The Point of Care Foundation

Anniversary Schwartz Round: What makes for a compassionate patient-caregiver relationship?

Background

Ten years ago, during summer 2005, to commemorate its 10th anniversary, the Schwartz Center asked hospitals to hold Rounds to discuss the topic, "What Makes for a Compassionate Patient-Caregiver Relationship?" Each facilitator was asked to guide the group discussion and distill practical suggestions for building compassionate patient-caregiver relationships. The discussion format was left to the individual hospital, but suggestions were made for a panel of patients and/or family members, a panel of caregivers [staff], or a focused discussion of the topic. 54 hospitals, over half the hospitals running Rounds in the US at the time, took part.
The findings were written up by Dr Darshak Sanghavi as a paper, 'What makes for a compassionate patient-caregiver relationship?' in *The Joint Commission Journal of Quality and Safety* 32(5) May 2006.

The idea for our own Anniversary Round

Ten years on, with over 100 organisations running Rounds in this country, we wanted to repeat the exercise here. This wasn't a research project but rather a chance to record a 'national conversation' about compassion. We thought it would be interesting to see how discussion at the Rounds would reveal how many themes we had in common, and whether our UK healthcare context, and the gap of ten years might mean that the conversation would be different.

We suggested to sites that they hold a Round in September 2015 which asks the same question: "what makes a compassionate relationship between caregiver and patient?" We recommended that the panel should speak about this both from the perspective of caring for patients, and/or from the perspective of when they, or someone in their family (or a friend) has been a patient.

We received accounts of 20 Rounds, including acute hospitals, mental health services and hospices. Sites approached their Round in a variety of ways. Panels were made up of clinicians and non-clinicians and some chose to recount when they or a family member had been a patient. Some chose a patient story to illustrate compassionate care and challenges associated with it. Participants in the Rounds were the usual mix of doctors, nurses, allied health professionals, support, management and administrative staff.

The themes that emerged were presented by Joanna Goodrich at a breakout session at The Point of Care Foundation's conference on 16 December 2015, (where most delegates had

experience of Schwartz Rounds) and points from the discussion that followed are included in the summary below.

Themes of the Anniversary Rounds

1. **What is compassion? What do we mean by compassion? How is it demonstrated?**

Many spoke about compassion as **small acts of kindness**

A panellist described how his mother had spoken about a small incident when she was offered a cup of tea when accompanying his father to a hospital appointment and how cared-for she felt by this small act.

Another spoke of a nurse taking lunch to a patient in the discharge waiting room knowing that he was going home to an empty house and had been looking forward to a cooked meal.

At one Round they talked about the combination of "expert care, everyday kindnesses":

"I don't think you can give compassionate care if you're not giving good clinical care"

Others wondered whether in order to be compassionate there has to be suffering

Another quoted the Dalai Lama: *"Be kind whenever possible. It is always possible"*

Time

The theme of having or making time came up often. Demonstrating to a patient that you have time: take time to actively listen, be in the moment. The quality of attention is itself an act of compassion.

Touch

People display compassion in different ways. Some show 'honest emotion', and you can also show compassion through touch. A physio talked about this and then reflected that maybe it's easier for physios – they strip off and examine each other as a large part of their training so they're used to it.

Seeing the person in the patient

"When a patient can feel they are a person and not a patient that's a good experience of care"

One of the [hospice] panellists spoke about the belief that what makes a compassionate patient-carer relationship boils down to a shared humanity, and learning to drop perceptions of both ourselves and others, accepting yourself and others and sharing the experience and sharing the relationship. If you see the person first everything else comes into context.

2. **How is compassion achieved?**

Boundaries: balancing personal and professional

This was a predominant theme – when to bring something of yourself personally to the relationship, over and above a purely professional relationship. Is it possible to be compassionate otherwise? This may involve revealing your own emotions in a way that might seem uncomfortable, making yourself a bit vulnerable.

"*Going beyond the professional boundaries can allow us to be compassionate"*

A Consultant described how a few weeks after one of her patients died her parents came in to thank her, and told her details of the funeral. The Consultant became emotional and cried with the parents – which made her feel compromised. She felt it was not her role as the Consultant to cry. On reflection though she felt she was being human rather than just being professional and had permission to grieve. One of the audience reflected that displaying some emotion is not the same as breaking down.

Another audience member reflected "*as a nurse I have struggled with how much to share about myself with patients but the longer I have been a nurse I've learnt that a human to human relationship builds more of a rapport. …it's when I've let my guard down a little bit that I've had a better connection with patients. There is a fine line that we are always trying to tread"*

Giving of ourselves comes at a cost. However, one speaker recounted a situation where she was protected by her colleagues and managers who advised she did not become emotionally involved with a mother whose son was dying on the inpatient unit (because it was close to her own personal situation). But it meant she felt stifled, and the relationship felt unnatural, and she felt her ability to be compassionate was limited.

It was however suggested by several that there are limitations to what a person can safely cope with.

