In this paper I hope to convey to the reader where compassionate care arises, what obstacles it faces and how it might hurdle them. Since the Francis report, especially great attention has been placed on the relationship between healthcare staff and patients. As a medical student I’m taught oft of the long gone days of the paternalistic philosophy and how now we have gone now in the direction of the patient being central (like the customer is always first); but to me this equally misses the point of healthcare, that the practitioner and patient are equals. I believe that enabling compassion to thrive in healthcare is the key to restore the equality in the therapeutic relationship, that we are all humans, all equally vulnerable and culpable.

The discussion has very much been a useful dialogue in my own mind, about the dichotomy between professionals and persons, and where in my own practice I can draw the line. We’re often warned about not becoming emotionally entangled with patients, and adopting the manifesto of professionalism to ensure that. For me, writing this essay has been a way to rectify being both a professional and a person to a patient.

My essay concludes that instigating compassion in mental health care will be rather counter intuitive and that lessening intervention will achieve more than increasing it.

Joseph Morwood F-Year Student St Georges Medical School

"Compassionate care in psychiatry: An unattainable goal?"

Until recently, the word "compassion" was reserved for select circles. A mention in the MDT might have stunk of sanctimony: Piety and professionalism? - Alarm bells, not church bells would ring. But like many facets of spirituality, compassion has slowly found a place amongst the other secular spiritual spin-off's; mindfulness, happiness, wellbeing, all booming buzz words in the care lexicon, all replacing attributes lost to the medical model's mechanistic theory of disease.

Described succinctly by Professor Paul Gilbert as "Kindness, with a deep awareness of the suffering of oneself and of other[s] ... with the wish and effort to relieve it“¹, compassion has long been a desired but not required asset of the caring professions. In 2010, compassion in healthcare became headline news. The Francis report, an investigation into care failings in the mid-staffs trust, found culture deep deficiencies in standards of care, suggesting that many of the most vulnerable NHS patients were in receipt of inhumane levels of healthcare. It was quite obvious that something was lacking in healthcare culture that enabled such poor standards to perpetuate.

A suggestion, amongst others from the report, was for "Caring, committed and compassionate staff“² as a remedy to patient neglect. Commitment and care are established roles of healthcare professionals, but compassion seemed slippery. Was it possible to commentate on practitioners’ moral integrity as part of their work life?

Compassion had now been promoted from a virtue, to a job description, and as an under-investigated territory of modern healthcare many questions still hang in the air: Is it a cost effective intervention? Is it compatible with NHS culture? Is it even possible within the content of psychiatric experience? These are significant obstacles, but the vast weight of evidence suggests it not as unattainable as we think.

Mental health services in the NHS have lost an equivalent of £253 million in funding over two years, prompting the president of the Royal College of Psychiatrists to claim mental health services are “running dangerously close to collapse”. In this financial context, any system wide intervention needs evidence to support its cost effectiveness. A service wide emphasis on compassion would no doubt require reforms in policy and training, requiring considerable investment. Some might suggest compassion is merely an optional extra in the face of few resources, a luxury at the expense of psychiatric hospital beds, all icing and no cake.

But there are good reasons to suggest enhancing the compassionate qualities of staff, enhances the care of their patients. The therapeutic alliance is a term used to describe the quality and strength of a relationship between the therapist and client, and it is widely agreed that a good outcome is more likely where a good therapeutic alliance has been established. Perhaps this works on a similar level to the much underestimated placebo effect, where as little as the colour of a pill can affect efficacy and where similarly, the quality of the therapeutic interaction can highly influence patient outcomes.

Although we cannot admit to understanding the mechanisms behind the placebo or therapeutic alliance, it is undeniable that they exert large effects on patient outcomes, and these are two very reasonable mechanisms to suggest compassionate care that enhances the therapeutic relationship, can alter patient outcomes for the better. Hence it would be reasonable, to suggest that a compassionate service would offer greater efficiency and therefore lower costs.

