doesn't make sense.*'⁵

Target culture

We have been complicit in a move from person-centred care to a target culture. The Quality and Outcomes Framework has done some good but also some harm. I am not convinced that targets, generally based on single disease studies or so called 'best practice', work in the complex world of comorbidity that our patients inhabit, and the world of complex multisystem disease that we inhabit.

In medical trainees we have bred a generation of clock-watchers: we make them log their hours and pay them by the hour, and are then surprised when they behave like shift workers. Perhaps the GP equivalent is 'one problem per appointment'. This is a coping mechanism, clearly quite wrong, but GPs are overwhelmed. I would not be prepared to wait for 4 hours in accident and emergency, but the implementation of this target has had perverse outcomes with amazing stories of 'work-arounds'. The implementation of well-intentioned ideas can get in the way of compassionate care.

Personal overload

It is at the personal level that compassion has been squeezed, and in the individual patient encounter that the manifestations of compassion are apparently lost. What is it that leaves a doctor to not notice or, worse, notice but not act on the realisation that the food tray for a patient with a stroke who has hemispatial neglect is on their 'blind side'? One element is pressure of work, whether it is the GP registrar who is too busy to spend time with the lonely

patient or the GP who has to decline a domiciliary visit as it is 'only social'. The Chief Inspector of Hospitals, reviewing his first hospital visits, said, 'people sometimes ask, is compassionate care a thing of the past? Absolutely not, it's very much alive and well. But where individuals are under such strain, usually due to staffing levels, compassion can be overwhelmed.'⁶ This is equally true in general practice where workloads have doubled in 10 years and GPs are breaking under the strain.

Mechanisation

Care has become mechanised, and in this something intangible has been lost. Instead of the simple act of taking the pulse, patients are attached to a machine that measures and displays blood pressure, oxygen saturation, and pulse; but what of the arrhythmia that makes the machine inaccurate, or the rhythm and character of the pulse, or the feel of the vessel wall? But all this is less important than touch: that simple human contact that is so vital in a time of need.

REINFORCING COMPASSIONATE CARE

'The only thing necessary for the triumph of evil is for good men to do nothing.'

(Anonymous. Commonly, but incorrectly, attributed to Edmund Burke.)

Recruitment

In interviewing applicants to medical school and in meeting new medical students I see keen, articulate, intelligent, and apparently caring young people. Medical schools work hard to select the best students, but successful applicants are merely the winners of the rat race of medical school recruitment. And do the high number wanting to be surgeons rather than GPs perhaps store up problems for the future? Could we do more to recruit on the basis of values? Health Education England (HEE) is working with universities to recruit to the values of the NHS Constitution and considerable effort has gone into talking with students and teaching them about the values of the Constitution.⁷ This is not new but the focus is. Universities report that being clear that they are looking for values has empowered their recruiters, and that they are finding the calibre of recruits to be better than those they had recruited in previous years.

"We serve and treat people, not targets. We should regain that love, that compassion, and develop personal and professional resilience."

Loss of empathy

So does education and training squeeze compassion out of us? The evidence from studies of empathy in medical students and junior doctors is that there is no diminution of empathy over time.⁸ Recruitment to GP specialty training has for many years now recruited on the competences of what makes a good doctor, including empathy and sensitivity.⁹

So, we are, in general, recruiting people who care, and training does not squeeze caring out of them. Therefore, it is largely the context of the NHS or the demands of modern health care that overwhelms. The more we focus on systems, science, and targets, the more, it seems, we lose the human face of medicine.

Another translation of *caritas* is love. In its purest sense we need to regain, or not be afraid to admit to, our love of our patients; and in love we find empathy and sensitivity. As a profession we must stand up for what is right and minimise the reductionist tick-box approach. We serve and treat people, not targets. We should regain that love, that compassion, and develop personal and professional resilience.

REGAINING COMPASSION

Humanism in medicine

At the 2011 RCGP Conference, Linn Getz talked of humanism in medicine as '*an enlightened solidarity with the patient as a living culturally-situated human being*'. She encouraged us to consider this as trust, belonging/nourishment, respect, care, honour, and pride. I wonder if the focus on clinicians as scientists still loses something of the richness from the arts and humanities; the understanding of the human condition.

Humanities in medicine

For many years John Salinsky has encouraged doctors to love literature and apply it to our patients, saying 'it helps me see my patients as human beings'. He quotes Iona Heath as saying:

'Patients come to doctors to give an account of experience and sensations that they have found troubling or difficult. They must find words to communicate distress

*and the listening doctor must find words to signal that he or she has at least partly understood. Novelists use words in ways which show they have understood parts of the experience of all of us.'*¹⁰

Perhaps prospective medical students should be required to have at least one A level in the humanities? Or, more radically, should biochemistry in the undergraduate curriculum be replaced with arts and humanities? We need to develop curricula about life rather than about disease.

Role modelling

One of the surprising outcomes of HEE's work with universities on recruiting for values is that students do not always see them manifested in their educators, who may provide examples of poor role modelling. And what of the black humour that so many of us use? We justify it as a defence mechanism, but does it really betray an underlying inoculation against human suffering?

CONCLUSION

We need to build into curricula and into training ways of articulating and accepting the emotional cost of being a doctor, and supporting people through it rather than training them to ignore it, of developing compassionate resilience. We can use the arts and humanities to help us in this task. Ultimately compassion in care is about our values and behaviours. As doctors we must stand up for this, demonstrate it ourselves, and challenge its absence. We should challenge our own practice and challenge our contracts where they put 'bean counting' ahead of compassion. I am not convinced that all care is bad. The vast majority is good but we have been complicit in a system that has allowed poor care, neglect, and inconsiderate care. Wisdom is described as, '*a balanced combination of compassion and knowledge, indeed the "fruit" of these two.*'¹¹

Care and compassion are not lost but they can be overwhelmed. We must support compassionate, high-quality care and I believe we should also support compassionate resilience.

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