Tools for Intercultural Education of Nurses in Europe (IENE 3)

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COMPASSION TOOL

Theoretical component

Principles and Values

Compassion has its roots in religious ideologies and it concerns sharing the suffering of others. Thus, the principles that underpin this tool are:

- Shared learning
- Valuing experience
- Building on what is already known
- Equality of access
- Exploring similarities and differences
- Tolerance
- Fostering curiosity
- A commitment to life-long learning

- Respect
- Dignity
- Equity
- Human rights
- Acceptance
- Inclusion
- Empathy
- Professionalism

Aims

When you have worked through this tool, you will be able to:

- Articulate the need for the focus on compassion in current nursing practice;

- Discuss the meaning of compassion from different viewpoints: your own, patients' and their families'; colleagues' viewpoints;

- Reflect on your own practice in relation to the provision of compassionate care that is safe and effective for a variety of different patients;

- Identify strategies to nurture your own practice in this respect.

What the research says

In England, compassion has risen to prominence in the media and policy circles following reports of unsatisfactory care of patients (Straughair, 2012a; Dewar, 2013; Price, 2013), which identified cruelty and neglect, unnecessary suffering, degrading and inhumane treatment (Staughair, 2012a) of people with learning disabilities (at Winterbourne View) and mostly frail elderly patients and patients who were nearing death (at Mid Staffordshire NHS Foundation Trust) (Hehir, 2013). Concern has been raised that nurses have lost sight of basic, compassionate care (Price, 2013).This emphasis on compassion is set in an increasingly complex healthcare context (Dewar, 2013).

These reports suggest that the most frail, vulnerable and powerless people in society are most at risk of receiving poor care. Good care and compassion are often reserved for 'attractive' people (CAREIF, 2013).

Kim (Kim and Flaskerud, 2007) draws on her own experience of being a patient (in USA) and contrasts health professionals who demonstrated efficiency and clinical expertise with those who demonstrated connectedness and understanding but not particularly extraordinary skills. However, caution should be exercised in viewing two types of nurse – the efficient nurse and the caring nurse. Compassion is a relational concept and thus cannot be considered within a vacuum. Compassion arises in nursing encounters with patients, so there is a need to consider compassion alongside expertise. Within nursing literature, compassion is often discussed within the context of what 'good care' looks like, and so much of the literature is about good nursing practice, for example, care that is 'safe and effective but also compassionate' (Adamson and Dewar, 2011, p43).

In their work on developing a culture of compassionate care, Cummings and Bennett (2012) note that:

- Nurses generally come into contact with their patients and their families when they are at their most vulnerable and when *'care, compassion and clinical expertise matter most'.* (2012, p6);

- The focus on compassion is part of a wider drive to improve the quality of care;

- Values at the heart of the vision for nurses, midwives and care-givers are underpinned by 6 Cs:

    - Care

    - Compassion

- Competence
- Communication
- Courage
- Commitment

Cummings and Bennett define compassion, in the draft vision, as follows:

> *'Compassion means care given through relationships based on empathy, kindness, trust, respect and dignity, regardless of the circumstances and seeing the person behind the condition'* (p10).

Alongside this nurses need to connect compassion with the very best technical care and the highest levels of knowledge.

The revised definition in the completed vision defines compassion as follows:

> '*Compassion is how care is given through relationships based on empathy, respect and dignity – it can also be described as intelligent kindness, and is central to how people perceive their care'*
> (NHS Commissioning Board, 2012, p13).

So, providing compassionate care means being able to use the best available evidence to support nursing actions. Rather than seeing compassion as something that can be taught and learnt in a vacuum, it is important to link the nurturing of compassion to all nursing activities. As Dewar and Christley (2013) argue, rather than being one of the six values, compassion is at the heart of the other 5 values. Compassion is what unifies the other 5 values. For example, compassion requires empathy, courage and commitment to gather insight into patients' experiences and represent them to others in authority (Price, 2013).