However, beyond the theoretical there is only developing evidence to support this. Studies find patients give more information on their symptoms to staff members who demonstrated empathy, frequent A+E attenders assigned to compassionate care had fewer repeat visits with higher satisfaction than those treated normally and lower anxiety levels from compassionate treatment can enhance healing. Despite promise, there is definitely a deficit in research, one that the King’s Fund hopes to end by suggesting a comprehensive research agenda. As is often the case, research drags far behind practice and what is needed are confident steps in the direction of the reasonable evidence we have.

But when dealing with mental health, is compassion still applicable? Unless the care worker has experienced the illness that afflicts their patient, can they be capable of compassion? Take Schizophrenia for example, where the patient’s insight into

conventional reality becomes skewed, vastly subverting their perception and experience. Such a condition is phenomenologically inaccessible to an unaffected person. Physical symptoms such as toothache, although subjective, may still be relayed to others by what the phenomenologists call ‘inter-subjectivity’, as experiences congruent within a comparable reality. But when realities are outside our own, such as in psychosis, can we comprehend experiences enough to harbour compassion?

The psychiatrist and poet Christine Montross struggled with a similar thought, how to accompany patients on a journey so utterly alien and unknowable:

“To fear that you might kill your own child, to scour your face with sandpaper, to swallow bedsprings – this is the ‘purity of pure despair’. If I am to abide with these patients, then I must accompany them to that place among the rocks, to the sweating wall. I must face with them the uncertainty of what lies beyond… I must look at what I’m asking them to endure and I must look at it full in the face.”

Realities may be mutually exclusive, but Montross argues that suffering is not and that by ‘abiding’ with a patient, we are guiding them. She uses the image of a frozen lake, where beneath the ice sheet all is unknown, impenetrable but to the smallest crack.

“The patients we work with have fallen through the ice in the middle of a frozen lake… my job… is to go out to them, to be with them on the thin ice, and to work with them to get them out of the frozen water”. 13

We don’t need to see the depths of a patients trouble to have as Gilbert puts “A deep awareness” of their suffering, enough so to be compassionate. Compassion is not so much exchanging what we see, but rather what we feel. It is a mutual feeling of suffering.

Compassion may be applicable to all experience but a question arises over its compatibility with all cultures; can its process be quite so easily crystallised into the box ticking business model of contemporary healthcare?

And this really is the crux of the problem, because it seems compassion cannot be driven by top down policy, but only thrives in cultures that give room for compassion to grow. In a letter signed by leading academics, Professor Paul Gilbert argues:

“While it is very seductive to believe that you can threaten people into becoming compassionate, all the evidence is you cannot and that you will make things worse. As the Francis report notes, NHS services can be time-pressured, accounts-driven, and job-threatening, whereas compassion grows in compassionate, supportive environments. There is evidence that the greater the time pressure we put people under, the more empathy can be compromised in our brains.”

So perhaps we reach a different conclusion to the one the Francis report may have intended; compassion is indeed attainable but must be done in a radically different way to other health interventions. In Intelligent Kindness, John Ballat and Penelope Campling argue that we must restrain “The emphasis on ideologically driven prodding, manipulation and incentivisation from the outside to provoke ‘improvement’”. 15 The unnatural attempt to augment health services to reach political and commercial ideals, they argue is what


brought us to the Francis report in the first place, and furthermore no further enforcement or prodding of principles will get us anywhere. Instead they suggest the balance will come through:

“...Putting the focus on learning from, and building outwards from, the central human activity of bringing intelligent kindness to the healing relationship. Promoting a culture and organising systems that liberate and nourish that work will set in motion a genuine and rich dynamic reform. The challenge is to begin, in earnest, to apply our collective intelligence and solidarity to make this happen.”16

Ballat and Campling encourage organising a culture around natural human relationships, rather than a model for therapeutic relationships shaped by a contrived policy. What they suggest is that our health system should mirror our innate ability for compassionate behaviour as opposed to relying on disingenuous markers of efficiency and effectiveness. We must not force people but rather allow them to be compassionate.

Compassion is an attainable goal and one that’s conceivable and compatible within modern mental health, but to enable it we should be looking to nourish and support and not impose or enforce it into being. Practically speaking what’s needed now is research to better understand how compassion is best developed in institutions and to further elucidate on the benefits to staff and patients in mental health care. From there, there is no road map or recipe, but instead a need for trust in human nature and its capacity for kindness.

16 ibid. (pg189)