In another Round someone observed that it is important to have boundaries within your compassion. You are <u>not</u> in their shoes; you are not going through this experience like they are. Do not over-step the boundaries of compassion.

Several spoke about how they had 'flexed' the rules to be able to demonstrate compassion. In another Round someone asked
"*You're more than just a doctor; you're a person as well. These boundaries are incredibly important and there is a reason for them but sometimes they are too constricting? It makes me think who's benefit are they really there for? Are they there to protect ourselves from feeling? Some don't benefit others so who do they benefit? How can staff be looked after with flexible boundaries without losing control?"*

3. **Can we teach compassion?**

One participant thought s/he had learned compassion as part of family life growing up – the seed had been nurtured then.

Another observed that s/he felt that society is changing, which is having a detrimental effect on compassion - from a caring society to one where we decide if we like or dislike people.

Others thought that compassion is an innate human characteristic – not just feeling the suffering of others but being motivated to do something about it.

There were examples given of seeing other staff being compassionate and going out of their way to try to relieve others' suffering. This role modelling has been quite significant for staff and helped them to refocus and to think about their own practice

It's tough and takes courage

That it is not easy to be compassionate frequently emerged in discussions:

"*Hang on in there even when they push you away"*

It does upset me very much when I can't make things better and I become overwhelmed with sadness and need a hug myself from my colleagues

Someone talked about how s/he is always mindful of being told as a junior member of staff that we need to dig deep for courage.

An example of this was given in another Round:

"*…he was a young man but he had a stroke and I was frightened to see him as I knew he would look different, and I was unsure what I could say to him, and how he would be able to communicated with me. I had to build up my courage to go, and I will never forget how his whole face lit up when he saw me there. I'm so glad that I didn't abandon him"*

4. **What helps us to understand compassion?**

Patients show us compassion

Others said that particular patients had taught them compassion.
Very often patients are observing us as much as we are observing them – they are seeking a 'connection'.
They teach us how to behave; a nurse described how the mother of a teenaged patient who had died on the ward came back later in the day to thank the nurse for her care, and how this had meant so much to her, that in the midst of trauma and the death of her daughter the woman had taken the time to come back to say thank you.

Being on the other side of care

Many spoke about how it was only when they had had experience of being a patient themselves that they truly understood what compassion meant.

I remember being 8 years old in hospital, my Mum had to go home and I was scared and upset and one of the nurses who lived in the nearby nurses' home went home after her shift, collected an assignment she had to do and did it by the bedside to keep me company

A panellist described himself as a confident, resourceful person who did a lot of research about what he wanted for his treatment when he went into hospital, but how this all went out of the window and he became a vulnerable patient, feeling paralysed with anxiety and very afraid and powerless. He remembered the kindness of the attending nurse who came to the bed and held her arm out to be held. This small act of kindness was overwhelmingly helpful.

Drawing on the experience of being a relative has also revealed the importance of compassion to many. One person told how he was in the hospital chapel while a close relative was having surgery after a very serious accident, and the nurse who had been taking care of him came to find him, and took his hand, and told him that the surgery had been successful. He said that it was the way she did this that alleviated a very difficult situation.

One commented on how the experience of being a patient or a family member receiving care from a professional carer is 'magnified'- being able to recall moments, conversations, words, actions in a way that you wouldn't normally remember things in 'normal' life situations.

It is often the 'non-professional' who makes a difference

A panellist whose father had been dying in hospital described how a HCA tried to find a CD player so that her father could have the music he always listened to – and this made a difference. She also took the time to shave him and cut his nails and it was this simple act which restored her father back to being her dad and the man she had always known.
One person talked about how he felt that the only genuine care for his mother was given by one of the catering staff who took an interest in trying to find foods that his mother might enjoy.

Barriers to compassion

Compassion fatigue

This was characterised by compassion being a finite thing, which can be depleted, illustrated by how staff feel when they get home: it is hard to be compassionate at home when it's all used up at work : "*if only they would wear pyjamas at home!"*

Another said: "*we see so many patients in a day I have no compassion left for my husband at the end of the day".* Conference delegates talked about how mood and capacity for compassion fluctuates and that perhaps equity means saving compassion for those who need it most.

In another Round someone said “*We have a lot of sadness at work – you have to hold it together.”* She had begun to believe that because of this she had become desensitised and lost the ability to feel and when she had a family crisis of her own was almost reassured by how upset she felt.

Pressure and time

There was a consensus that pressure of work and lack of time are the enemies of compassion. One panellist, working as an F1 doctor felt she had lost compassion at the end of her last placement where there should have been 4 doctors and it was only her and a colleague, the hospital was on black alert and patients ‘became a nuisance’ and it became a ‘nuisance to talk to relatives’

Coping strategies were talked about: one person described hiding in the toilets just to get five minutes breathing space. Another talked about averting her face so that she would not have to engage with the patients.

Type of patient or client

It was agreed at several of the Rounds that it’s harder to be compassionate towards some types of patient, particularly if they seem ungrateful: “*I was angry – how dare you? – and then felt guilty”.* It was suggested that some patients may not be able to receive compassion. One person observed that for some people, just being on the receiving end of compassion can make them angry.