Definitions – How has compassion been defined in research studies?

Compassion is a concept that is difficult to reduce to a key set of measurable elements, but there is now a plethora of literature relating to compassion, both across Europe and the Atlantic.

The term means 'to suffer with', from the Latin *com* (together with) and *pati* (to suffer) (Schantz, 2007). Compassion has its origins in religious ideologies (Armstrong, 2011; Straughair, 2012a; CAREIF, 2013). Compassion is a central focus of many spiritual and ethical traditions, from Buddhism to Confucianism to Christianity (Goetz et al).

Certain elements that contribute to compassion can be found in the literature. These include:

- Humanity
- Respect
- Being non-judgemental
- Kindness

- Empathy
- Fellow-feeling
- Sensitivity to patients' experiences
- Being moved by another person's suffering
- Witnessing another person suffering and experiencing a subsequent desire to help (Goetz, Keltner and Simon-Thomas, 2010).
- Not only acknowledging suffering, but also acting toward alleviating it (Schantz, 2007)

This is important to note, that in nursing practice compassion entails more than being aware of suffering in others. It entails acting on that awareness: many authors agree that compassion goes beyond recognition of suffering to having an active desire to alleviate another's suffering (CAREIF, 2013); *'... the capacity to perceive, feel and act towards suffering'* (CAREIF, 2013).

Dewar (2013) identified key dimensions of compassionate care:

- It is a subjective experience
- The quality of the relationship is important
- It relates to the needs of others
- It recognises suffering and vulnerability
- It requires emotional connection and interpersonal skills

Cingel (2011) engaged in qualitative research which analysed in-depth interviews with nurses and patients in order to determine 'What is the nature and significance of compassion for older people with a chronic disease in nursing practice?' Cingel conducted interviews with 30 nurses and 31 patients with a variety of chronic diseases in the Netherlands, and was able to describe compassion as a process comprising 7 dimensions:

- Attentiveness
- Listening
- Confronting: verbalisation of suffering – acknowledging and valuing by the nurse
- Involvement
- Helping: assisting with activities of daily living that the patient can no longer perform
- Presence: being there
- Understanding

This is broadly similar to Proctor's (2007) claim that compassion entails:

- Active listening
- Ensuring patient dignity
- Anticipating anxiety
- Acting to prevent or ameliorate suffering

While Curtis (2013, 2014) suggests that the origins of compassion are thought to be innate and learned in relation to compassion towards people we know and care about, the origins of compassion for strangers are not so certain. Compassion is an 'other-orientated state' (Goetz, Keltner and Simon-Thomas, 2010). Compassion is likely to be most intense in response to the suffering of individuals who are self relevant, i.e. those who are most important to one's wellbeing, for example, offspring, relations, friends, partners, people who share similarities, group members; and goal relevant, i.e. a general value that all people should have equal rights and opportunities (Goetz, Keltner and Simon-Thomas, 2010).

Goetz et al further argue that analysis of the evolution of compassion suggests that appraisal processes that give rise to compassion entail an assessment of 'deservingness', whereby undeserved suffering should elicit compassion. This entails making judgements about the degree to which an individual is responsible for his or her suffering. It is important to be aware of these processes in order to consciously suspend judgements in nursing practice. For Schantz (2007) compassion entails notions of doing good and justice in which there is no place for making judgements about people's deservingness of compassion.

The primary function of compassion is to facilitate cooperation and protection of the weak and those who suffer (Goetz, Keltner and Simon-Thomas, 2010).

> *'Compassionate nursing practice can be defined as comprising: the enactment of personal and professional values through behaviour that demonstrates the emotional dimension of caring about another person and the practical dimension of caring for them, in a way to recognise and alleviate their suffering.'*
> (Curtis, 2013a: 3)

So, what can we gather from this literature to use in the formation to learning and teaching tools?

