New Paradigms In Healthcare

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The Art and Science of Compassionate Care: A Practical Guide

Springer

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In the first two decades of this new millennium, the self-sufficiency of Evidence-Based Medicine (EBM) have begun to be questioned. The narrative version gradually assumed increasing importance as the need emerged to shift to more biologically, psychologically, socially, and existentially focused models. The terrible experience of the COVID pandemic truly revealed that EBM alone, while being a wonderful scientific philosophy and containing the physician's paternalistic approach, has its limitations: it often ignores both the patient's and physician's perspectives as persons, as human beings; it pays relentless attention to biological markers and not to the more personal, psychological, social, and anthropological ones, removing the emotions, thoughts, and desires of life, focusing on just the "measurable quality" of it.

Health Humanities, Medical Humanities and Narrative Medicine are arts intertwined with sciences that allow to broaden the mindset and approach of healthcare professionals. helping them to produce better care and more well-being.

Aim of this series is to collect "person-centered" contributions, as only a multidisciplinary and collaborative team can meet the challenge of combining the multiple aspects of human health, as well as the health of our planet, and of all the creatures that live on it, in a common effort to stop or reverse the enormous damage committed by humans during our anthropocentric era: a new paradigm of healthcare, education and learning to create a sustainable health system.

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Preface

There is no dispute that the current human society is in front of multiple crises. A prophetic document issued by WHO and United Nations Children's Funds (UNICEF) underlined that "*Unless we act immediately, we will continue to lose lives prematurely because of wars, violence, epidemics, natural disasters, the health impacts of climate change and extreme weather events and other environmental factors. We must not lose opportunities to halt disease outbreaks and global health threats such as antimicrobial resistance that spread beyond countries' boundaries*" [1]. Today, human society meets multiple crises that create a challenging environment fostering more resilient and sustainable healthcare systems.

The COVID-19 pandemic has dramatically affected our lives and imposed huge health and economic implications worldwide, as Cappelen et al. noted in their paper [2]. Based on this paper, "*this crisis implied unprecedented medical, economic, and societal challenges leading to an enhancement of the unemployment rate and of the existing health inequalities*". Climate change and its subsequent natural disasters are another big health threat facing humanity and healthcare professionals worldwide [3]. War, including the last war in Ukraine, security crisis, and violence have contributed to the enhancement of health inequalities and poverty with an impact on premature death, poor quality of life and prolonged financial crisis. Finally, the burnout epidemic and ways to be resilient in the healthcare environment should be a priority.

An antidote and significant tool to successfully manage the aforementioned challenges whilst improving healthcare quality is the introduction of evidence-based compassionate care [4]. Unfortunately, ample evidence is showing a lack of compassionate care and most importantly decreasing compassion in our society in general [5, 6]. Almost half of Americans reported that the US healthcare system and healthcare providers are not compassionate [7].

The key word in a book that addresses compassion and compassionate care is that of suffering. Suffering is present in all unprecedented human crises mentioned above. As Dempsey noted "*There are pain, fear, death, exhaustion, loss and uncertainty about the future*" [8]. This uncertainty is translated into depression and anxiety, reducing people's capacity in living independently and enjoying their lives. It advises for resilient healthcare services with a well-trained and coordinated workforce, a healthcare system that invests in caring based on positive relationships and the best interactions and practices to offer new directions in a changing world.

Caring is a key word that is reflected throughout this book. Caring could be translated into compassion, and Paul Gilbert supports this evolving process that requires three cognitive competencies to give rise to different insights and wisdoms, namely: knowing awareness, empathetic awareness, and knowing intentionally [9].

To what extent do these multiple crises have an impact on the moral attitudes of human beings? Cappelen et al. examined how a reminder of the COVID-19 pandemic causally affects people's views on solidarity and fairness [2]. In a recent Opinion, the EC Expert Panel (EXPH, 2021) on effective ways of investing in health explored the concept of solidarity from both theoretical and implementation perspectives with a focus on health emergencies and how the principle of solidarity is enshrined in European Union (EU) law (2021). It summarised a set of recommendations, including the following: *"The EU could invest more in strengthening integrated people-centred primary care including availability of interdisciplinary work, information and communication capacity and technology, prevention, health promotion and management of chronic care and vulnerability and as well as health care of socially isolated groups"* [10]. This represents another indication of the need to focus on communication and compassionate care skills.

However, how much can we learn from this crisis? To what extent could this current painful experience lead the current world to construct a more compassionate society with a healthcare workforce capable and resilient to compassion fatigue? Paul Gilbert writes that if we are to create a more compassionate world, it depends on how we formulate, contextualise, and think about two issues:

1) Be much more engaged with the suffering in the world and how to address it, and as part of this,
2) Address the challenge of 'resource caring and sharing' versus 'competitive controlling and holding' [9].

Questions as to what extent we can use compassion as an antidote to suffering and how compassionate connected care can improve safety, quality, and experience, as Dempsey reports, guided the construction and content of this book [8].

The overall aim of this book is to provide a practical guide on how we can deliver care that makes a difference. Our aim is to bridge the gap between theory and clinical practice in compassionate care, the heart of caring.

The main objectives are to provide:

1. A new holistic framework for implementing Compassionate Care in clinical practice
2. Practical skills for healthcare professionals on how to better manage the burnout epidemic and ways to be resilient in the current healthcare environment
3. A compassionate care curriculum based on a well-rounded and multidisciplinary approach
4. Description of new models for spiritual compassionate care, patient-centred care, and self-care

5. The physiological, psychological, spiritual, and financial benefits of Compassionate Care
6. Role of compassionate care in primary, secondary, and tertiary care

It is a unique patient-centred guide with specific cases and examples on a variety of important pillars of high-quality care that can be put into daily clinical practice making a difference.

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Contents

Compassionate Care and Evidence-Based Medicine

1

David Haslam

Learning Objectives

1. Using the best evidence is essential in healthcare.
2. Applying evidence requires understanding your patient's views, fears, needs, and hopes.
3. High-quality evidence is generated using strict criteria to ensure validity.
4. Compassion includes empathy—being able to understand suffering in others.
5. Shared decision making does not mean simply devolving decisions to your patients.
6. Focusing simply on tasks rather than patients risks diminishing compassion and diminishing care.

Introduction

Every clinician aspires to deliver high-quality care. Clinicians worry if challenging working conditions make this hard to achieve, whether through excessive workload, too few staff, poor facilities, or insufficient resources. Clinicians want to deliver the very best for their patients, to live up to the aspirations that they had when joining their profession. They are taught to follow evidence, to use the principles of evidence-based medicine.

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Modern medicine can be technologically magnificent. Recent advances in pharmaceuticals, diagnostics, and genomics offer so much. The potential for new and exciting scientific developments offers so much more. But without compassion, and kindness, medicine can only deliver part of what our patients deserve.

The early months of the Covid-19 pandemic were horrifying. The image of patients dying alone, with relatives and loved ones being banned from being with them in their final hours, broke hearts all around the world. But what was so striking in many of the emotional news reports was how the focus wasn't solely on the intubation, the high-tech monitors, and the skilful staff, but also on just powerful and important compassion can be. There were stories of nurses and other staff sitting with dying patients "so they weren't alone". Holding their hands, albeit with gloves on, to demonstrate humanity and caring. Both relatives and staff absolutely recognised the vital importance of these aspects of care and were heartbroken when these could not be provided. Compassion is not an additional extra to technological and therapeutic care. It is fundamental and central to good care. It is a key part of evidence-based medicine. When you or I am ill, we will want to be treated with technical efficiency, with the best possible clinical guidelines being followed, but we will also want care and compassion.

This book offers many definitions of compassion, but in the context of compassion and its relationship to evidence-based medicine, it is worth offering a clear view of how these vital concepts might blend together.

A Definition of Compassion

My preferred personal definition of compassion is "The humane quality of understanding suffering in others and wanting to do something about it [1]". There are many other definitions, and whilst compassion may be hard to describe, it's also a straightforward concept. After all, as patients or as relatives, we know when care is being delivered with compassion and when it is not.

Compassion involves demonstrating characteristics such as empathy, sensitivity, kindness, and warmth—and when these are lacking, all too frequently one of the factors that underpin poor care is an attitude to care that is task based rather than person centred. Task based care is frequently impersonal and whilst completing necessary tasks is important, it should not totally dominate patients' experience of care. Instead, people want to be treated with respect, dignity and compassion, attributes that cost nothing.

Unfortunately, in many healthcare systems across the world, politicians have prioritised efficiency. It might seem curious to start a sentence which describes an aspiration to efficiency with the word "unfortunately". After all, in cash-strapped healthcare systems, efficiency really matters. It is also no surprise that politicians demand measurable metrics in order to be reassured that the money they invest in the system is producing results.

Prioritising genuine patient-centredness and caring may at first sight appear to slow the delivery of care. Compassion requires a holistic approach, rather than segmented blocks of care that can be ticked off a list of tasks that have been completed. One study of nurses in Australia showed that efficiency appeared to be reinforced by an embedded and naturalised cultural practice amongst the nurses, which was to value fast paced and completed tasks, because of the recognition it would receive from peers [2]. But this created problems of its own, because the failure to be person-centred meant many nurses found that their professional values were unmet, leading to moral distress and workplace dissatisfaction.

As Mahatma Gandhi is quoted as saying, "Happiness is when what you think, what you say and what you do are in harmony". This tension between clinician aspirations and the reality of the way they are expected to deliver care can have a major impact on morale, on workforce retention, and ultimately on the quality of care that can be offered to patients.

A Brief History of Evidence-Based Medicine

Since ancient times, and in every society, most clinicians generally chose the treatments that they offered based on what they believed was the most effective. They believed that cupping, or the application of leeches, or venesection worked. They believed in the primacy of their own experience. They knew, or had been taught, that a treatment worked, and so they continued to use it, safe in the knowledge that it was standard practice, but more likely simply making the same mistakes with ever increasing confidence. (This approach to defining best practice is used by some complementary medicine practitioners even today.)

The earliest philosophical roots of what we now know as EBM extend back at least as far as Pierre Louis and the Paris Clinical School in the early nineteenth century, but the term, "Evidence Based Medicine" first started to be used by investigators at McMaster University only during the 1990s [3]. In 1996 the term was more formally defined by Sackett et al. who stated that EBM was "the conscientious and judicious use of current best evidence from clinical care research in the management of individual patients" [4].

And evidence truly matters. In my first ever hospital job as a doctor many years ago, patients who had suffered heart attacks were kept on strict bed rest for three weeks and were forbidden from doing so much as walking to the toilet, instead having to suffer the indignity of the bedpan. Indeed, not every patient who had suffered a heart attack was even admitted to hospital—before the advent of coronary care units, there was little evidence that admission helped.

One doctor's career span later, everything has fundamentally changed. Rather than being kept on strict bed rest, victims now receive urgent hospitalisation and intensive treatment, followed by rapid mobilisation—prolonged immobility is now known to be hugely dangerous. Three weeks of bed rest has become a second-day gym referral, an astonishing change. Research—continuing research—has tested each form of therapy and found which are beneficial and which are not.

However, I still have a heartfelt thank you letter from the family of one heart attack victim who I treated way back in 1972. They wrote that they were intensely grateful to me and my colleagues for the care that had "saved his life". We now know that he was lucky to have survived the treatment, let alone the heart attack. The bed rest that we had so confidently insisted on as part of his care was in reality the perfect recipe for a pulmonary embolism, but we simply didn't know. I learned long ago that recovery and gratitude are not necessarily evidence of effective treatment.

Practitioners—and especially complementary practitioners—who proudly present piles of thank you letters as 'evidence' that their treatments must be effective need to be aware of this. The many thank you letters I have received from patients whose treatments have subsequently been shown to be useless doesn't mean that my doctoring didn't help—I was doing my best, and I hope I was treating them with kindness and compassion—but the research is clear that many of the actual therapies were, at best, an irrelevance. Practising medicine by following the evidence is critically important.

Criticisms of Evidence-Based Medicine

In their 1996 paper, Sackett and colleagues recognised that the concept remained a "hot topic" noting that criticism ranged from EBM being "old hat" to it being "a dangerous innovation, perpetrated by the arrogant to serve cost cutters and suppress clinical freedom". For this reason, the paper went on to expand the definition, clearly stating that "the practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research". The paper added, "increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patient's predicaments, rights and preferences in making clinical decisions about their care".

It is therefore clear that at the very beginning of the modern evidence-based medicine movement, the physician who is most identified with this topic was referring to the importance of compassion.

Nevertheless, criticism continued. In a 2014 paper entitled, "Evidence-based medicine: A movement in crisis", Trisha Greenhalgh and colleagues noted that, "From the outset, critics were concerned that the emphasis on experimental evidence could devalue basic sciences and the tacit knowledge that accumulates with clinical experience" [5]. The paper noted that critics questioned whether findings from average results in clinical studies could inform decisions about real patients, who seldom fit the textbook description of disease and differ from those included in research trials [6].

Clinical Guidelines

The main way in which most clinicians use evidence-based medicine is through clinical guidelines. After all, it is impossible for individual clinicians to keep totally up to date with the extraordinary amount of new research that is continually being produced on every given topic that they might treat. For this reason, a synthesis of best practice will be required, and it is crucial that such guidelines can be trusted. In the past, many guidelines were barely disguised marketing materials paid for by the pharmaceutical industry. The best guidelines are now produced following a series of international criteria called the Appraisal of Guidelines for Research and Evaluation (AGREE), or an adaptation of them [7]. These look at whether each guideline:

- Was based on the best evidence available
- Used expert input
- Had patient and carer involvement
- Used independent advisory committees
- Involved genuine consultation
- Underwent regular review
- Had an open and transparent process, and was tough on conflicts of interest
- Considered social values and equity considerations

Organisations such as NICE in the UK (The National Institute for Health and Care Excellence) have developed guidelines on a vast range of topics, and these are used in many healthcare systems around the world. However, many clinicians ignore some of the most important words in every guideline.