It’s more difficult with unlikeable patients –We may have difficult feelings towards our clients and the comment was made that it’s then very hard to hold onto your compassion and see things from the client’s point of view.

In one mental health trust there was some discussion about whether or not it might feel easier to feel compassion for people who can’t help themselves, or who are seen to be more disadvantaged at the outset.

Does compassion stop when patients push us away or are in denial about their illness or diagnosis, or prognosis or death? There was a strong belief that being present is sometimes just enough. Not going away or giving up on people is also important. “*You can sometimes take a break with people, and sit down together with a cup of tea or coffee.”*

One panellist, when describing a colleague behaving badly towards him, reflected how it is always worth remembering that we are not always in receipt of all the facts when dealing with others, which might help to explain their behaviour. Others had spoken about forgiving patients’ behaviour when they realised what story might lie behind the ‘patient’ in the bed, or behind the rude and aggressive behaviour of relatives.

What can help compassion?

Taking care of ourselves/compassion for oneself

"You need compassion for yourself and for each other before it can be offered to others."

Participants in several of the Rounds talked about the need to take care of themselves and that 'it is ok not to be perfect".

"*There is something about helping yourself and being selfish sometimes in order to build resilience…There are limitations to what a person can safely cope with and a balance between deep unmanageable feelings as humans and being professional. It's complex as these situations involve relationships between humans."*

At the conference delegates reflected on how we need to be human to be compassionate and that, being human, we will all make mistakes. It is important to acknowledge this.

The support of colleagues

But, as someone observed: "*Relationships with colleagues is key – it's not just about self-compassion".*

Many discussions touched on how important this was and there was a general consensus that 'everyone gets compassion fatigue' and how important it is to be kind and supportive to colleagues.

One panellist spoke about the overwhelming support she had received from colleagues after an intimidating interview with CQC inspectors and how she felt proud and motivated to work in an organisation where people went out of their way to support her.

It was observed that everyday relationships are particularly difficult in times of change. A word of thanks from a colleague who knows and understands the work involved and truly appreciates it makes a huge difference and is the best sort of reward.

We can create conditions in an organisation

…..for compassion and empathy to thrive, such as reflective practice, and Schwartz Rounds! The irony was noted that the more pressured we are often the less we give ourselves reflective space – when we need it most.

Schwartz Rounds

Participants spoke about how Rounds helped them to regain compassion:

"You wonder if, when you're busy, you lose compassion, but hearing stories it brings back compassion and it is always there."

There were some reflections on how the Rounds helped participants to normalise their experience and that it helped to discover that other people felt the same as they did: "*You're not on your own in how you feel".*

Discussion

The literature on compassion talks about its literal meaning of 'suffering with' and others have added that it is about feeling for another's suffering and wanting to do something about it. Valerie Iles has talked about compassion as requiring 'acts of work and courage' and that appears to be borne out by the discussions held in this anniversary Round.

Ten years ago Sanghavi found that many of the things said in the Rounds were reflecting on "small acts of kindness" and this was exactly the same ten years on in the UK. It is clear that, like Ken Schwartz, those who talked about being a patient, or a loved one being a patient found that these small acts took on a much greater importance and meaning, and are what is still remembered often years later, when much else is forgotten.

Although participants in the Rounds felt that lack of time prevented them being as compassionate as they would like to be, these small acts do not actually take up time. It is more likely that feeling under pressure is what robs people of the ability to feel that they want to give even as little as a smile or a quick kind word (and patients have become 'a nuisance'). Lack of time and the feeling of being under pressure as a threat to compassion emerged more strongly in our Rounds (compared with ten years ago in the US) which comes as no surprise in the current NHS context.

Ten years ago Rounds participants talked about compassion fatigue and this is still seen as an important theme.

Sanghavi highlights how many caregivers talked about establishing common ground with patients. Our Rounds participants were a little more ambivalent about this, finding that it might be easier to be compassionate where you could either identify with, or share personal information with a patient but that carried risks of crossing a boundary. Some felt uncomfortable mixing personal with professional, and some found they didn't want to do that for their own protection -for fear of being hurt. Others, however, thought it was essential in order to be compassionate and show compassion. This was a theme taken up at the discussion at the conference where it was felt that being authentic with patients is critical, and that if we are not sure how much of ourselves to reveal we can often get cues from patients.

Respect for a patient's individuality emerged as a theme in Sanghavi's paper and our Rounds participants echoed that – there appears to be a consensus that it is a basic principle of compassion to see the person in the patient, and respond to their situation.

His final theme was good communication, which did not emerge particularly strongly in our Rounds (but maybe is taken for granted?)

In all settings (hospices hospitals and mental health) there was a marked level of agreement about the importance of role models, the importance of compassion for oneself, and the challenges and ‘work’ of compassion. Most markedly there was an emphasis on how crucial it is for staff to be compassionate to each other as much as to their patients.