Compassion: its neglect and importance

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SUMMARY

Does it matter that personal care of one doctor to one patient is being diluted by larger teams with increased delegation of work? In arguing that it does, this paper focuses on compassion, 'fellow feeling which is likely to be expressed'. General practitioner morale, patient satisfaction, and clinical medicine are examined, and teleology, game theory, and 'psycho-immuno endocrinology' touched upon, to come to the paper's conclusion, which is to call for the resuscitation of the 'Personal Doctor'.

Keywords: compassion; continuing care; personal care; morale.

Introduction

THE exact time and date of his death are unknown but his obituary was written by James McCormick in the *Lancet* on 7 September 1996.[1] He was little mourned. Those who had remained well acquainted with the Personal Doctor recognized he was moribund the year before when the British Medical Association (BMA) and Chief Medical Officer, somewhat prematurely, rang his death knell.

In July 1995 the BMA published a booklet, *Core values for the medical profession in the 21st century*. [2] In a subsequent article,[3] the Government's Chief Medical Officer, Sir Kenneth Calman, enumerated a further three core values. Compassion did not appear in the nine values recommended for the future doctor. To the Personal Doctor, general practice without compassion was as therapeutic as air without oxygen.

This paper will argue the weakening — yet the desirability and usefulness — of compassion as a necessary value for general practitioners (GPs). This will be done in the hope that the values of the Personal Doctor survive his demise. I shall adopt the slightly archaic definition of compassion as 'fellow feeling which is likely to be expressed'. Certainly this will include the more current sense of 'pity moving to action'[4] but it will also include joy and other emotions that move to similar expressions — for example, the sorrow expressed knowing that the 17-year-old's pregnancy wasn't planned, but also the shared joy and smiles on the baby's arrival.

Talking of compassion in a scientific journal such as this is awkward and even a little embarrassing, partly because there are no units of measurement. The nearest surrogate is the soulless 'continuity of care'. We have rightly become comfortable with numbers because of the power they have brought with the advancement of scientific method, but it is folly to neglect what is important simply because it cannot be counted.

Disengagement

One current model[5] of dissecting the work of a GP is to reduce the whole to four parts. These are, in reverse historical order:

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The business component

From 1948 to 1990 this was of modest importance. With fundholding and the desire to increase cost-efficiency it has demanded a considerable amount of clinician time.

The preventive component

The current scale and relative importance of this activity is quite recent, dating from the introduction of the sphygmomanometer and structured antenatal care in the 1930s.

The biomechanical component

Although this is as old as history there has been a recent explosion of its potency and importance.

The biographical component

This part of the GP's work predates history. It is concerned with the whole patient and with the patient's management and adaptation to the ills and vicissitudes of life. It is in this component that personal care and compassion reside. Unlike the other three components it is less open to measurement and counting.

Increasingly, the emphasis in general practice is focusing not on the doctor, the patient, and his or her illness, but on the practice, the population, and its morbidity[6]. There can be no doubt that general practice (or primary care, as it has now become) is burdened with increasing amounts of work, the volume and nature of which would have been quite unthinkable 20 years ago. The pot is brimming over. What has spilled out is the time-honoured personal care. Visits to the chronically ill were among the first to go. Postnatal visits are under threat, as are 'home from hospital' visits. This squeezing of the biographical component is not a new phenomenon, having been strikingly documented by Cartwright and Anderson as early as 1981.[7]

In addition, the opportunity to provide continuity of care diminishes for doctors who share patients.[8] Compassion is correspondingly eroded, being unable to grow in the infertile environment of the 'anonymous consultation'.

Dissatisfaction

Patients are increasingly unhappy. The number of patients' complaints about GPs is rising fast.[9] More patients are turning to alternative medicine and systems of treatment[10] that are largely or wholly unscientific, sometimes brazenly so.

Worryingly, there is evidence that this discontent is directed more at the younger doctors and the training practices.[11] This means that patients are less satisfied with those practices that are arguably at the forefront of change — those that are thought by the profession to be the most advanced in terms of training and management structure. These are the practices and the doctors that represent the future. The stage is set for patient satisfaction to get worse, not better.

Despite the undoubted progress of the scientific management of disease, patients are turning to other sources of help for their illnesses. This could be described as the patients' paradox. There is a corresponding doctors' paradox. This is that doctors are turning away from general practice at the very time when it is perceived by the medical profession to be in the ascendancy, both politically[12] and, more importantly, intellectually. There is the familiar litany of diminished recruitment to general practice, ear-

lier retirement,[13] and poor morale.[14]

Clues

There appears to be some protection afforded to the doctor by knowing the patient.[15] Patients are more concerned with rudeness, and with lack of sympathy and understanding.[16] There is no apparent relationship between the doctor's technological competence, as judged by exams and recertification, and being sued.[17] The protection from being sued, it is argued, is 'bedside manner'. It should come as no surprise, therefore, to learn that morale is higher in single-handed practices than in small practices, and higher there than in large practices.[11,18] Moreover, the Medical Defence Union has recently noted that there are fewer complaints against single-handed practices, arguably the least developed and most traditional. The fact that both parties, patients and doctors, are increasingly dispirited suggests either coincidence or a shared fundamental cause (or causes).