Guidelines, Not Tramlines

Every guideline produced by NICE currently starts with the following section, headed "Your responsibility":

> The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardians.

This is critical. These are guidelines, not tramlines. They should be followed unless there is a good reason not to, and that does not include simply saying that you don't believe that the guideline is correct. After all, the process that has been gone through to deliver the guideline will have been totally rigorous, following similar principles to AGREE.

But nevertheless, there will be occasions when the evidence may not apply to a particular patient. These include the impact of comorbidities, when a patient's other medical conditions may well have an impact on the appropriateness of a recommended treatment. As an example, a recommendation to use a particular treatment for treating arthritis may be inappropriate in a patient who also has chronic renal disease. Patients with multiple comorbidities may present a particularly complex challenge.

And never forget that evidence-based medicine and compassion are not in competition with each other—the art versus the science. They are entirely complementary, each benefiting the other.

Patient Autonomy and Shared Decision Making

A further critical factor which may impact whether guidelines are followed relates to the vital importance of patient autonomy. Put simply—whose body is it anyway? Application of the evidence base may clearly show the benefits of a particular course of action, but your patient may not agree. As a simple example, a patient's cardiovascular risk profile may make it clear that treatment with a statin would be beneficial, but the patient may not wish to take this course of action.

Patient autonomy is a central facet of medical ethics, but it also requires the clinician to ensure that the patient is fully aware of the facts about the treatment under consideration, with a full understanding of both benefits and risks. Simply saying that "the evidence shows this treatment works" is authoritarian rather than compassionate medicine. Compassionate care will consider the patient's ideas, concerns, expectations, and anxieties, and will fully address these.

Shared decision making is an increasingly important aspect of practising medicine. It is a collaborative process through which a clinician supports a patient to reach a decision about their treatment, the right treatment for them individually. It is not simply a question of the clinician passing the decision over to the patient… "You make up your own mind". Instead, it encourages a discussion which brings together the clinician's expertise, such as treatment options, evidence, risks, and benefits, and combines this with what the patient knows best, such as their preferences, personal circumstances, goals, values, and beliefs.

This particularly applies when we are dealing with long-term, preventative treatments when it is crucial that patients are actively involved in their own care. Most of us would be inclined to ask our doctor to make the tough decisions for us if we were acutely ill with a life-threatening condition. But if we are dealing with preventative medicine, where taking a tablet may be beneficial and may have side-effects, it is vitally important that the patient is central to any decisions that are taken. Shared decision making ensures that treatment is a collaborative process through which a clinician supports a patient as they reach decisions.

Such shared decision making is appropriate in almost every situation where a 'preference sensitive' care decision must be made. This means any case where there is more than one reasonable course of action and the decision involves trade-offs, any case where the evidence for one option over another is unclear or any case where individual values are important in the decision [8].

Remember that early definition of evidence-based medicine which stressed that care should involve the "thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care". Ally this to the definition of compassion as being "The humane quality of understanding suffering in others and wanting to do something about it".

Compassionate Care in the Future

As medicine and healthcare become ever more scientifically complex, with powerful new interventions becoming available such as using genomics and artificial intelligence, some might believe that values such as compassion will become less and less relevant. In contrast, I believe the opposite. After all, we all recognise the emotions described in the writings of Shakespeare over 400 years ago—emotions like fear, and love, and trust, and anxiety, and compassion. People, as opposed to technologies, have changed very little in all these years. There is no reason to believe they will change in the next hundred years. As the world becomes ever more complex, digital and networked, people will still stay the same. Issues like feeling safe, and feeling cared for, and being able to trust will matter just as much they ever have done. As another poet once said, "The more everything changes, the more it stays the same".

Combining the best use of research-derived scientific evidence with the best use of personalised care and true shared decision making can result in the best possible provision of high-quality care. The motto of the UK's Royal College of General Practitioners is "Cum Scientia Caritas" often translated as "Scientific knowledge applied with compassion". This surely is the quality and model of care that every clinician should aim to offer. It is the care we too would hope to receive.

Into Practice

- When using evidence, it is important to consider the individual needs, values, expectations, and hopes of your patient.
- Decisions on care, other than in emergency and time-critical situations, should include a full discussion with the patient about benefits, risks, and alternatives.
- When using clinical guidelines, take note of the processes used to derive them. Ideally these should conform to the AGREE criteria.

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Compassionate Self-Care for the Compassionate Healthcare Professional: Challenges and Interventions

2

Andreas Anastasiou and George Samoutis

Learning Objectives

1. to explore what it means to self-care
2. to integrate home-life and work-life and understand how one affects the other
3. to explore and provide own definition of what success is
4. to understand how lack of self-care is affecting our relationships at home and work
5. to acknowledge and validate gender differences and challenges in self-care

Introduction

Healthcare workers are routinely asked to satisfy the emotional, physical, and often spiritual, needs of others, both at work and at home. These often taxing demands and expectations make them particularly vulnerable to experiencing compassion fatigue, post-traumatic stress disorder (PTSD), depression, and anxiety, as well as personal relationship challenges such as a compromised quality of patient care [1].

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It is precisely because her/his life's work so intrinsically involves taking care of others, that the healthcare professional has an even greater responsibility to take care of oneself as well.

Throughout the past twenty years in our professional practice as a psychologist and a family physician, respectively, we have had the opportunity to interact and collaborate with a range of healthcare professionals on all levels of hierarchy. In the process, we have become acquainted with what we have come to understand as recurring presenting issues for those in the helping professions. In this paper, we share five case studies from our clinical practice to help underscore the critical role of self-care in enabling healthcare providers to achieve a high quality of life while extending compassion to others, in both professional and social contexts.

Case 1: Restrictive Emotionality

Luke is a sixty-year-old male surgeon who came to therapy presenting with symptoms consistent with depression and anxiety. He had decided to come to therapy after a long discussion with his wife and two adult children in their twenties, having come to the realization that he had, by and large, not participated in their upbringing and feeling alienated from them as a result. The client had begun to understand that he did not really know his children, who wanted to and needed to be known by their father. He also became mindful of the fact that his wife had come to resent him, as she experienced a sense of identity loss, having compromised her own personal and professional growth as the demands of her husband's work and career had always taken precedence over any of her wishes and needs. While he was saving lives, she had been changing diapers, providing homework assistance, doing school runs, arranging playdates and making doctors' appointments. This more traditional division of labor had come at a cost to the couple and to the family as a whole. She wanted him to be much more present at home, to listen better, and to do more of his part in raising their children. He also realized that he had lost his ability to communicate empathy and compassion to his wife, children, as well as patients and colleagues. He was suffering from covert depression, one that does not deprive the sufferer of functionality but instead manifests itself through anger, irritation, and extreme stress, usually directed toward those closest to him. He had become authoritarian in his family interactions, emotionally detached, controlling, and highly critical of others. He noticed that the behaviors of his wife and children towards him had become motivated not by a desire to make him happy but by a perceived need to prevent him from losing his temper/becoming angry at them. He had also begun to experience symptoms of compassion fatigue in his interactions with his patients, whose medical and emotional needs now elicited strong feelings of annoyance in him. In addition to that, he dealt with guilty feelings towards his family from being emotionally and physically absent.

Case 2: "I Need to Need"

Diana is a forty-two-year-old female physician who sought psychological support following a disproportionately strong emotional outburst toward her elementary school-aged elder child. Her symptoms were consistent with compassion fatigue and anxiety disorder. She routinely was in a bad mood and felt irritable, becoming aware that her listening skills, along with her ability to communicate empathy and compassion to her family, friends, and patients had overtime become significantly compromised. She also experienced deep resentment toward her husband for not being supportive and for blaming her for not spending enough time with her family. In an outpouring of emotion during a therapy session, she expressed her newly found understanding that the emotional demands placed on her, both at home from her family and at work from her patients and colleagues, had served to deplete her of her emotional, physical, and spiritual resources. She thus expressed her need for solitude: "I want to go away for some time to relax with no one in my head." Along with this newfound realization, guilt ensued. How could a mother, wife, and a successful professional abandon everyone to take care of herself at the expense of all others who had come to count on her? She had learned how not to need, realizing that she instead needed to also learn to—at least to a healthy degree—to be able to rely on others. In the course of her therapy, she became aware that she had constructed a life from which she needed to escape, living instead for the eventual vacation away from the demands of daily life, in the process neglecting her own psychological needs. Her life had become inconsistent with her true identity. As a result, she experienced what American psychologist and person-centered therapy developer described as incongruence. Rogers (2) posited that whenever one lives a life inconsistent with one's real identity, vulnerability to psychological disorders ensue, primarily depression and anxiety.

Case 3: Self-Doubt

Jane is a forty-four-year-old nurse at a large hospital who came for couple's therapy with her husband Rob following an intense argument during which they were verbally abusive to each other in front of their young children. They acknowledged the deterioration of their fifteen-year-old relationship, which they perceived as having reached "rock-bottom." Jane had also been on medication to deal with symptoms of depression and anxiety. Draining shift work and numerous other demanding aspects of her profession had placed additional stress on her relationship with her husband. She had also found herself being constantly irritated with almost all others, both at home and at work. In talking with some of her colleagues, she observed that they were experiencing very similar symptoms. Jane felt emotionally empty and found herself feeling resentful of anyone who had any needs or placed any demands on

her. Believing she was failing to meet their expectations of her roles as wife and mother, her husband and in-laws were highly critical of her. Jane soon realized she felt lonely and trapped—and as a result depressed—in both her marital and professional relationships. In exploring her own needs, she gained insight into how ingrained self-doubt had become in her thinking, in the process losing herself. Rob, a very dynamic man in his own right and one who had developed a highly successful career in the corporate world, would amplify Jane's confusion about herself in a self-assured and subtly authoritarian manner. These dynamics caused Jane significant distress in the form of anxiety. In observing herself in these experiences, she realized that was responding in similar ways to those at work with similar personality types, in particular supervisors and doctors. She became conditioned to have instinctual, involuntary, emotional, and physiological responses triggered by other people's behaviors such as tone of voice, or even just a look that she would either rightly or wrongly interpret as invalidating. She had to work on reclaiming her identity and not becoming symptoms of other people's issues.

Case 4: Emotional and Verbal Self-Oppression

John is a thirty-seven-year-old cardiologist who had been referred by his wife to seek psychological help following a number of angry outbursts toward her over the previous 3 years. She had given him an ultimatum to seek therapy or else she would leave the relationship. The sustained stress from his work at the hospital took a toll on his mental and physical health, experiencing panic attacks on a regular basis. Thinking he was about to die, John would self-administer an electrocardiogram 2–3 times a week. As the results revealed a healthy heart, he would find temporary relief from his anxiety, later repeating the same step in the cycle. Having "let [himself] go," John took comfort in food, gaining enough weight to be classified as morbidly obese. His free time dwindled as he could not turn away new patients who needed him and whom he knew he could help. Plans he and his wife shared to have a family, and the considered expenses he realized this would entail, also weighed on his decision to take on a heavier workload as he was the one with significantly higher income earning power. As his main focus became his work, there was little time left for anything else or anyone else. John became easily irritated with anyone who had any need for him or placed any demand on him for his time. His wife reported that he had morphed from a kind, compassionate, fun-loving man to an angry, keep-away-from-me aggressive one. John acknowledged the transformation, one completely inconsistent with how he saw himself. This incongruence caused him anxiety and left him feeling lonely and isolated, his relationships becoming superficial and routine, including that with his own wife. Feeling lonely and frustrated in her marriage, she had begun to reassess the relationship and question whether she wanted to stay in it. In the course of therapy, John came to understand that his wife was a solid base in his life and that in the midst of his preoccupation with work and family responsibilities he had come to nonetheless take her for granted. Early on in his

psychotherapy process, he had set as his initial goal to invest more in his relationship with her. In order to accomplish this goal, he began to spend time with her, establishing mutually agreed couple routines and new traditions and, crucially, sharing his feelings, thoughts, fears, and hopes with his spouse about various aspects of his life. He became aware that he had been suffering from "emotional constipation" that was toxic to his relationships and his wellbeing more broadly. His panic attacks had been his body's way of telegraphing its need to take care of it. A key intervention proved to be to allow his wife the opportunity to serve as a good listener to him as someone who cared for and understood him. He described the process as relaxing. John's case emphasizes the importance of having a good listener/social support in our life and utilizing him/her.

Case 5: Injecting Life into Living

Leia is a thirty-two-year-old medical student who sought psychological services to cope with the overwhelming demands of medical school. She complained of not having enough hours in the day to carry out her responsibilities as a student, wife, and mother of a young child. Leia felt constantly tired and had problems with storing and retrieving information. As her sleep hygiene was compromised, she found herself being struck by headaches, stomach pains, and recurring cold sores on her lips. She reported finding herself comparing herself to other medical students and also becoming hyper-aware of the feedback of her supervisors, who often lacked sensitivity and empathy. Becoming a doctor represented the culmination of a lifelong dream of hers and had entailed a major career change. The medical school experience, however, had extracted life from living. In attempts to alleviate her symptoms, she had resorted to conventional medication, only to realize her interventions had been only temporarily effective as they did not address the root cause of her somatic condition. Leia had also been experiencing great guilt for neglecting her husband as an emotionally and financially supportive partner. Paradoxically, she resented being dependent on him to pick up the deficit in her own contributions to the parental relationship and to the running of the household. Guilt ensued when she engaged in any self-care activity such as exercising or having coffee with a friend. She perceived these as taking time away from her studies and family life. She also questioned her ability to assimilate the material and to perform well in the practical component of her coursework. Nonetheless, she rationalized her stressful experience by echoing the old refrain heard from a number of her medical student peers, "This is medical school." Leia also wondered what life would be like for her after she graduated from medical school. How much time would she have to spend with her family? How mentally present would she be able to show up for others? How involved would she be in the raising of her child? Would she be able to cope with the stresses and anxieties of having another child, something that both she and her husband wanted? She questioned if that was the life she truly wanted to have. She became aware that an essential factor for a meaningful life with a shot for happiness

was time. Time for her, time for her husband, time to play with her child, and time to just be. The main point of this case is to redefine what success means. And this is a very individual process.