Curtis, Horton and Smith's (2012) study identified the following components of student socialisation in compassionate care:

- Personal exposure
- Theory exposure
- Practice exposure

Practical component

In order for you to learn about compassion from practice, it is important to start a reflective diary. In this diary, you should record incidents of receiving and giving compassion.

1. Awareness

You must be able to care about yourself to be able to care for others. The ability to remain compassionate in practice is strengthened by the quality of support you receive. It is important to understand the experience of giving and receiving care.

Activity 1.1: Your own experiences of compassion

We know that compassion is a subjective feeling, so it is important to consider your own feelings about compassion.

1. Think about a time when you were suffering in some way, maybe you were stressed about something. Was someone kind to you? Did someone convey compassion for you? How did you feel?

Make some notes about what helped you to feel better.

What would be your own personal definition of compassion?

2. Reflect on your own experience in the care giving process – be aware of thoughts and feelings.

Why did you choose nursing as a career? Maybe you chose nursing because you wanted to help people, to contribute to the alleviation of suffering.

To what extent do you feel able to uphold the values you held when you chose nursing as a career?

Are there any barriers that are hindering your ability to provide care with compassion?

Activity 1.2: Other people's experiences of compassion

The Centre for Applied Research and Evaluation International Foundation (CAREIF) is an international mental health charity based at the Centre for Psychiatry, Barts and The London School of Medicine and Dentistry, Queen Mary University of London. The document '*In Conversation with Compassion and Care'* (CAREIF, 2013) contains a selection of narratives relating to thoughts on compassion and care from people from a range of backgrounds.

Read this document in order to get some idea of the scope of the concept:

http://www.careif.org/downloads/Events/careif%20Compassion%20and%20Care%20PDF.pd f

2. Knowledge

Activity 2.1: Understanding the concept of compassion

Read the following article in order to enhance your knowledge and understanding of compassion:

Staughair, C. (2012) Exploring compassion; implications for contemporary nursing.Part 1. *British Journal of Nursing,* 21(3): 160-164

We know that compassion takes place in a relationship. Benevolence towards others is widespread and studies suggest that suffering and need elicit compassion universally (Goetz et al).

However the ways in which compassion functions – the reduction of suffering and the formation and maintenance of cooperative relationships – almost certainly vary across cultures (Goetz et al). Goetz et al hypothesise the possibility that cultures that are very interdependent may have a tendency to feel compassion for in-group members; while independent cultures may have a tendency to feel compassion for out-group members. However, this hypothesis remains unproven. As a general rule, cultures vary in their outward displays of emotion.

Kim and Flaskerud (2007) discuss similarities and differences in cultural expression of compassion. Western patients and nurses are more likely to say and acknowledge what they are feeling, providing an opening for the nurse to express compassion. In the East patients do not express their feelings openly to health professionals and for the nurse to try to express feelings for them might be unwelcome in what is considered a professional, not a personal, relationship. However, this is a huge generalisation and you must always be alert to individual differences.

You also need to be alert to gender roles in the giving and receiving of compassion. In many cultures, compassion may be considered a feminine trait and be confined women's roles.

While being alert to differences, it is important to focus on the commonalities and *'... meet people across borders as fellow human beings ...'* (CAREIF, 2013)

Activity 2.2: Similarities and differences in giving and receiving compassion

Seek out opportunities to gain experience with different patients and in different settings and situations. Record your experiences in your reflective diary. As time goes by, you will be able to reflect on these experiences in order to build up your repertoire of responses to patients in a range of situations.

Remember Cummings and Bennett's (2013) definition:

> *'Compassion means care given through relationships based on empathy, kindness, trust, respect and dignity, regardless of the circumstances and seeing the person behind the condition'* (p10).

While nurses must be compassionate towards all their patients, we know that vulnerable and powerless people are most at risk of receiving care that is not compassionate. Vulnerable people include people who are elderly, have learning disabilities, have mental illness, do not speak English, have recently arrived in the UK, or are socially excluded.