Suggestions of importance

Despite this dilution, erosion, and neglect of personal doctoring, there is evidence that personal care does matter. Lower rates of hospitalization of children, and of older people receiving more personal care, have been found in urban areas in the United States (US).[19,20] More efficient use of antibiotics in urine infections has been found in one study in the United Kingdom.[21] The need for analgesia in labour and the duration of the third stage are reduced when a known midwife is present.[22] These studies are suggestive but not overwhelming. But surely, if personal doctoring is so important, one would expect to find much more evidence of it in action, and many more examples of its effects.

Suggestions of great importance

Looking outside the confines of clinical medicine we can find some powerful reasons to suspect that personal doctoring matters a lot. In biology, the theory of evolution allows us to discuss the purpose of biological adaptations. It helps us to understand the prevalence and distribution of sickle cell disease and thalassaemia (as a counter to malaria), the origin of non-insulin dependent diabetes (as a counter to famine), and the benefit of psoriasis (as a counter to scarlet fever). The medicine man, shaman, or doctor is a feature of all societies, both current and historical. Such a social constant must have some survival value to those who use the services of these people. The fact that present-day patients choose to see a doctor they know, and want to feel kindness, is an expression of this adaptation. But does this adaptation remain purposeful, conferring some as yet unidentified benefit, or is it as vestigial as the human appendix?

In the realm of applied logic, game theory has demonstrated a fundamental difference between one-off and continuing relationships.[23,24] Powerful computer simulation shows that the best strategy to maximize personal gain in a series of one-off encounters is to enter into an agreement and to renege. Dealing with an ongoing relationship is qualitatively different, and can be succinctly described as tit-for-tat. (Recognition of this has been a boon in helping me treat my large practice population of 'drug addicts'.) If we now accept personal doctoring as important, how does it operate?

Compassion as the mechanism

There is evidence that stress results in morbidity. It is well recognized that a husband is more at risk of death in the coming year if his wife has just died.[25,26] A recent study[27] looked at women attending a breast lump clinic. Those who had some major emotional trauma in the preceding year were three times more likely to have a cancer diagnosed. The Whitehall Study of senior civil servants[28] showed that, even when all variables known to have an impact on health are taken into account, a strong positive correlation remains between rank or grade within the organization and good health and longevity. Punch biopsies of skin heal more rapidly in the non-stressed.[29] Another study suggests many more miscarriages happen in women who are stressed.[30]

There is good evidence that compassion relieves stress. A recent study[31] of emergency room treatment of 'down and outs' in the US provides some evidence of the positive benefit of a little compassion. The compassion was minimal, a cup of coffee and a chat with a volunteer stranger — and, for the occasional lucky patient, a canteen lunch. Contrary to expectations, patients treated with this elementary courtesy returned less frequently in the first month than their peers who were treated in the usual way; in other words, they were better.

An earlier landmark study[32] of mortality of patients who had suffered a heart attack showed that the factors of greatest prognostic importance were not the measurables (smoking, blood pressure, and cholesterol) but a loving spouse and a supportive work supervisor. Blood pressure, often thought to indicate stress, is lowered by having a dog[33]. How much more important, therefore, is the love and affection of a loved one? A mother's kiss to her child's bruised knee is probably the world's best pain killer. Simply telling a loved one 'I hurt' lessens the pain.

A common factor in these important studies is that they concern human interaction and that the biochemical mechanism or mechanisms are unclear. What is clear is that the conventional explanations of health and ill health are seriously incomplete. Some eminent epidemiologists[34] are concluding that what is emerging is an underlying general causal process, which *expresses* itself through the different clinical diseases, and that this fundamental mechanism is intimately concerned with the functioning of the brain, and through it with the endocrinological and immune systems.

Lessons for the future

If compassion really is beneficial, then those life events that are seen to be significant by the patient are truly significant for their disease processes as defined by the medical profession. The patient's wish to be treated as a person, to be comforted and strengthened, is transformed from apparent perversity to rational desire. Similarly, this strengthening is a need which doctors should struggle to satisfy rather than acquiesce to its continued erosion. It would best be provided by resuscitating the Personal Doctor.