Case 6: A Preventable Death

David, a sixty-year-old married with 3 children interventional cardiologist and head of department, was running a very busy clinic working numerous hours per week. During that time, he engaged in numerous professional activities that included management tasks, conferences, professional development, and national medical committee participation. He was obese, suffering from hyperlipidemia, generalized anxiety disorder, and sleep apnea. Making no time for exercise, family activities, or hobbies, he ate late at night with friends after leaving his clinic. He rarely contacted his family doctor for medical reasons as he was basically self-diagnosed, self-treated, and self-medicated. In the process, he had been postponing lifestyle interventions due to his work-related activities, David died from sudden death due to acute myocardial infarction.

Self-Care: Challenges

A common theme that emerges from all the above cases is a general inability and lack of motivation to self-care, and to be kind to oneself. The loss of self in the demands of the profession is core to the issues addressed in psychological therapy. A frequent homework that we give clients in the healthcare industry is to explore ways of being kind to themselves by developing an awareness of what they need. This typically comes after the difficulty in answering the question, "How do you take care of yourself?" Many times the initial response to this question is a pensive smile or faint laughter.

One of the most difficult challenges for medical professionals is to embrace the healthy shift from being a care provider to the recipient of psychological or medical care services. Making time for such an adjustment is in and of itself stressful because it requires time and space—as well as an acceptance of their own vulnerability and needs. Time is a valuable commodity. Increasingly, many psychological sessions take place online or on the phone, inserted between patient appointments or on clients' drive home to or from work. The length of the phone session typically reflects the time it takes to drive from work to home, or vice-versa. The decision to seek psychological support will often follow a long period of being comfortable in the familiarity of one's own discomfort. Many of us may not feel well but may get used to this less-than-optimal state of existing. Finally reaching "rock-bottom" is a very difficult place to find oneself in, but not necessarily a bad one, as that is the place where people become aware and mindful of the need to see a mental health professional. This self-awareness is one of the areas of Emotional Intelligence, particularly important for healthcare workers. Fessel and Coleman (2020) emphasize the

importance of physicians and healthcare workers to take care of their emotional and physical health in order to prevent burnout, compassion fatigue and somatic illnesses. Needless to state, healthcare professionals must avoid self-diagnosis, self-medication or treating members of their own family [2]. Positive outcomes include greater doctor–patient trust, higher levels of patient satisfaction, less physician burnout, better results, improved productivity, and higher job satisfaction.

Self-Care: Interventions into Practice

Before outlining some basic self-care techniques, it would be imperative for each healthcare professional to explore the strategies that work best for him/her. This is a very individual exploration that needs to be delved into without any outside distractions or influence. The healthcare professional must assume responsibility for his/her own wellbeing. Crucially, the chosen methods of self-care must be consistent with one's identity. They have to feel "right."

1. Prioritize and invest in meaningful, healthy relationships, especially those with your family members [1]. Good relationships can help physicians prevent burnout [3]. A way to assess the quality of our life is to be mindful of our feelings when entertaining the idea of joining someone or engaging in a given event, whether going home to a spouse and children on the way from work, going on vacation with someone, returning to one's daily life from vacation, meeting someone from dinner or going to another social event. Finding oneself experiencing discomfort, whether a general unease or plain dread at a given thought begs for further exploration on one's part. Two of our most important destinations for joy must ideally be home and work. And what typically determines joy is the quality of relationships that we engage in. It is therefore imperative, to both one's psychological and physical health, to establish meaningful connections in both areas of one's life.
2. Be mindful of how you connect with but also how you might alienate others, and practice *kenosis*, the Greek word connoting creation of a physical, psychological, professional, and spiritual space where two or more people are invited to enrich one's existential experience.
3. Acknowledge your capacity to be narcissistic and work on your ability to empathize [4]. Mindfulness techniques such as meditation focusing on kindness can decrease anxiety and are associated with better overall wellbeing as well as a greater capacity to communicate empathy and compassion [5].
4. Have a good listener in your life. In the case of John, what proved to be therapeutic was opening up to his wife about his thoughts and feelings, allowing her to respond to him with compassion and empathy. In relationships in which partners extend empathy to each other, there is more emotional intimacy and relaxation.
5. Acknowledge and express needs. In the case of Diana, she became almost completely focused on others such as her family members, her patients, and her colleagues at her expense. Ultimately, she worked on expressing her needs with

no guilt. Also, as a woman, she was particularly vulnerable to compassion fatigue, and lower professional fulfillment [6].

6. Exercise. Physical activity in the form of exercise has been shown to be effective in reducing symptoms of depression and anxiety [1]. Even though exercise will not in and of itself solve any problems, it typically places an individual in a better emotional and physical position to address life issues.
7. Remove from your schedule unnecessary sources of stress. In all the cases presented in the beginning of this chapter, a major issue was not having enough time to do daily activities. Explore what can be removed from daily/weekly schedule to have more time for self-care. Research suggests that valuing time over money is associated with greater happiness and overall wellbeing as well as better decision-making [7, 8].
8. Take care of your physical health. Many medical students and physicians alike believe that they must always adjust to the demands/needs of their patients and colleagues and that asking for help due to excessive stress/pressure will be perceived as a sign of weakness. They are therefore less likely to discuss any health concerns with others [9]. David's case illustrates the need for healthcare professionals to engage in lifestyle interventions and avoid falling into the trap of self-medicating and self-diagnosing.
9. Seek psychological support when you need it. One of the first signs of mental health is the awareness and acknowledgement of personal challenges for which one needs support from a mental health practitioner. The option to see a psychologist should be encouraged rather than resorting to self-medicating [10].
10. Introduce mindfulness about self-care in medical school training. This must be infused into all aspects of medical school training and explicitly emphasized by instructors.
11. Be aware of relapse. Most of the times people seek psychological help when they reach "rock-bottom." This is a very difficult place to be at but it can be an instructive one as that it is the point at which people decide that they cannot continue their life as it is and that they therefore need to do something about it. Through their work with a psychologist, they initially make the necessary changes in their life and have their symptoms alleviated. This could be a period of vulnerability and susceptibility to relapse because this may be when people gradually revert to their old lifestyle. This is where some maintenance work should be done with a mental health practitioner to monitor progress and to become mindful of symptoms of relapse.
12. Spiritual care can help healthcare professionals recognize and respond to the needs to the human spirit, including the need for meaning, purpose, and connection [11, 12] Spirituality has been shown to be a protective factor among an array of healthcare providers mitigating cognitive, emotional, and physical symptoms of burnout [13]. Additionally, spirituality is related to lower levels of exhaustion and greater patient empathy [14]. (See **Chapter 10**. Compassionate Spiritual care).

Redefining Success

Even though what it means to be successful is a very personal topic for exploration, the following questions frequently emerge during the course of psychological therapy among healthcare workers:

"Am I happy with my life?"
"Did I get into the right field?"
"Am I cut out for this?"
"What is it like for my spouse to have me as a husband/wife?"
"What is it like for my children to have me as a father/mother?"
"What is the experience of my patients of having me as their physician?"
"What would my colleagues say about me? How do I affect them?"
"Do I have a pressing need to escape from my life?"
"Is there any unfinished business in my life?"

These questions can be used as guides to help explore and uncover what may matter most to oneself and will most contribute to a one's sense of psychological wellbeing and sense of purpose—along with the motivation to proactively look after one's physical health. Instructively, a quote popularized by late US senator Paul Tsongas shortly after he was diagnosed with cancer, that "No one on his deathbed ever said, 'I should have spent more time at the office'" finds resonance with the work of Bronnie Ward [15], a palliative care volunteer in Australia who documented her dying patients' epiphanies in the last three to twelve weeks of their lives. In that process, five top regrets emerged: (1). "I wish I'd had the courage to live a life true to myself, not the life others expected of me"; (2). "I wish I hadn't worked so hard"; (3). "I wish I'd had the courage to express my feelings"; (4). "I wish I had stayed in touch with my friends"; and (5). "I wish I had let myself be happier."

The emerging issues discussed in this chapter strongly point to a need for healthcare workers to reflect on their needs and to extend to themselves (and often their loved ones) the kind of compassion and self-care they routinely extend to others. The decision to adopt healthier self-care practices must be understood as such as a process of the implementation of practices, however gradual, rather than as single-time interventions. The maintenance work required for self-care is, in a very real sense, akin to the professional development practices healthcare professionals exercise and fully expect of themselves. Effectively extending care to others, particularly over the long haul, necessarily involves doing so from a position of physical, psychological, and emotional strength.

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Compassionate Care in Crisis

3

Neophytos Stylianou and Priyanka D. Reddy

Learning Objectives

1. Appreciate the importance of compassion during crises
2. Realize the effect compassion has on specific crises
3. Identify how can compassion help alleviate crises

Introduction

> A kind gesture can reach a wound that only compassion can heal.
> – Steve Maraboli

An unstable situation of extreme danger or difficulty is considered a crisis. It is a term that can be quite wide and encompasses many aspects. For example a crisis of the healthcare system can occur when there is an outbreak, an epidemic or even when healthcare workers become overwhelmed and cannot meet the needs and demands of patients/customers.

Crises, which inevitably lead to strained resources (human, equipment and financial), while healthcare workers try to balance personal and work struggles, result in a challenge for ensuring the provision of compassionate care. Among the many lessons learned from facing the vast number of challenges that healthcare systems

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faced in the last decade, is the importance of preparedness as well as the need for compassion when crises arise. The numerous crises emphasized the role of compassionate care. As Dr. Stephen Trzeciak, co-author of "Compassionomics: The Revolutionary Scientific Evidence That Caring Makes a Difference" wrote in his book "compassion could be a 'wonder drug' for the 21st century, and for the challenges facing today's healthcare leaders" [1].

In the twenty-first century, our communities face healthcare challenges that are unprecedented and inevitably will reform the approach to healthcare crisis management. With the overburdened healthcare infrastructure threatening to crumble, considering policy changes that shift the focus to ground-up change can aid population health revolutions that can benefit the systems within healthcare, its workers, and the families and communities that they serve. By examining cultural issues, and the evolving priority issues, we can understand that underlying all of them is one common issue, a gap in compassion at a fundamental level in all areas of society. The primary focus of compassion must be to support equitable process outcomes and solutions for families and communities, and healthcare workers that care for them. Without equity, the cyclic nature of unequally distributed resources will create further underserved and disadvantaged populations.

Researchers define compassion as an emotional response to another's pain or suffering involving an authentic desire to help. It is slightly different from a very closely related term of empathy. Empathy is the feeling, understanding or detecting of another's emotions and resonating with that. Compassion takes it one step further, taking ACTION to help alleviate that to some extent. Why do we need compassion in healthcare? Aside from the improved outcomes for the patients, even though most studies conclude that further studies are needed, [2, 3] compassion provides healthcare workers resilience, lack of burnout, trust in their leadership, the feeling of being cared for and cared about, that they are valued, the sense of belonging, as well as that they are in control of their work [4], values that are vital in crisis management.

Crises

Pandemic Crises

We can only begin with the current and most recent global crisis, the COVID-19 pandemic. This is currently the most prominent crisis, which has added an unprecedented layer of stress and trauma to the many challenges that healthcare workers have long faced. In addition to revealing social and economic inequities, once again, [5] it clearly showcased the critical role compassion has on healthcare [6].

The restrictions in movement, the instructed and mandated self-isolation, the pressure on jobs and organizations and as a result, the unstable economy, and the anxiety about our health and that of our loved ones were unlike anything witnessed in a generation.

At the beginning of the pandemic, humanity was sailing into uncharted territories; patients did not have the information they wanted as the virus was new and the

scientific community did not have any information on it. Healthcare workers were trying to provide care, but they both were anxious of the situation not to mention the stress caused by the fear of them passing on the virus to their immediate family. As healthcare workers began being exposed to infected patients more and more, as well as through their personal life, inevitably they were infected. This led to the service being severely understaffed causing an ever-increasing workload and eventually leading to burnout. This increased workload and burnout has led to more pressure at work and less time to practice what could be considered as the expected health care, that of compassionate care. Studies have been performed that indicate that the mental health of the population was affected but also that health care workers have been burned out. Burnout in general has been identified to be negatively correlated with compassion to others [7].

Refugee Crises

The refugee crisis which has been ongoing for the last 15 years, has resulted in massive waves of migration towards Europe and the Western world. Besides sufficient and appropriate healthcare services, these vulnerable populations need compassion. According to UNHCR in 2021, there were 27.1 million refugees (a 78% increase compared to 2011 data) [8]. Refugee's lives are almost unimaginably awful for the twenty-first century. By the time they arrive in refugee camps, they will have experienced trauma on a scale that most people can barely comprehend. They arrive at camp exhausted, hungry, lonely, and scared with some of them losing family members during the trip. Most will have weakened immune systems and be suffering from multiple underlying health and psychological issues. Being in the camp which is usually overcrowded and unhygienic have limited access to healthcare and are quite vulnerable.

The Syrian refugee crisis, the unstable economy, and the constant wars have created a massive inflow of resettlement into Europe [9]. Understanding the cultural, physical, and emotional needs of this vulnerable population should be a fundamental goal before offering any kind of help including care. Safeguarding their human dignity while adequately showing compassion, respect, and direct care for basic needs should a priority. Although physical needs are addressed first, compassion through mental health check-ins is rare due to the limited resources available. Many countries in Europe are now performing vulnerability checks as soon as the migrants enter the camps but again what is actually done with those data is still not clearly defined. Compassion can be shown in many ways, and it is important to ensure that verbal and non-verbal communication is met with compassion and respect.

