



Is It Possible to Develop a Compassionate Organization?

Comment on “Why and How Is Compassion Necessary to Provide Good Quality Healthcare?”

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Abstract

This paper represents a commentary to Marianna Fotaki's Editorial: 'Why and how is compassion necessary to provide good quality healthcare?' Within this commentary, I discuss some of the issues raised by Marianna Fotaki, and conclude that we should work towards an organizational culture which considers the important concept of compassion by focusing on the well-being and teamwork of all involved.

Keywords: Compassion, Organization, Training, Healthcare

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In an interesting Editorial, Marianna Fotaki¹ explores the question as to ‘why and how compassion is necessary to provide good quality healthcare.’ In addressing issues as to whether compassion can become a moral sentiment and lead to developing a system of norms and values underpinning ethics of care, the author discusses multidisciplinary approaches to the issue of morality. Furthermore, the author argues that whilst there is recognition of the role that compassion plays in individual morality, it is often in conflict with organizational logics and policies.

I am in agreement with many of the questions raised and the points put forward by the author of this Editorial. My personal view is that compassion is not only concerned with the interaction between healthcare professional and patient, but that it extends across the entire organization – including hospital managers, administrative staff, auxiliary staff, and policy-makers. After all, can a compassionate individual sustain such a virtue if placed in a noncompassionate organization?

Compassion is a rapidly growing field of interest and as a concept it includes many other virtues (eg, sympathy, empathy, altruism, respect), but the difference between compassion and the many individual virtues contained within it, is that compassion goes beyond feeling for another person, and implies some form of ‘action.’ This action could be quite simple such as offering kind words and providing comfort. As such, compassion does not imply developing strong emotional bonds/relationships with patients (which might in turn be unhealthy for the healthcare profession at an emotional level), but it does involve noticing and taking action, and also consideration of the unique independent values of the patient.

We are constantly reminded of the issue of paperwork and targets that healthcare professionals are expected to meet, and as suggested in Fotaki's Editorial: ‘proposals to incentivize

compassion should be geared towards promoting prosocial behavior rather than imposing a new set of burdens and target measures.’ On this latter point, it would of course not be satisfactory to introduce additional burdens via incentivising compassion, because the well-being of healthcare providers themselves is also important to consider. As we are aware, healthcare providers are often under strain, from large amounts of paperwork and target meeting, and burn-out is a growing issue, as strongly observed within a recent general practitioner (GP) study which identified a very high risk of burn-out in the United Kingdom GPs.² Thus, any training or education on the topic of compassion should be extended to include all of those involved in the healthcare setting to ensure a compassionate approach not only towards patients, but also towards other members of the healthcare team.

The incorporation of training in compassion could be beneficial for many valid reasons. The physiological benefits of compassion have been reported in a number of studies which show that kindness and touch reduce anxiety, and alter the heart rhythm and brain function in both the person providing compassion and the person receiving it. Furthermore, a compassionate approach changes the brain's response to stress and increases pain tolerance.³⁻⁶ As such, it would seem that a compassionate approach can benefit all concerned (both the recipient and the receiver).

It is possible that the training of doctors and nurses may over-emphasise scientific knowledge rather than practical skills, development of basic care, compassion, and other personal skills. Placing compassion on the medical curriculum or operating short courses or interventions might seem like a good way forward. However the content may be difficult to establish without a more in-depth understanding of factors which might hinder or promote compassionate care and fundamental problems may exist in defining and measuring compassion.

As such, utilising an established theoretical framework to develop an instrument/model for understanding and measuring compassion (either at the level of training or during professional practice), might allow for the ascertainment of specific barriers to compassion, and factors which might affect the well-being of healthcare providers, thus impacting on the care that is delivered to patients.

I feel that for any source of training to be, as Fotaki suggests, 'adequate' then it should be offered to all involved in the healthcare setting – including managerial staff, administrative staff, policy-makers and so on.

Further questions come to mind of course, for example – if we are to implement 'adequate training': How can we achieve this?

As early as 1983, Pence,⁷ in a well-cited essay, raised the question as to whether compassion can be taught. Utilising the differing views of ancient philosophers, Pence drew on the opinions of Socrates (who claimed that virtues cannot be taught), and Protagoras (who claimed that everyone teaches virtues). Pence concluded that compassion can be taught if medical education systems reward this virtue alongside other medical virtues.

Traditional teaching methods might not be the most appropriate way to initiate training in compassion. However, innovative and interactive teaching techniques such as the use of video clips, group discussion, examples from theatre, art and literature could be of great value.

There are also various initiatives in place that can help to improve patient care and provide support to healthcare professionals. The Point of Care Programme⁸ for example, aims to 'improve patients' experience of care and increase support for the staff that work with them. Likewise, the Schwartz Centre,⁹ has developed what is known as Schwartz Centre Rounds which involves regular meetings with staff to discuss the emotional and social challenges associated with their jobs and to reflect on their experiences.

Sustaining compassion over time, within the healthcare setting, would probably depend on a number of factors: support, refresher courses, discussion groups, workshops, etc. However, a good starting point could be to implement such training at an undergraduate level, both to student doctors and nurses and to allied health professionals and others working towards careers within healthcare. Certain undergraduate courses are already in existence, and seem to be welcomed by students.^{10,11}

To this end, I understand Fotakis' comment that 'providing adequate training to healthcare professionals...to remedy poor care and neglect may be an effective way of ensuring that nurses and doctors treat their patients with compassion only if it is followed by specific measures and policies that will nurture and develop such attitudes.' Likewise, I understand

the statement that 'Managers and organisations are critical to the creation of an ethical environment but the overall policy framework in which they operate is even more important.' However, I believe that such procedures require feedback and evaluation and development of measures via the utilisation of a theoretical framework for understanding barriers to care, and for understanding 'what goes right' and 'what goes wrong' within the healthcare setting.

We can not expect there to be a 'Gold Standard' for promoting compassion, but I do feel that we should work towards an organisational culture which considers the important concept of compassion by focussing on the well-being and teamwork of all involved.

Ethical issues

Not applicable.

Competing interests

Author declares that she has no competing interests.

Author's contribution

SS is the single author of the manuscript.

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