References

1. McCormick J. Death of the personal doctor. *Lancet* 1996; **348:** 667-668.
2. Bayley T, Browse N, Kilpatrick R, *et al. Core values for the medical profession in the 21st century*. London: BMA Publications, 1995.
3. Calman K. The profession of medicine. *BMJ* 1994; **309:** 1140-1143.
4. Shorter Oxford Dictionary. 3rd edn. Oxford: Oxford University Press 1965.
5. Toon PD. *What is good general practice?* [Occasional Paper 65.] London: Royal College of General Practitioners, 1994.
6. Pratt J. *Practitioners and practices: a conflict of values?* Oxford:

Radcliffe Medical Press, 1995.
7. Cartwright A, Anderson R. *General practice revisited: a second study of patients and their doctors.* London: Routledge and Kegan Paul, 1981.
8. Freeman GK, Richards SC. How much personal care in four group practices? *BMJ* 1990; **301:** 1028-1030.
9. General Medical Council. *Annual Report 1993*. London: GMC, 1993.
10. Complementary medicine is booming world wide. [News item.] *BMJ* 1996; **313:** 131-133.
11. King M. *Stress management in general practice.* [Occasional Paper 61.] London: Royal College of General Practitioners, 1993.
12. Dorrell S. *Primary care: the future.* London: NHS Executive, June 1996.
13. General Medical Services Committee. *Medical workforce.* [Task group report.] London: British Medical Association, February 1996.
14. McBride M, Metcalfe D. *General practitioners' low morale: reasons and solutions. Br J Gen Pract* 1995; **45:** 227-229.
15. Blankfield RP, Kelly RB, Allemagno SA, King CM. Continuity of care in a family practice residency program. Impact on physician satisfaction. *J Fam Pract* 1990; **31:** 69-73.
16. Levinson W. Physician-patient communication: a key to malpractice prevention. *JAMA* 1994; **272:** 1619-1620.
17. Entman SS, Glass CA, Hickson GB, *et al*. The relationship betweeen malpractice claims history and subsequent obstetric care. *JAMA* 1994; **272:** 1588-1591.
18. Hayter P, Peckham S, Robinson R. *Morale in general practice.* Southampton: Institute for Health Policy Studies, 1996.
19. Alpert JJ, Robertson LS, Kosa J, *et al.* Delivery of healthcare for children: report of an experiment. *Paediatrics* 1976; **57:** 917-930.
20. Wasson JM, Sauvigne AE, Mogidniki RP. Continuity of outpatient medical care in elderly men. *JAMA* 1984; **252:** 2413-2417.
21. Nazareth I, King M. Decision making by general practitioners in diagnosis and management of lower urinary tract symptoms in women. *BMJ* 1993; **306:** 1103-1106.
22. Flint C, Poulengeris P, Grant A. The 'Know your Midwife' scheme: a randomized trial of continuity of care by a team of midwives. *Midwifery* 1989; **5:** 11-16.
23. Nowak MA, May RM, Sigmund K. The arithmetic of mutual help. *Scientific American* June 1995; **272:** 50-55.
24. Nowak MA, Sigmund K. Tit for tat in heterogeneous populations. *Nature* 1992; **355:** 250-253.
25. Parkes C, Benjamin B, Fitzgerald R. Broken heart: a statistical survey of increased mortality amongst widowers. *BMJ* 1969; **i:** 740-743.
26. Rees WD, Lutkins SG. Mortality of bereavement. *BMJ* 1967; **4:** 13-16.
27. Chen CC, David AS, Munnerty H, *et al.* Adverse life events and breast cancer - case control study. *BMJ* 1995; **311:** 1527-1530.
28. Ferrie JE, Shipley MJ, Marmot MG, *et al.* Health effects of anticipation of job change and non-employment: longitudinal data from the Whitehall II study. *BMJ* 1995; **311:** 1264-1269.
29. Liecolt-Glaser JK, Marucha P, Malarky W, *et al.* Slowing of wound healing by psychological stress. *Lancet* 1995; **346:** 1194-1196.
30. O'Hare T, Creed F. Life events and miscarriage. *Br J Psychiatry* 1995; **167:** 799-805.
31. Rendmeier DA, Molin JP, Tibshirani RJ. A randomised trial of compassionate care for the homeless in an emergency department. *Lancet* 1995; **345:** 1131-1134.
32. Medalie JH, Goldbert U. Angina Pectoris among 10,000 men. *Am J Med* 1976; **60**: 910-921.
33. Patronek GJ, Glickman LT. Pet ownership protects against the risks and consequences of coronary heart disease. *Med Hypotheses.* 1993; **40:** 245-249.
34. Evans RG, Barer ML, Marmar TR. *Why are some people healthy and others are not: the determinants of health of populations.* New York: Aldine de Gruyter, 1994.

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