In addition to the provision of adequate healthcare services for these vulnerable populations, it is important to include compassion and empathy as core elements of the care provided to establish an optimal approach to enhance quality and improve outcomes. It is widely acknowledged that compassion, kindness, respect, acceptance, empathy, attention to basic needs, and consideration for one's dignity are

essential for relieving pain, promoting a quick recovery from acute illness, assisting in the management of chronic illness, and reducing anxiety. These virtues also help with better resource management and cost-cutting.

Healthcare Crisis

It is a no-brainer that we are experiencing a healthcare crisis an event that is no longer only affecting developing nations but developed ones as well. The aging population, the now becoming regular financial crises we experience, the pandemic, the ongoing wars around the globe, all contribute to the worsening of the healthcare crisis. In Europe, with a long tradition of institutionalized social welfare the healthcare crisis was made quite evident with the 2012 economic crisis and austerity measures in Greece which lead to an increase in poverty, vulnerability of patients, and stigmatization of the migrants that coincidentally was taking place at the same time as the refugee crisis. Healthcare crises are often associated also with a communication crisis as it can be the lack of communication that contributed in the escalation of the specific crisis. This was evident with the COVID-19 pandemic which WHO names an infodemic [10].

Especially with the pandemic and the "do more with less" approach, there is an abundance of evidence to show that healthcare workers are burned out. Burnout to healthcare providers is an unwanted syndrome as it can compromise the quality of care. In a recent study performed in Cyprus, it was found using validated tools for burnout that burnout is not caused due to patients but due to lack of resources and other factors. This indicates that healthcare providers want to provide care but other obstacles are limiting them. Several studies report that practicing compassionate care can be something that can minimize the effect of burnout and have a positive effect on both the patient, the healthcare worker and by extension the system as fewer resources will be eventually needed for the patient, lower probability of medical errors, fewer medications and referrals are prescribed and there is a lower chance of readmission or even admission if compassion is provided in primary care.

During a healthcare crisis, leadership should be empathetic, responsive, and in tune with the diverse needs of a population. Strong healthcare leadership during a crisis begins before the event even happens—and it continues well after the crisis is over. Healthcare crisis management should go beyond addressing the concerns of those who are receiving treatment. It also should acknowledge the needs of the employees providing that treatment.

Many leaders are currently facing tough decisions about the viability of their businesses. It is at times like these that compassionate leadership is needed more than ever. Companies, including healthcare, that explicitly care for their people when times are tough, have been found to perform better in the long term as their employees work harder and are more committed to helping their employer recover from the crisis [11]. Compassion cannot be mandated, however, so it requires leaders to step up and set the tone. If leaders show warmth and communicate with empathy and are seen to prioritize employee well-being in these tough times, this goes a

long way in setting an organizational context for compassion to thrive. It goes without saying that if we care about each other as human beings, compassion and dignity at work are basic requirements, and the ability to exercise competent compassion is an essential professional skill [12]. The problem is that compassion is still considered a soft skill despite all the evidence that exists out there indicating it is more than that.

Compassion Crises

Do all these crises reveal a deeper, more pronounced crisis? It is widely accepted that these crises led to health workers practicing care with a lack of compassion. What is a common denominator for all these crises is the lack of compassion due to various reasons such as the lack of time, personnel, expertise, and knowledge. In a way, this could be expected as healthcare workers possess the ability to move on from one patient to the next without it being too big of a burden. However, in such a big industry as the healthcare sector is there space for a factor that is not well defined or understood? Many studies have determined that the relationship between the doctor and patient is of utmost importance to patient outcomes and how much trust the patient can give to the doctor. Lack of compassion implies the excess usage of medical resources to find answers rather than speaking to their patients. Additionally, this lack of compassion can also be translated to adherence to medical advice after the patient leaves the hospital. A study out of John Hopkins University that tested patients with HIV found that those with a positive relationship were "associated with 33% higher odds of adherence to therapy, and 20% higher odds of having no detectable virus in the blood."

A study from 2012 published in the Journal of General Internal Medicine found that 56% of physicians said they don't have time for compassion [13]. This is enhanced in the era of electronic health records, where there are enormous data to show that health care providers spend more time looking at their screens rather than the patient. According to Stephen Trzeciak, 40 seconds is what is needed to save a life (both the patients and healthcare workers) [1]. Compassion has been absent for quite some time from the healthcare sector but as more and more evidence comes out that the various factors that prevented it are not true, compassion should be reintroduced as it can be taught and learned (Chapter 4).

Conclusion

After almost three years of the pandemic crisis, many healthcare leaders are finally coming up for air and taking proactive steps towards organizational well-being. Compassion in health care should be a given as it is a core human value. Healthcare providers enter the demanding field of healthcare because they want to help people, and patients on the other hand want providers to care about their well-being. Compassion is not something that you are born with but as it is also showcased in

other chapters of this books, can be taught and should be taught to all healthcare stakeholders. The most important lesson that the pandemic has given us is that the system needs to be well prepared for emergencies like the one we are experiencing

Healthcare systems across Europe and the world are presently tackling numerous challenges including mounting financial burdens, dwindling resources, as well as migrant and humanitarian crises. Compassionate care should be at the core and an integral theme of the person-centered care provision. Additionally, as shared-decision making can be considered as the cornerstone of evidence-based practice, healthcare providers should move further than just talking empathetically to patients and coworkers to developing a compassionate, evidence-based frame for safe and trusting interaction. Compassionate leadership and shared decision-making should be the core focus of any care pathway. Use of a compassionate care approach has shown decreased anxiety, prevention of chronic illness, quicker recovery, and better compliance of management and treatment options. Starting with a clear understanding of the needs, values, and belief systems that permeate vulnerable populations, clinicians can lead with respect, compassion, and empathy. Via skills and cultural training, this can bridge the gap between healthcare workers and recipients of care.

The need for a new model for compassionate leadership is now even more pronounced. Leadership should be empathetic, actively listening to the needs and problems of their employees and should practice sentimental judgement. Showing more compassion in leadership can boost/improve the employees well-being and thus increase productivity, reduce absenteeism and overall improve quality of service provided.

As we turn our attention to how organizations and individuals can now move towards recovery, it's imperative that healthcare leaders, educators, and policymakers take action to cultivate a sustainable, supported healthcare workforce. After all, caregivers are humans before they are heroes, and when they are suffering, they too need care.

Into Practice

- Practicing compassion in times of crisis does not require time, but a mindset change on the individual level and a culture change on the organizational level.
- Compassionate leadership is fundamental to compassionate healthcare as the exhausted employees need someone to guide them on the right path. Employees who are convinced that they work in an environment which is governed by compassion, tend to perform better in terms of quality of care provided.
- Leaders which show a compassionate approach tend to build work environments that improve both the staff's as well as patients' lives.

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Cultivating Compassion in the New Generation

4

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Learning Objectives

1. Understand the importance of developing compassion in the new generation of healthcare professionals
2. Determine if compassion can be taught
3. Outline methods that can be used to teach compassion
4. Give examples of what skills and values need to be cultivated
5. List ways to measure the effectiveness of Compassionate Care education

We suggest using this chapter as evidence-based guidelines when deciding on educational reforms in healthcare. Real-life patient experiences from healthcare professionals are also included in boxes throughout the chapter. These can be combined with the teaching methods described to cultivate compassion in the new generation.

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Introduction

Spanning more than 2000 years ago, compassion has been defined in many ways. An example worth looking at is the one of a child: "When someone gets hurt, we go and look after them and then we make funny faces." This response practically demonstrates that compassion includes an awareness of the suffering of another, coupled with the wish to relive it. In contrast, empathy encompasses only the understanding of the pain of another and sympathy, the reaction of pity towards them.

This definition also alludes to the irrelevance of age in the understanding and real-life application of compassion. If a 5-year-old can do it, it is safe to assume that medical students can.

A more practical definition of Compassionate Care (CC) is also required before we proceed. In the words of patients and clinicians across many studies, compassion is described as therapeutic actions or inactions: "helped control your pain," "understood your medical problems," "small acts of kindness," "going over and above," "attending to the little things," "giving others the gift of quiet, time, and space," visible, persistent, and dedicated presence of the clinician [1, 2]. Compassion is, therefore, a combination of virtues and skills such as empathy, altruism, self-reflection, advanced communication skills, intercultural communication competence, active listening, supportive body language, conflict transformation, trust, honesty, and teamwork.

The following patient experience, kindly narrated by Dr Nicholas Herodotou, a Palliative Medicine consultant, illustrates a heartfelt example of therapeutic inaction that prioritizes quality of life over prolonging life.

"*Please Dr, let me die*"; When Overtreating a Palliative Patient Causes Greater Harm than Good.

Therapeutic inactions

I was requested to assess a 68-year-old married man who had multiple progressive co-morbidities over a period of 19 years, significantly affecting his quality of life. He was confined mostly to bed, had limited social interaction and suffered a loss of marital intimacy due to a huge enterocutaneous fistula which discharged over 2L/day into his stoma bag. His other medical conditions included cardiac disease, recurrent pulmonary emboli, ischemic limbs, intra-abdominal bleed post-surgery and recurrent sepsis. He was receiving artificial nutrition and had deteriorating renal function. Over four years, he had a total of 144 days of hospital admissions. The consultant in charge was struggling to maintain homeostasis regarding his nutritional input and worsening renal disease. The patient repeatedly expressed the wish to be allowed to die over several months as he felt he could not continue with his futile medical interventions. The medical teams did not listen to the patient's wishes.

A psychologist was supporting the patient. I advised the patient that legally, he has the right to refuse any medical treatment, providing he is deemed to have capacity and is not so severely depressed as to affect his decision making. His face lit up for the first time and he expressed his gratitude that I was the only doctor to listen to his wishes.

A psychiatrist reviewed the patient and deemed him to have capacity and that he was not so severely depressed as to affect his decision making. Plans were made for the artificial nutrition and other medical treatments to be stopped and to transfer him to a hospice for terminal care. I did emphasize that this was not euthanasia or physician assisted suicide but allowing him to die naturally from his illness.

Before leaving the hospital, he hugged his wife and said to her: "I'm sorry my love, but I can't cope anymore." They both wept in my presence, but there was both a serenity and acceptance; the struggle had finally ended. He died peacefully in the hospice five days later with his wife and young son present.

The patient's consultant's comment to me after stopping all this treatment was that: "This patient's clinical management has been fundamentally altered for the good by what you did."

We must give patient's their dignity by maximizing their quality of life in their last days and avoiding futile overtreatments that merely prolong life.

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Why Is This Important for Students?

> Educating the mind without educating the heart is no education at all
> Aristotle [3]

Compassion is the cornerstone of the healthcare profession. Patients have systematically ranked it as the most or one of the most important factors in their treatment [4–6]. A compassionate approach works in two ways. Firstly, it allows the patient to easily disclose information as they know the person listening deeply cares. This approach ensures that what is essential to the patient has been said. Thus, healthcare professionals will treat the patient, not just the symptoms. Critical details are not missed and patients are less likely to lie, and more likely to comply [7, 8]. Secondly, it works on a biochemical level by accelerating recovery, increasing pain tolerance, gaining better control of the chronic illness, and improving psychological symptoms such as anxiety and depression [9–11]. Simply put,

imagine you are sick, and you feel that no one cares about you versus the situation where many people care, want you to become better and are actively doing something about it. The second situation is more likely to lead to a healthier and happier patient.

It is also proven to be better for Healthcare Professionals (HP): "Happier patients equal happier clinicians." Studies show that CC increases job satisfaction and sustainability and decreases the risk of burnout [2, 7, 12, 13]. Therefore, compassion increases patients' quality of life and the HPs. It is thus to no one's surprise that the UK General Medical Council recommends CC teaching in medical education [14]. Since we aim is to provide quality of life, we should aim to cultivate and sustain CC in the new generation of healthcare and management students.

How Compassion Is Developed or Eroded

> If you talk to a man in a language he understands, that goes to his head. If you talk to him in his language, that goes to his heart.
> Nelson Mandela

The question of whether virtues such as compassion can be taught can be dated back to ancient Greece. Socrates believed virtues are a "gift of the Gods," whereas Protagoras argued that everybody teaches them. In 1983 Pence published an essay, "Can compassion be taught?," where he concluded that Protagoras was correct, and a healthcare system can develop moral ideas [15]. Pence argues that medical education should reward compassion alongside clinical skills and factual knowledge. Many others, such as Saunders, Chochinov, Egan, Rogers, and Haslam, report the same conclusion: Compassion can be developed and eroded [5, 16–19]. Successful modular CC teachings at hospitals around the world also fortify this conclusion [20–22].

Following a distillation of the current literature surrounding compassion, barriers and factors that erode compassion are ranked.

1. *Medical schools, nursing schools, and healthcare professional training* can be a barrier to compassion and even "teach it out" of students. If, during training, the basic and clinical sciences are not coupled alongside the application of virtues it can cause the neglect and even decrease of a holistic, patient-centered, CC approach. Research reports that medical students may lose the ability to empathize with their patients during clinical training—also referred to as "hardening of the heart" [16, 23]. This is a well-documented phenomenon observed in many countries that dates to 1961 [24] and one that should alarm us. If left unattended, situations arise and assist in producing tragedies such as the Francis report. A report into the serious healthcare failings of a UK hospital Trust [25]. The Francis report identified the absence of compassion as a contributory factor and advised the use of compassion aptitude tests.