Does your experience suggest any cultural differences? Any gender differences? Any differences in relation to age? Any differences in relation to socio-economic status?

While it is important to note differences and similarities, do not try to categorise your patients too much – an older person will have a gender, a culture and could possibly have a learning disability or mental illness.

3. Sensitivity

We know that compassion involves interpersonal skills.

Compassionate communication includes respect for, and interest in, patient experience (Price, 2013). This means being sensitive to the patient experience. It will also entail making adjustments to meet the needs of your individual patients.

Activity 3.1: What matters to patients

Ask patients what they found helpful. Record your findings in your reflective diary.

What are the similarities and differences in your individual patients' responses? Make two lists – one of the similarities and one of the differences.

How will you adjust your practice as a result of what your patients are telling you?

4. Competence

Price (2013) argues that compassionate care requires expertise – understanding of experiences, concerns and expectations of patients, relatives, lay carers.

We know that being compassionate entails respect for fell human beings and being non-judgemental. But it also entails the ability to anticipate suffering, to recognise suffering, to be moved by suffering, and then an active desire to alleviate suffering.

Activity4.1: compassionate care that is also safe and effective

During your nursing practice, identify a role model – a nurse about whom you can say 'That is the sort of nurse I want to become'.

What is it about this nurse's practice that you admire?

What does he or she do that has inspired you?

How does he or she relate to patients, convey compassion, ensure care is safe and effective?

How would you describe his or her professional values?

Activity4.2: Your professional practice

Use your reflective diary to look back over the incidents you have noted and your responses in these situations. How do you feel that your own practice is developing?

Critically analyse your own practice. Do you feel you are acquiring the skills to engage in compassionate care that is safe and effective?

Are there any barriers to delivering compassionate care that is safe and effective?

Feelings of compassion should increase when the individual feels capable of coping with the target's suffering (Goetz et al).

In order to be able to engage in the levels of involvement with patients that may be required in therapeutic compassionate professional nursing relationships, it is crucial that you are supported in your practice.

You should be able to discuss your progress with your mentor who should support you.

Compassion needs to be shown towards colleagues as well as yourself and your patients and their families. Think about the effect of your own practice on other members of the team.

Activity4.3: Doing good and justice

Being compassionate also means being able to advocate on behalf of your patients. This requires courage and commitment.

Are you developing the skills and confidence to take on this role?

What help might you need?

Sadly, sometimes you will experience dissonance when you are not able to put the theory you have learnt into practice – this is often due to variability in practice.

Think about the help you might need to develop and maintain resilience in order to overcome these difficulties and to maintain your professional status.

Assessment component

Formative assessment:

Reflective account – incident from practice – identifying what has been learned and learning needs.

Summative assessment:

Critical analysis of a case study

Structured essay

Evaluation component

1. Self-evaluation: the learner should evaluate how the tool has assisted learning and what has been learned. This stage of evaluation should focus on use of the reflective diary and the development of awareness of compassion.

2. Peer evaluation: peer learning groups should discuss their use of the tool: how it has assisted learning and what has been learned. This stage of evaluation should focus on knowledge gained regarding compassion and what it might mean for different people in different situations.

3. Teacher evaluation: teachers should evaluate the tool through observing classroom activities that demonstrate students' developing skills in delivering compassionate care, focusing on how they relate to patients' suffering.

4. User group evaluation: it is important to involve patients (or former patients) in the evaluation of this tool. User groups could be approached to invite them to comment on the tool. In areas where users are involved in classroom teaching activities, user group members can be invited to evaluate the tool's effectiveness in helping students towards competence in compassionate care, through observing and taking part in classroom activities that require students to identify patients' suffering, to acknowledge it, be moved by it, and articulate ways of alleviating it.

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Useful websites

CAREIF (2013) In Conversation with Compassion and Care.
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