2. *The result orientated, "box-ticking" environment*. Although in many cases students may be taught the application of virtues during pre-clinical years, once they enter the battlefield these become a luxury not a priority. This phenomenon is evident from several studies looking at components of quality care, where clinicians prioritized technical skills over intrinsic qualities, opposite to patients' views [26–29]. Both technical skills and intrinsic qualities should be of equal importance.
3. *Compassion fatigue/Burnout* is an epidemic among healthcare professionals worldwide. It affects approximately 500,000 physicians in the USA alone and is estimated to cost 12 billion dollars annually in terms of burnout cost, which causes increased physician turnover [30]. It is estimated that 80% of burnout is related to organizational factors. To address these organizational factors, the American Medical Association promotes the Stanford Wellness Framework, which includes three domains. One of them is a "Culture of Wellness" promoting "compassion for colleagues, patients, and self" [31].
4. *Absence of personal life experiences*. Experiential learning is regarded amongst academics as the best way of teaching. As a result, variability in experiences, goals, and motivations causes variability in the inherent virtues present in students at baseline.
5. *Shortage of compassionate role models during clinical training*, and therefore the absence of corrective behaviour towards students neglecting the application of virtues [8]. If the next generation is to be more compassionate than the current, the culture in healthcare needs to change, starting with each of us individually. Problems start at the top of pyramids.
6. *Unmet need for validated quantitative CC metrics*. Literature is flourishing in this area albeit, it is in its infancy. An updated critical review in 2022 highlighted the need for validated psychometric instruments identified the Sinclair Compassion Questionnaire (SCQ) as the best available tool [32].

Other barriers that are more difficult to address but deserve mentioning include high work stress, case complexity, long hours, difficult patients, time pressure, lack of teamwork and communication, and bad organizational structure.

Remedying the above barriers will create many opportunities to develop compassion in the younger generations. These opportunities will act as CC enablers. Other important CC enablers are also noted below:

1. *Culture change*. Shaping the ethos of a group of people has troubled leaders over the years. Many criticised it as an impossible task to achieve in short periods. However, if the focus is shifted to changing the environment and not the people then some noteworthy outcomes can be seen. Manifestations of Nature in the clinical environment such as windows, images, and indoor plants significantly decrease patient pain, anxiety, depression, and ultimately length of stay [33]. Other environmental factors such as the architectural layout and organization of

hospital units affect the visibility of patients and thus patient outcomes. Although physician outcomes were not recorded in the above studies, it is imprudent to think these changes will not positively affect HPs. The HPs may act as mediators of patient outcomes. Higher quality research is needed to determine if this is a true phenomenon. Nonetheless, our behaviour is undoubtedly shaped more than we believe by our environment.

2. *Personal experience*. These enabling experiences can occur prior to medical school through personal events or can take place through training. Role models that exhibit compassionate behaviour must be highlighted and prompted to teach or preferably have students spend time shadowing them [34]. Nursing students have also identified fewer mentoring opportunities as a barrier to developing compassion through healthcare training [35].
3. *Positive Reinforcement* should come from senior clinicians, when compassionate behaviour is noticed at all levels of HP.
4. *Starting as early as possible*. One can argue that values are habits repeated many times, Will Durant, in his work "the story of philosophy", remarks, "We are what we repeatedly do. Excellence, then, is not an act, but a habit." We believe the same applies here, since compassion is a set of applicable virtues, it's a matter of creating and reinforcing positive habits over a long period of time. The longer that period, the stronger the habit. James Clear's work on habit building can be of use [36].
5. *Humanities and Art*. Haslam and Chochinov suggest that humanities and arts such as literature, poetry, music, film, and theatre can be fruitful channels in developing compassion since they help us visualize and better comprehend the lives of others [5, 16].

Most of the above barriers and enablers of compassion will be further discussed and practically addressed in the following section.

What to Teach and How to Teach It?

> Education without values, as useful as it is, seems rather to make a man a more clever devil.
> C. S. Lewis

Following a thorough screening of the current evidence for teaching compassion, we introduce the 3C approach: Cultivate, Check, Conserve [1, 37, 38]. Each step in the 3C process is defined individually for each stage of medical education: Prospective Medical Students, Medical Students, Junior Doctors, and Senior Doctors. The practical advice for these four stages is also applicable and advisable to all other healthcare professionals, such as nurses, psychologists, and even healthcare managerial staff.

Cultivate, Check, Conserve

The word cultivate is used instead of teaching because it refers to the intrinsic ability of the individual to acquire virtues or skills through experiential learning contrary to the attainment of information and facts through teaching.

Table 4.1 outlines the "material" to be communicated when aiming to culture compassion. Table 4.2 is a non-exhaustive list of the different teaching methods that can be used in each of the four medical journey stages. Teaching methods are also divided into didactic (theoretical tuition in seminar form), practical (hands-on tuition such as role play), and experiential (exposure to planned patient interactions imitating actual clinical situations).

The reasoning behind the division of Table 4.1 into skills and virtues is that they are encouraged differently; thus, approaches to teaching will vary. **Skills** can be taught in didactic and practical ways similar to the way we teach other practical skills such as taking blood and inserting catheters. **Virtues** are primarily taught by experiential learning since they are much harder to communicate and stem from a uniquely personal and multifactorial background.

It is vital for the development of compassion that skills are accompanied by Virtues. Virtues make the skills a genuine reaction that can be deeply felt by the individuals and not a robotic movement or even a facade. It is surprising how easily patients can tell that someone is putting on an act or is genuinely empathetic. Addressing these is more challenging but achievable if we allow experiences to teach and not ourselves.

Table 4.1 What to cultivate to achieve compassion

Virtues	Skills
Empathy	Self-reflection
Trust	Active listening
Honesty	Advanced intercultural communication
Humility	Teamwork
Love	Conflict transformation
Gratitude	Supportive body language and voice tone
Mindfulness	Adversity activated development
Responsibility	Shared decision making
Patience	Cultivation of therapeutic relationships
Forgiveness	Patient centeredness
Kindness	Self-compassion

Table 4.2 How to cultivate compassion

	Teaching Methods	PMS	MS	JD	SD
Didactic	*Standard lecture-based* teaching through theory-based discussions and presentations.	X	X	X	X
	Cinemeducation uses media to supplement teaching such as short films to explore the biopsychosocial aspects of health [39]. You can find short films used in compassionate care courses delivered by the International Institute of Compassionate Care (IICC) on this link (http://symponesi.org/iicc-video-gallery/). [40]	X	X	X	X
	Case-based Learning (CBL), is a case-based education method grounded in the analysis of medical records to restore the real clinical scene and prompt students to identify and develop new areas of learning [41].		X	X	X
	Problem Based Learning (PBL) is defined as a student-centered pedagogy in which participants are allocated to groups of up to eight persons under non-directive tutors and given tasks or challenges that reflect situations that are relevant to the working environments they are anticipated to experience [42].		X	X	X
	CBL and PBL combination [43].		X	X	X
Practical	*Role-playing* engages students with real patient scenarios and allows them to actively think and thereafter reflect on their actions by answering open-ended questions on their performance [44].	X	X		
	Swartz rounds have been around since 2002 and have been spreading all around the world, simply because they work. These are "healthcare staff conversations about the emotional impact of their work. They provide an evidenced-based framework which has been proven to improve staff well-being and teamwork which ultimately has an impact on improved person-centered care… 85% of staff feel better able to care for patients after attending Schwartz Rounds" [45]. We believe even medical student involvement is beneficial.		X	X	X
	Teaching is regarded among the best ways of learning. Thus, as part of school projects (PMS), SSC components (MS), or academic teaching opportunities (JD, SD), emerging healthcare professionals can participate in the teaching of CC to younger generations. Increasing awareness, understanding, and application of CC by tutors and tutees [46].	X	X	X	X
	Flipped Classroom, is a successful teaching method as a subcategory of teaching where students are given material to go through before the session. This material is then explored actively through problem-solving and case scenario activities [47].		X	X	X
	Narrative medicine has been promoted as an innovative and effective means of stimulating medical students' professional development by teaching them to approach their patients' experiences of illness with more understanding and compassion [48].		X	X	X
Experiential	*Visits* to Palliative Care units such as hospices helps in the understanding of quality of the life over prolonging suffering. Treatment is sometimes worse than the disease.	X	X		
	Short placements with role model clinicians. We are beings that mimic, we see, we do, thus experiencing compassionate care can be one of the best teaching methods. Even the prevention of bad role modelling could also be very successful in preventing detrimental behaviours clearly documented in the literature [49].	X	X	X	X
	Narrative medicine		X	X	X
	Patient Journey's. Patient visits to share and discuss their experiences. This involves patients in medical education, giving them the stage to voice what is important to them [50].	X	X		

Legend 1. PMS: Prospective Medical Student MS: Medical Students JD: Junior Doctors SD: Senior Doctors.

Prospective Medical Students

Cultivate: It is crucial that we start as early as possible in medical training by introducing these virtues and skills. We would go to the extent in saying even before medical school. CC at this stage can be cultivated through work experience, especially if it becomes examinable in medical school interviews. Moreover, to facilitate this development Medical Schools can provide short online and in-person CC courses (view teaching methods Table 4.2) in secondary schools with current medical students, perhaps as part of Student Selected Components (SSC). Experts argue that this will not only foster compassion in prospective medical students but also prevent verbal, physical, and emotional aggressive behavior in all class members [51]. Starting early is key.

Check: Applications for medical or healthcare education require a checklist of items to be completed (volunteering, shadowing, personal statement and educational achievements) which is then examined through panel interviews or multiple mini interviews (MMIs). A recent change towards MMIs has been observed in the UK due to their effectiveness at testing a greater variety of skills, with tasks such as role play and professional judgment stations. MMIs can, therefore, facilitate the examination of compassion through the virtues and skills outlined in the introduction. It will then be made an area to work on before applying to medical school through shadowing and volunteering experiences. Prospective students will learn to value its importance and practice its application in real situations even before attending interviews.

Conserve: Preservation of CC will occur subsequently throughout medical school.

Medical Students

Cultivate: In behaviour modification strategies and other successful teaching methodologies, the idea of spaced repetition is prevalent. The same is true for teaching compassion. Following the examples of modules delivered in Cyprus, Greece, and the UK that generated successful qualitative and quantitative evidence, delivering a hybrid modular overarching theme in healthcare teaching across all years of study is suggested to be one of the strongest ways of teaching compassion [20–22]. Modules should include the cultivation of skills and virtues as seen in Table 4.1 with methods of teaching seen in Table 4.2. The design of modules should be a product of focus group meetings with medical schools' administrative staff, professors, human resources staff, clinicians, and medical students regarding their **Needs, Ideas, Concerns and Expectations (NICE).** An analogous process should take place with the respective managerial staff of hospitals when designing modules for Junior and Senior Doctors.

An example of a successful module structure delivered to healthcare professionals (nurses, clinicians) and managerial staff in a hospital in Cyprus can be seen in Table 4.3. Modules were cumulative (built on each other) and were taught through

Table 4.3 Example of Modular course taken from Shea et al., case study [20]

Module title	Content
1. Applying Compassion within the context of the hospital setting	Historical and religious backgrounds; attention to basic needs; example approaches to specific conditions; compassion across the organization; cultural awareness; CC during financial crisis; barriers and sustainability; can compassion be taught
2. Patient-centered care in hospitals	Main concepts and measurements; how to apply, what we need to change among the health care workforce, organizations and patients; seeing the person in the patient; implementation in the local setting—barriers and constraints
3. Applied CC	Developing a culture of CC; enabling CC in acute hospital settings; applied CC; conflict transformation
4. Intercultural Communication Competence in Healthcare; Teamwork Communication in Healthcare	The impact of culture in doctor–patient relationships as well as among staff members in healthcare settings; communication dynamics and strategies for effective and compassionate self-care, patient care, and in healthcare work teams.
5. Advanced communication skills	Impact of consultation and communication style on the patient's experience; advanced communication skills; employing effective communication tools; assessment of improvement of communication and consultation skills
6. The therapeutic compassionate relationship	The healthcare professional as a drug; impact of a good quality therapeutic relationship in patient satisfaction, professional fulfillment, compliance, complaints and effective time management; measuring the therapeutic relationship

presentations, theory-based discussion, real-life examples, stories, videos, and role-playing. Randomization of participants into working groups and qualitative/quantitative feedback were also core elements of the course.

An example of using a real-life story to teach active listening (AL) and shared decision making (SDM) has been kindly provided by Dr George Samoutis. In this case scenario the patient, Maria* is presented (until**).

"Dr, please listen to me," Treating the Whole Person

Therapeutic actions

Maria* a 40-year-old female academic professor came to see me due to chronic episodic migraine headaches over the last couple of years which recently had become unbearable. She had no other past medical history, had tried trigger avoidance, several medications (triptans, magnesium, NSAIDs). She was married with 2 children, was a non-smoker, took no illicit drugs, and took limited exercise. She visited several doctors but couldn't find a solution and she was desperate to be relieved from the pain. She ran several tests (e.g., blood testing, MRI brain) without any pathological findings. **

We sat and talked for 15 min. I realized that I needed to listen to her more, so I asked my secretary to reschedule my next appointment. It was a critical time to actively listen to her. I used active listening, shared decision making and the 3S CC model (Chapter 10: Compassionate Spirituality) and at some point, she started crying and said *"Can I tell you something I haven't told anyone before ?*"

I nodded and Maria began, *"I am an introverted person and do not share my emotions easily. I have been bullied at my university by my colleagues in a promotion process and have been exhausted emotionally having thoughts of hurting myself. Not even my husband knows about my problems at work and my thoughts."* I replied, *"Now that we know the root cause we can move on together to treat your headaches*." We used therapeutic relationships, CBT and adversity activated development models, exercise as well as homeopathic remedies (aurum, natrium muriaticum) based on patients wishes and beliefs. The results were remarkable: After 5 years she is still pain-free and fully functioning with very rare episodes of migraine that resolved without the use of painkillers.

Prof George Samoutis MD,PhD, CCT, PGCertHBE(UK)

**pseudopatient names used, facilitating compassion*

Participants are asked thereafter to describe how they would communicate with Maria, what questions they would ask and why. Following discussion, the case scenario reading is completed. A reflective discussion is facilitated, and the take-home message is highlighted.

Take-Home Message

AL, SDM in Clinical Practice

Define the problem, from the patient and doctor's point of view

Active listening, empathy, therapeutic relationship, patient-centered and 3S approach (Chapter 10: Compassionate Spirituality)

Explain/educate without overloading

Assess patient's level of health literacy

Check for understanding

Identify and repeat most salient points

Listen and reflect patient's preference

Discuss plan forward: What happens next? Safety netting

We also strongly propose training medical students to include a patient-centered pneumonic in history taking. Namely **IS NICE**. **I**mpact of the condition on patients' quality of life/daily living, **S**afety netting to manage clinical emergencies and promptly report "red flags," **N**eeds (Physical, Emotional, and Spiritual needs), **I**deas, **C**oncerns and **E**xpectations.

Check: CC in medical schools can be tested in a few ways. By using measures such as the Sinclaire Compassion Questionnaire (SCQ) (https://www.compassion-measure.com/) and the 12-item Schwartz Center CC Scale [32, 52] we can test CC in Objective Structured Clinical Examinations (OSCE) stations and at placements. CC can also be tested at the end of medical school situational judgment tests with unambiguously targeted questions.

Conserve: Preservation of CC will occur subsequently throughout junior doctor placements.

Junior Doctors

Cultivate: Professional Development Courses on CC development and prevention of Compassion fatigue can be run as overarching modules throughout placements as per the teaching methods and material presented (Tables 4.1 and 4.2). Short (1–2 week) shadowing schemes of role-model physicians can also be effective.

Check: Quantitative and qualitative compassion scales [32, 52] are used to evaluate junior doctors at placements and major examinations such as the MRCP (UK).

Conserve: Preservation of CC will occur subsequently throughout senior doctor practice.

Senior Doctors

Cultivate: Professional Development Courses on CC development and prevention of Compassion fatigue can also be run to include Senior and Junior Doctors. Shadowing fellow role model clinicians (1–2 consultations) would facilitate interprofessional learning of CC and form an ongoing part of professional development for trained practitioners.

Check: Quantitative and qualitative compassion scales [32, 52] are used to evaluate senior doctors at revalidation.

Conserve: Preservation of CC will continue throughout a HP career.

Conclusion

Compassion's absence or presence can be felt at all levels of human relationships, between patients and HP, between HP and even within ourselves. It is in our very nature to benefit from compassion mentally and physiologically. Consequently, it is of utmost importance to develop this quality in the individuals people seek in their darkest hours. We hope this chapter can be of use in healthcare educational reforms.

Into Practice

Prospective Medical Students

1. Short courses online and/or face to face in secondary school
2. Experiential learning through work experience at nursing homes and hospitals

Medical Students

1. Integration of CC teaching in the curriculum
2. Experiential learning of CC skills and behaviors during clinical placements
3. OSCE stations testing CC
4. Testing of CC at end of medical school exam

Junior Doctors

1. Professional Development Courses on CC and prevention of Compassion fatigue
2. Shadowing Role-Model physicians (1–2 weeks)
3. Development of CC and fatigue quantitative scales

Senior Doctors

1. CC should be part of revalidation
2. Professional Development Courses on CC and prevention of Compassion fatigue
3. Shadowing Fellow Role Model Clinicians (1–2 consultations)
4. Development of CC and fatigue quantitative scales

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Compassionate Care Within the Primary Health Care Setting: Before and During a Public Health Crisis

5

Sue Shea and Christos Lionis

Learning Objectives

1. Recognise the traditional role of primary health care, and how historically compassion has been embedded within this.
2. Draw attention to the changes that have taken place within PHC as a result of the COVID-19 crisis, and how PHC delivery has had to adapt to these.
3. Understand the vulnerability of certain patient groups within the PHC setting.
4. Appreciate the additional role of PHC in addressing issues such as loneliness, the vaccination roll-out and provision of effective communication to enhance adherence and promote health.
5. Realise the importance of a compassionate approach and solidarity to protect the welfare of patients and those involved in their care.

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Traditional General Practice and the Role of Compassion

Primary health care (PHC) has traditionally represented a valuable resource for patients and their families, addressing a range of symptoms and conditions whilst taking into account the psychological and biological needs of the individual. A compassionate approach is therefore crucial within this environment to develop trust and to ensure positive outcomes. Indeed, more than two decades ago, Taylor spoke of the 'resuscitation' of the personal doctor suggesting that 'general practice without compassion is as therapeutic as air without oxygen' [1]. Likewise, Barry and Edgman-Levitan observe that 'caring and compassion were once often the only "treatment" available to clinicians' [2].

Uygur and Smith describe compassion in family medicine as a multifaceted concept that may be seen as a virtue, an emotion, or a personal trait, adding that an exploration of the different constructs of compassion can aid our understanding regarding the development and maintenance of a compassionate approach [3].

In a qualitative study, aimed at exploring family physicians' capacity for, and experiences of compassion in practice, Uygur et al. [4] identified three key areas that physicians felt had an impact on their ability to be compassionate. These three areas included motivation (core values) for compassion, capacity (energy and emotion) for compassion, and the patient–doctor connection related to compassion. The authors describe the interrelationship of these key concepts as the 'Compassion Trichotomy' which may determine the evolution or devolution of compassion among family doctors [4].

Fernando et al. [5], suggest that when dealing with suffering, a compassionate approach leads to positive emotions among physicians but as with other emotions compassion may be affected by internal and external factors. For example, GPs must deal with a number of pressures and responsibilities as well as their own personal and family issues. Fernando et al. describe being a doctor as a 'complex biopsychosocial activity' which could lead to the individual 'forgetting' the main reason for becoming a doctor despite the benefits of a compassionate approach for both patients and doctors themselves [5].

Furthermore, the concept of empathy is seen as being a fundamental feature in GP–patient communication [6]. In a qualitative study, Derksen et al. attempted to examine empathy in general practice and to explore the perceptions of both patients and GPs regarding how and why their wishes and expectations regarding empathy sometimes remain unmet. The conclusions drawn from this study demonstrate that a number of circumstances may prevent the delivery of empathy, including practice organisation, time pressures, and the GP's own psychological and professional well-being which may affect their capability to deliver an empathetic approach [6].

As such, several attempts have been made by various Universities across Europe to introduce undergraduate courses to teach medical students the concept of compassion. Among the first of these was the Medical Faculty of the University of Crete, which has successfully delivered an elective addressing the concept of compassion [7].

The above summarises certain views and observations prior to the unexpected COVID-19 crisis, which has led to somewhat dramatic changes in the traditional structure of PHC. Thus, incorporation of compassion into PHC services is potentially more crucial than ever, particularly in terms of protecting vulnerable individuals, providing reassurance to help alleviate anxiety and other mental health problems, and empowering people to engage in safe practices (more on compassionate care and crises can be seen in Chapter 3).

In the remaining sections of this chapter, we discuss a number of situations and circumstances which are likely to be affected by the COVID-19 outbreak and may have an effect on re-thinking and enhancing compassionate care within PHC.

Changes in Family Medicine Following COVID

The outbreak of the COVID-19 pandemic has led to a number of unexpected changes in the delivery of family medicine, whereby face-to-face consultations have deteriorated considerably, being replaced by telephone or video consultations. This has inevitably led to GPs having to rely heavily on listening skills when advising patients, without the advantage of observation and non-verbal communication.

An editorial by Lionis and Petelos in 2020 highlighted the challenges, priorities, and tasks for the generalists at the time of the COVID-19 pandemic with a focus on research, health care policy making, and clinical practice. Among several statements, this article underlined that 'Individuals and families have been under enormous stress, experiencing fear and anxiety. To respond effectively, generalists have to be adept at using e-health tools and equipped with sound communication skills. Updating existing curricula to enhance the capacity of generalists with motivational interviewing and compassionate care skills should extend to self-compassion and self-protection, for a sustainable health workforce to increase the resilience of health care systems and communities alike' [8].

This new approach to family medicine could be seen as a somewhat controversial issue in that although in many cases a telephone consultation may suffice, the lack of face-to-face communication may result in important issues such as unhealthy behaviour and weight gain remaining unnoticed.

Following widespread agreement in 2020 that in order to contain COVID-19, consultations would need to be performed remotely, Murphy et al. conducted a study to explore the impact of remote consultations among 21 general practices in the UK. This study demonstrated that although telephone consultations were sufficient for many problems, GPs were worried about longer-term clinical risks and found it difficult to set a threshold on when a patient needed to be seen on a face-to-face basis. In general, GPs differed in terms of their confidence in telephone consultations and although many recognise certain benefits of remote consulting, they felt that the model would need to evolve if delivery of primary care is to continue in this manner [9].

In an interesting study performed in Ireland by Homenuik and Collins, the ways in which general practice has changed in response to COVID-19 were explored. The

study had the advantage of survey data collected prior to the pandemic which could be utilised as a comparison with data collected during the pandemic. A significant decrease in face-to-face consultations together with an increase in telemedicine consultations, and a decline in consultations not related to COVID were observed. Furthermore, almost all participating practices reported a decline in patients aged under 6 and over 70 years of age [10].

Homenuik and Collins suggest, however, that the telephone triage method does not lead to a reduction in GP workload and a longer-term evaluation of how this system might impact patient-centred care is required to ensure that the importance of trust, communication, and patient safety is maintained within the GP–patient relationship [10].

Tao et al. draw attention to the fact that compassion represents the cornerstone of quality of care and that there are various ways in which compassion can continue to be expressed during COVID-19. However, there is a lack of reports on the effects of telemedicine and compassion with regard to specific patient groups. These authors suggest that people with epilepsy represent a group who are susceptible to mental health issues and that anxiety is likely to be heightened among this patient group during the pandemic. They identified that when treating patients with epilepsy during COVID-19, a compassionate intervention delivered via telemedicine proved an effective method for decreasing anxiety and depression and improving quality of life. These authors conclude that further research is required to identify successful methods of delivering compassionate care to this patient group [11].

De Zulueta argues that a switch to telephone consultations in primary care involves a deeper issue in the sense of loss of touch and this may be particularly relevant in terms of the well-being of individuals who live alone or who are vulnerable. De Zulueta suggests that touch is an important means of communicating emotion, that can act as a buffer against stress, and enhance trust, concluding that loss of touch may undermine the GP–patient relationship. Thus, we should once again recognise the importance and healing power of touch [12].

An eight-country European qualitative study explored patients' and primary care professionals' (PCPs) experiences of primary care delivery in the first wave of the pandemic [13]. This study identified that patients accepted telemedicine when PCPs spent time to understand and address their concerns, but a minority preferred in-person consultations. PCPs felt that remote consultations created emotional distance between themselves and patients, and they reported medical and social concerns when invited to manage diverse COVID-19-related conditions.

However, a 2021 OECD report suggests that although wide usage of digital technologies was much less common prior to the pandemic, the speed with which this transformation has taken place is evident. The report suggests that advising people with mild symptoms via consultations from home aids in limiting the spread of infection to others and can also free up capacity to treat people with serious illness or critical conditions [14]. On the other hand, problems arise with the fact that many people without COVID-19 failed to access or seek attention for their condition during the onset of the pandemic, leading to a lack of, or delayed, diagnoses and treatment.

Furthermore, as pointed out by Huston et al., difficulties have arisen in terms of providing patient-centred care to certain patient groups during COVID-19, particularly those with mental health issues or who are unfamiliar with the use of technology [15].

As reported by Murphy et al. delivery of primary care on a remote basis is suitable on many occasions but GPs vary in their levels of confidence regarding this method since remote consulting requires different skills. It is, however, important to recognise that the pandemic has necessitated changes in health care delivery particularly as GPs represent the first point of contact for many health problems and as such, they are at high risk of coming into contact with infections themselves [15].

As suggested by Jenkins et al., the role of the family doctor is traditionally broad and adaptive, but COVID-19 has introduced many challenges to this role as a result of social distancing and limited face-to-face contact. This has led to uncertainty requiring reflection and a renewed focus on caring [16].

The changes that have taken place in PHC delivery since the outbreak of COVID-19, particularly in terms of remote care delivery, remain a controversial issue in terms of risks and benefits. To maintain compassion in PHC in accordance with traditional values and somewhat dramatic changes to care delivery following COVID-19 perhaps calls for re-thinking the structure and organisation and monitoring the success of telemedicine if this approach is to continue in the longer term.

Role of GPs in the Vaccination Roll-Out

In addition to the challenges faced by GPs regarding PHC delivery during the pandemic, a further issue of importance concerns the role of GPs in the vaccination roll-out and the importance of providing reassurance and encouragement.

It is perhaps well known that when a vaccine is recommended by doctors, people are more likely to engage in this process [17]. In recognition of the important position of GPs in providing advice regarding the COVID-19 vaccination, Poon et al. investigated the concerns and practices of GPs regarding recommending the vaccination to patients. This study revealed that factors related to GP recommendation of COVID-19 vaccination included actively holding relevant discussions with patients, length of time in practice, and the GPs own vaccination status. The latter represented the strongest predictor of GPs recommending the vaccine to their patients [17].

Furthermore, a study by Day et al. which sought to explore the perspectives of physicians in Texas regarding vaccine acceptance identified high acceptance among primary care physicians. These physicians further reported confidence in their ability to address concerns that patients may have regarding the vaccine. Confidence was particularly strong in terms of educating patients and providing factual information to reduce concerns [18], and was lowest with regard to addressing personal or religious issues. These authors report that with additional training, primary care physicians can utilise the trust that their patients have in them and that this could have a positive impact on the rates of vaccination uptake [18].

In an editorial by Harnden et al., attention is drawn to the fact that historically PHC teams are noted for their success regarding immunisation programmes, and that PHC is in a good position regarding the minimisation of vaccine uptake inequalities. Harnden et al. suggest that good uptake is reliant on the GP's relationship with his/her patients, and how knowledgeable they are regarding the local population. In addition, Harnden et al. raise the important issue of GP communication with ethnically diverse groups given their higher risk of mortality. Maintaining trust in GPs is therefore crucial in ensuring that the most vulnerable in society are protected and cared for [19].

Given that GPs have a strong chance of increasing patient confidence in the vaccination programme (including those who are vulnerable), Katzman and Katzman suggest educating PHC clinicians on the importance of talking to their patients regarding plans for vaccination which could include offering kindness and listening empathetically. These authors draw attention to the fact that patients have their own thoughts regarding COVID-19 vaccination including mistrust, anxiety, and fears which require a reassuring approach from the GP [20].

In attempting to address the vaccination roll-out process, the University Hospital of Heraklion in Crete was one of the first health care outlets in Greece to become involved in this effort which involved a number of residents trained in family medicine [21]. Key to this initiative was a compassionate approach regardless of time limitations. This approach was particularly affective among the elderly who showed great appreciation for the warmth and friendliness that they received during the process. The approach was not without challenges, in terms of communicating with people with dementia or severe mental disorders; however, such challenges were overcome by maintaining close contact with the patients' family and caregivers [21].

The vaccination process requires an understanding of the local population together with knowledge of the fears and needs of the individual. Therefore, a compassionate approach is required whereby individual concerns are treated with gentleness and kindness in order to alleviate fears and provide reassurance.

Mental Health During COVID-19 and the Role of PHC

Prior to the pandemic, mental health problems have represented key causes of disability at a global level, and the further effects of COVID-19 on mental health have been substantial, including increases in depression, anxiety, and stress [22].

Several issues and uncertainties represent significant stressors and risk factors leading to an increase in emotional and mental health disorders related to COVID-19. Furthermore, people who are already suffering from a mental health condition could be at higher risk of becoming infected with COVID-19 [23]. The toll of COVID-19 at a psychological level is clear both among the general population, frontline workers, and especially among people with pre-existing mental health disorders [23].

In a study by Jia et al., modifiable and non-modifiable explanatory factors in association with mental health were examined. The non-modifiable factors that emerged from this study in association with stress, anxiety, and depression included

being younger, female and being in group at risk of COVID-19, whilst modifiable factors included positive mood, perceived loneliness, and concerns surrounding becoming infected by COVID-19. Thus, interventions aimed at alleviating modifiable risk factors could be effective in reducing the prevalence of mental health issues associated with COVID-19 in some individuals [24].

Carr et al. performed a study to assess trends in common mental health disorders recorded within primary care during COVID-19 in the UK. Primary care electronic records were utilised for this purpose, focusing mainly on the period between January 2019 and September 2020. Interestingly, although there is much evidence with regard to increases in mental health disorders during the pandemic, a reduction in contact with primary care settings was identified, suggesting an unmet need. Carr et al. conclude that such unmet needs could result in increased severity of mental health disorders, widening health inequalities, and increased self-harm. The authors suggest that delays in diagnosis and subsequent management need to be addressed, and health care services should be informed of reductions in patient contact in order to avoid potential growth in demand for future care regarding mental health disorders [25].

Ashcroft et al. suggest that PHC plays a key role in addressing mental health, and it is important to understand how such care delivery has been affected by COVID-19 in order to help inform future policy decisions. In a qualitative study by Ashcroft et al., the impact of the pandemic on delivery of mental health care in PHC settings in Ontario, Canada was explored. Three themes were identified including: transition to virtual care; increased demand for care; and impact on providers. These authors conclude that primary care physicians responded fast to increasing mental health demands and persevered despite the challenges they had to face. However, the situation has placed pressure on these health care providers, and the capacity of primary care to deal with mental health issues needs to be enhanced [22].

Likewise, in an editorial by Mughal et al. it is reported that 90% of mental health problems are cared for in PHC settings representing 40% of PHC workload. As the pandemic has potentially affected around 10 million individuals at a mental health level, arising from issues such as lockdown, bereavement, safety, and financial concerns, primary care is at the core in terms of addressing such an increase in presentations of mental health issues [26]. As such, a revitalisation in supporting mental health via PHC settings is essential.

Mental health disorders constitute a large percentage of the workload in PHC and compassion represents a crucial element of care. It is important to demonstrate attentive listening to ascertain the potential issues surrounding mental health problems and to identify possible risks and protective factors.

Loneliness and Isolation

Feelings of perceived loneliness can be very distressing, having serious health related implications both physically and mentally, and are also associated with psychiatric morbidity [27, 28].

Prior to the COVID-19 outbreak it was reported that around 46% of older adults in England report feeling lonely and are likely to visit their GP more often than non-lonely older adults [29]. With this in mind, Jovicic and McPherson sought to examine perceptions of GPs and the extent to which they were aware of loneliness among their older patients. The findings indicated some reluctancy among GPs in raising the issue of loneliness in that they did not feel that they had the ability to address the problem within primary care. Jovicic and McPherson identified that a certain amount of stigma was associated with loneliness, and this could affect communication between GPs and patients rendering open discussion about loneliness somewhat difficult. Thus, these authors suggest that training and support could be a useful method for helping GPs address social issues in collaboration with social/community care workers [29].

In an earlier study by Kharicha et al., researchers investigated the prevalence of loneliness in patients attending primary care settings. Their findings revealed that older people at risk or experiencing loneliness felt that the role of primary care was not equipped to deal with such an issue since it did not represent a physical problem. Participants considered that given the sensitivity of the issue, a good GP–patient relationship was necessary as GPs may be lacking in the understanding of problems that did not have a physical basis [30].

Lockdown measures were certain to affect experiences of loneliness, particularly in older adults, posing a risk factor for further mental health problems. The effects of lockdowns, particularly on the elderly and vulnerable groups have undoubtedly led to increased perceptions of loneliness during COVID-19, which could have harmful physiological effects and most certainly requires a compassionate approach.

However, as suggested by the Hussain, ways in which to address the concept of loneliness as part of holistic care are still not well understood, particularly as people experiencing isolation or loneliness may not seek suitable health information, which could have an effect on the management of existing conditions [31]. Because loneliness increases during pandemics, Hussain suggests that all professionals involved in health care should be aware that many people may have inadequate support systems. Indeed COVID-19 has demonstrated many harmful effects of loneliness, and as such it is important for HCPs to identify suitable support networks [31].

On the other hand, isolation and vulnerability have received a prompt attention during the COVID-19 pandemic. In an opinion document issued by the EC Expert Panel on effective ways of investing in health [32], the resilience of health and social care systems was discussed including a specific reference to the provision for vulnerable patient groups and how to sustain such provision in a system under stress. The panel issued various recommendations with two of them addressing vulnerable and isolated groups as: ‘In order to reduce vulnerability, primary care services should be supported and healthcare professionals, community health workers and informal care givers should be motivated to focus more on health promotion, lifestyle programs and intersectoral collaborative actions to increase health equity and resilience in the community’ and ‘Specific (inter-professional) training courses that aim at appropriately dealing with and reducing the vulnerability of socially deprived and minority groups should be standard in the undergraduate curricula of

institutions for health professional education'. Both recommendations indicate the need for additional training that primary care practitioners should be exposed to in order to meet the needs raised by the COVID-19 pandemic.

In a telephone survey by Wong et al. changes in mental health problems, loneliness, and attendance to primary health care in older adults with multimorbidity before and after the start of COVID-19 were investigated. The study identified an increase in insomnia, anxiety, and loneliness in older patients, many of whom had missed their appointments for scheduled care of chronic diseases. Risk factors for this finding included living alone, being female and having at least 4 chronic health conditions, leading the authors to conclude the importance of highlighting continuity of care in primary care settings and considering interventions such as telephone consultations, to address loneliness and improve mental health [33].

As noted by Godfrey et al., it is expected that patients should be treated holistically in that their physical, mental, and spiritual needs are met, as a number of factors can affect health or may serve as protective factors. In a study by Godfrey et al., the interesting question as to whether mental and physical health can be affected by loneliness even when protective factors are in place was investigated. This study identified correlations between mental health, religiousness, loneliness, and social integration, but a regression model revealed that loneliness was the only significant variable with regard to mental health even when other variables were present. These authors therefore recommend that loneliness screening should be integrated into health care appointments as it could prove a useful factor in the identification of other mental health problems [27].

Furthermore, a review by Heinberg and Steffen raises the issue of the impact of lockdown measures, and loneliness on obesity, in that loneliness and social isolation are likely to have an impact on dietary behaviours and physical exercise placing those at risk of weight gain in a vulnerable position in situations where loneliness and social isolation may be unavoidable [34]. This is an important issue, since people with obesity may be more prone to mental health problems and chronic disease.

In a paper by Shah et al. that discussed loneliness as a result of COVID-19 lockdown and social distancing, the extent to which digital technology could address this issue was also explored. These authors suggest that those most at risk of loneliness, including vulnerable and disadvantaged populations, should be provided with access to the appropriate technology to enable them to connect with those close to them in an effort to reduce physical and psychological risk. However, the authors recognise the implications involved in this, such as knowledge and access to digital technology [35].

During the lockdown, the number of individuals experiencing loneliness increased and was identified as being related to symptoms of both depression and psychosis, as well as substance abuse [28]. Thus, it is crucial to consider interventions to help prevent loneliness, particularly in vulnerable populations such as the elderly [28].

A compassionate approach is essential when addressing the sensitive issue of loneliness, and it is important to overcome the issue of reluctance in raising this topic. Treating the patient as an individual and utilising screening tools to ascertain

the extent to which a patient may feel lonely and to what degree they are affected by this could help in the development of interventions designed to reduce perceptions of loneliness.

Hard-to-Reach Populations/Rural Areas

It is also of great importance to consider the effect of COVID-19 on hard-to-reach populations, many of whom may be elderly and may lack sufficient understanding and information in relation to COVID-19 and access to health care. Hard-to-reach populations may include a number of vulnerable groups including those residing in rural areas, the elderly, and marginalised groups such as migrants.

It is well reported that a number of health care issues can arise in rural settings and that individuals residing in such settings are at risk of engaging in unhealthy behaviours, developing chronic disorders, and suffering from poorer mental health than those residing in urban areas [36]. In addition, such populations encounter problems regarding access to primary care physicians and specialist treatment, together with a lack of health care facilities [36].

A paper by Petrie et al. describes how health services engaged with small rural communities in Australia, Canada, Sweden, and the USA during the early part of the COVID-19 pandemic. The authors' aim was to share knowledge regarding workable initiatives so as to provide an element of positivity for rural communities. As part of an ongoing project, these authors sought to identify the conditions under which local health and care services can take responsibility for the design and implementation of service models that would meet local needs. Petrie et al. discuss the importance of collaboration and connection, not only within local communities themselves but also with private businesses, social enterprises and higher-level government. In addition, they emphasise the importance of levels of knowledge and familiarity of local environments together with elements of creativity in the use of limited resources, including technology [37].

The pandemic has led to a focus on telemedicine, but as suggested by Rush et al. it is unclear how effective this has been within rural communities. In a cross-sectional study designed to address this question, Rush et al. invited participants residing in rural Canada to complete an online survey. Most of the participants stated that they did have access to telemedicine, however around one-fifth of them reported that they lacked access to online mental health services [36]. It was clear from this study that participants preferred face-to-face consultations and did not wish for telemedicine to replace these, leading the authors to conclude that the effectiveness of telemedicine among residents in rural areas is partly dependent on their willingness and ability to engage in such care delivery [36].

In attempting to understand the impact that COVID-19 has had on PHC in rural areas in central China, Zhang et al. conducted a qualitative study with clinicians and patients in two rural areas. The findings that emerged from this study indicated that PHC clinicians faced considerable strain due to additional workload resulting from a requirement for them to focus on screening, tracing, and educating in relation to

COVID-19. In addition, face-to-face consultations were reduced and there was a lack of alternative contact options such as telemedicine, which was partly due to the fact that many of the patients were elderly and unwilling to change to an alternative consultation approach [38].

Overall, PHC clinicians reported many changes to their traditional way of working with and treating patients, owing to the new role of PHC in relation to epidemic prevention and control [38]. The authors conclude that under the circumstances, PHC could benefit from further support from non-medical staff to assist with epidemic control in order to allow practitioners to devote more time to diagnosis and treating patients. In addition, it is important to improve access to basic PHC services, especially for elderly residents who may not be able to travel, or those who cannot afford to travel [38].

In a study by Eshareturi et al., authors examined the experiences of marginalised groups regarding their health and well-being in relation to COVID-19 restrictions. Sixty-four individuals participated in the study, via a telephone survey whereby findings emerged that indicated adverse effects in relation to socio-demographic factors and deterioration in health. Problems in relation to gaining access to essential supplies and food were also indicated, as well as confusion regarding government public health announcements. These authors highlight the importance of ensuring support for marginalised groups including access to essential supplies [39].

In recognition of the difficulties that migrants might have in relation to access to primary care during COVID and barriers such as language problems and confusion, Knights et al. conducted a study to investigate the views of PHC professionals and migrants who had resided in the UK for less than 10 years. This qualitative study demonstrated that both PHC professionals and migrants felt that digital technology had increased inequalities in relation to access to health care, mainly due to access to and understanding of such technology, together with language barriers. Problems were also raised by migrants in relation to COVID-19 vaccination, whereby they demonstrated a number of beliefs, potentially resulting from misinformation [40]. These authors suggest that as the changes that have taken place within primary care as a result of COVID might become permanent, it is important to ensure additional support to migrant groups to address both access to services and hesitancy with regard to the vaccine programme [40].

It is therefore important to acknowledge the needs of vulnerable and hard-to-reach populations and to provide appropriate information in an understanding and compassionate manner in order to ensure the physical and mental well-being of such groups, particularly during and after the COVID-19 pandemic.

Organisational Factors

In a paper published prior to the COVID-19 pandemic, Fotaki raised the question as to why and how compassion is necessary to provide good quality health care. Fotaki discusses the fact that although there is a link between compassion and quality of care, it is not so clear as to how compassion can become a sentiment at a moral level,

influencing the values that underpin ethics of care. Fotaki argues that although we may recognise the important role that compassion plays in the morality of the individual health professional, this may conflict with the policies of the organisation. As such encouraging compassion among doctors and nurses is likely to be effective only when specific policies are in place to support and nurture the concept. Thus, recognition of the importance of compassion may not only require some form of education and training, but also appropriate policies within the health care system to enhance and cultivate the concept [41].

In commenting on the paper by Fotaki, Lionis suggests that it would be useful to explore the modification of the perceived behaviour of health care practitioners by focusing on family physicians. Furthermore, Lionis raises the possibility of incorporating a cognitive approach to explore the interrelation between individual motivation and social structure. Lionis further suggests addressing the question as to whether current belief systems can be changed by intervening in the social norms of medical practice or providing a convincing argument that a novel incentive-based setting may enhance the probability of a compassionate performance [42].

Furthermore, in response to Fotaki, Shea suggests that encouraging a compassionate approach should extend across the entirety of the organisation, including administrative staff, hospital managers, auxiliary staff, and policy-makers. As such, there is a need to extend education programmes and training regarding compassion to everyone involved in the health care setting to ensure that a compassionate approach is experienced not only by patients, but also by all members of the health care team [43].

Hofmeyer et al. draw attention to the fact that compassion is at the core of good medical care and that it not only benefits the recipient but also the provider, which is a potential reason why people may be attracted to working in health care. Where there is compassionate communication, there is also higher morale, more effective teamwork, and greater patient satisfaction and safety [44].

Due to the COVID-19 pandemic, many retired health care workers have demonstrated a willingness to return to the workplace to care for patients, leaving their own safe environments to do so [44]. As such, Hofmeyer et al. correctly suggest that these individuals should be assured regarding the safety of their work conditions and be provided with personal protective equipment and working conditions to reduce burnout. Addressing these issues is of great importance in order to maintain compassionate health care and patient satisfaction and safety.

Lloyd-Smith suggests that even though an organisation may be well prepared, it is impossible to anticipate all potential situations and engage in advance preparation for such events. During unexpected situations, the organisation will be met by an extreme lack of time regarding planning and implementation and as such organisational improvisation is required in the form of spontaneously finding solutions. Thus, Lloyd-Smith suggests that moving away from normal tight structuring, by allowing autonomy and providing encouragement to enable frontline workers to act spontaneously, leaders may increase the likelihood of overcoming challenges such as those that have arisen as a result of the pandemic [45].

As discussed by De Zulueta, a compassionate approach is central to human well-being. Adopting a compassionate culture within the health care system has positive effects on well-being and stress reduction, ultimately improving patient outcomes. De Zulueta suggests a shift from the 'organisation as a machine' to that of a 'living, complex system' adopting a culture which is compassionate in design and leadership, and which is inclusive and encourages good teamwork. This is especially important in times of crisis such as COVID-19, to allow for optimisation of patient care and to allow key health care workers to thrive [46]. In conclusion, De Zulueta raises key issues in terms of the important evidence that points to the positive effects of a compassionate culture including increased well-being, engagement and retention and improved patient outcomes. As such, compassionate leadership that offers emotional support to buffer stress, and that encourages a clear vision and a sense of belonging is crucial [46].

In addressing the Greek public health system, Giannopoulou and Tsobanoglou refers to challenges faced regarding organisational structure and the need to strengthen primary care and social support to enhance capacity and meet unmet needs. Giannopoulou and Tsobanoglou discuss the economic crisis that Greece has faced for some time, and how the health system was already struggling when the COVID-19 pandemic arose. Giannopoulou and Tsobanoglou therefore suggest the development of new models and approaches in the delivery of mental health care. Giannopoulou and Tsobanoglou further report on the impact of the pandemic on the Greek economy and the risk to mental health associated with this. However, as COVID-19 has exposed the gaps and limited resources in the health care system, an opportunity has arisen to re-think the organisation and delivery of services [47]. This may involve a more integrated system involving coordination between primary, secondary, and tertiary levels of care.

In conclusion, it is crucial to recognise the needs of health care staff so that occupational stress can be addressed, and a compassionate culture can be sustained [44].

Solidarity and the COVID-19 Pandemic

In a recent Opinion on effective ways of investing in health, the EC Expert Panel [48] explored the concept of solidarity from both theoretical and implementation perspectives with a focus on health emergencies and how the principle of solidarity is enshrined in European Union (EU) law (2021). It summarised a set of recommendations, including the following: 'The EU could invest more in strengthening integrated people-centred primary care including availability of interdisciplinary work, information and communication capacity and technology, prevention, health promotion and management of chronic care and vulnerability and as well as health care of socially isolated groups'. This repeats the Opinion that was compiled within the first year of the pandemic and it underlines the importance of focusing on vulnerable and isolated groups. This represents another indication of a need to focus on communication and compassionate care skills.

Concluding Remarks

Within this chapter, we began by looking at the traditional role of PHC, and the importance of a compassionate approach within the PHC setting prior to the unprecedented event of the COVID-19 pandemic.

We then went on to discuss the unforeseen changes to PHC delivery, and a number of situations and circumstances that need to be considered and reflected upon both now and in the future. These have included: the use of telemedicine and digital technology; the vaccination process and hesitancy; the persons' health literacy, and existing mental health conditions; the concepts of loneliness and isolation; hard-to-reach populations; organisational factors; and finally, the importance of solidarity.

COVID-19 has forced PHC professionals to change the way they think and operate and has introduced challenges and obstacles representing a learning curve for everyone. Perhaps now, more than ever, a compassionate approach is crucial for the protection and welfare of both patients and those involved in their care.

Into Practice

- Be aware of unexpected crises that might occur, and how PHC delivery may need to adapt to meet the needs of patients and their families.
- Promote listening skills which may prove crucial in situations whereby the advantages of observation and non-verbal communication may not be available.
- Re-think the structure and organisation of PHC and continue to monitor the effectiveness and problems associated with telemedicine.
- Encourage an understanding of the local population, including respect for their prevailing beliefs and promote sharing of the fears and needs of the individual.
- Consider the impact of any crisis on mental health and enhance the capacity of PHC to deal with mental health issues.
- Overcome the issue of reluctance in raising sensitive issues such as loneliness or potentially prevailing negative thoughts
- Acknowledge the needs of vulnerable and hard-to-reach populations and provide appropriate consultation and support.
- Strengthen an integrated people-centred approach to PHC, which focuses on communication and compassionate care skills.
- Ensure recognition of the needs of health care practitioners so that occupational stress can be addressed, and a compassionate culture can be sustained.
- Encourage care which is inclusive and promotes good teamwork.
- Consider the individual's family and social networks as important supportive mechanisms to alleviate daily stress and enhance connection and compassion.

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Compassionate Critical Care: A "3C" Model

6

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Learning Objectives

1. To understand the basic principles of CCC and how it is applied in the critical care setting.
2. To learn about end-of-life concepts in critical illness.
3. To apply the concepts learned in creating the environment for CCC to be learned, practiced, audited and propagated within an educational/professional environment.

Learning Bites

- Critical illness encompasses great and long-standing physical, emotional and spiritual suffering for critically ill patients and their families/carers who need a holistic therapeutic approach.
- Suffering starts upon patient's admission to the ICU with a life-threatening condition and is peaked when end-of-life decisions are needed, or long-standing disabilities are sustained, but it does not end with patient's discharge or death.
- All the above impose great deal of spiritual and psychological stress, also, to HCPs, which, if not relieved, can lead to burnout and can seriously affect fitness to practice amidst an unprecedented staffing crisis in health care.
- CCC is a model of care that is posed to alleviate suffering using a holistic and human spiritual approach and is proposed as an advantageous model of care that addresses the needs of patients, families and HCPs in parallel and in interaction.

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Introduction

Patients' and their families' suffering in the hospital environment, but especially in the Intensive Care Unit (ICU), leaves none untouched, and has recently gained public awareness during COVID-19 pandemic. The ICU is from the psychological perspective an inimical environment for both families and patients and potentiates the intrinsic to critical illness's stress and anxiety. Most stressful environmental factors referred concerning the patients include levels of noise, the light cycle, mobility restriction, life sustaining technologies and social isolation [1]. As far as it concerns how family's stress is generated, there is vast literature that refers to a number of reasons except of the obvious -life danger-, including watching the patient in a comatose state, unable to communicate with them, circumambient with wires and life-support equipment, as well as dressings, lack of clothing, changes in colour and body oedema [2].

Patients' and their families have needs that include not only physical (somatic) comfort and touch as far as it concerns the patients, but also psychological support for both parties. It is thus imperative for us as Health Care Professionals (HCPs) to identify, assess and address these needs. HCPs are expected to provide help by kneeling over their suffering in a humanistic way by enhancing their communication techniques, by considering the patient as part of a broader family system. In other words, ICUs are admitting families not critically ill patients as isolated human units!

Family members'/carer's direct and indirect involvement in patient's care is fundamental for both patients, family and health professionals as it builds trust, alleviates suffering, reduces stress and contributes to a better distribution and sharing of the role of patient's advocate, particularly when difficult decisions are to be made and patient's views and values are expected to be respected. Moreover, family is expected to play a key role to patients' wellbeing after hospitalisation, and should be empowered and strenghthened to undertake this role. In order to achieve a smooth communication and mutual understanding, corroboration should be made that HCPs are there to assist and support the decisions taken and choices made by patients and their families, by supporting them despite any conflicts in personal, religious or socialbeliefs.

Compassionate care today, despite gaining ground, faces important challenges that became iconic during COVID19 pandemic with patients dying alone, without their families, or a supportive hand in the cold and impersonal environment of an Emergency Department or an ICU. Health care systems are increasingly overwhelmed and staffing levels are dangerously affected from an international crisis in HCPs careers. The aforementioned can lead to poor quality of care and unprofessional or inhuman behaviour towards patients [3] and can promote turning a blind eye towards their family and their needs. This could also extend to and undermine community care and sustainability of post-hospitalisation plans as mentioned above, increasing readmission rates and cost.

Effective application and delivery of compassionate care would not happen as it would be part of a wish-list for the ideal model of care, but requires relevant

systematic training of ICU HCPs from the very beginning of their educational journey. Furthermore, CCC is a model of care that should be incorporated into daily practice in ICUs and audited accordingly using dedicated, pre-defined outcomes, ideally through interprofessional interaction [4]. The presence and contribution of a licensed clinical/health psychologist professional can greatly facilitate CCC and prevent conflicts in its application. The model of care based on regularly scheduled clinical rounds using multidisciplinary teams including a psychologist (as opposed to an ad-hoc referral scheme) has been extensively tested and documented in our department for a number of years [5], yielding extraordinary results at all levels, including care of the minor members of critically ill patients' families [6].

ICU Environment

The ICU environment is a complex setting, intended to treat critically ill individuals. It is a fast-paced environment, with a multitude of biomedical monitoring and life-support equipment. HCPs involved in patient care in such a setting are specialised in using such equipment, acting swiftly and proactively on 24 h basis to maintain life using advanced technologies and techniques, some of which are non-invasive, but frequently quite invasive. Patients are typically sedated (ideally lightly) and are connected to the abovementioned monitoring and life-support systems that support their breathing, circulation, renal function, etc. Noise is frequently at a high level due to constant alarms and interventions as well as managing emergencies. Day and night cycle is frequently broken and patients' level of consciousness/pain fluctuating intermittently in a not well predicted way. As a result, pain, shortness of breath, disorientation, confusion, even delirium is quite frequent, particularly in elderly patients, or those with predisposing factors like previous/hidden cognitive and mental health problems.

It has been recognised that the ICU setting as described above can become quite stressful for all the "residents" of this environment, including the families who as mentioned before should not considered as plain visitors [7]. This depends on patient's condition, stage of critical illness and decisions to be taken, particularly regarding the end-of-life or long-term / permanent disabilities. Due to their intense need to be there for their beloved person, in many cases, family members neglect themselves and might compromise their wellbeing and health. The way the above challenges are managed during patients' hospitalisation will also impact the long-term outcomes of patients', families' and HCP's mental health and quality of life.

Concept of Compassionate Care and Difference with Empathy

As there is a rising concern worldwide about the (in)human care we provide in ICUs, the CCC concept is increasingly recognised as a unique ingredient of a more human model of delivering care, which can have positive impact on patients, families and HCPs. Although it sounds like this concept has emerged only in the recent

years, there is a body of evidence that compassion is a trait in human behaviour throughout history. Considering the story known as Roman Charity, which depicts the compassion showed by a daughter towards her father, who was imprisoned and sentenced to death through starvation. The daughters' actions of compassion, by breastfeeding her father, surprised the judges and as the old man survived his sentence, made them to change their heart and set the man free.

According to a Dictionary of Modern Greek, commonly known as Babiniotis Dictionary, the word compassion, which in Greek translates to "symponesi" or "symponia" (modern Greek), means the emotional solidarity and practical expression of sympathy towards someone and the awareness of their pain. Sympathising someone means you support him emotionally and feel his pain. The most commonly used definition of compassion is when there is sensitivity to someone's suffering or pain with the desire to relieve the suffering. The definition encompasses a number of qualities due to its long association with major religions and philosophies. Such qualities are empathy, sympathy, kindness, respect and above all act in order to relieve someone's suffering. There is suggesting evidence that this particular approach changes the brain response to stress, alters the pain threshold and intensity, aids faster acute illness recovery, and improves chronic illness' management reducing anxiety [3].

It is an important part of nursing ethos, and viewed by important historical figures such as Florence Nightingale, to be a moral virtue and substantial quality which nurses should possess [8]. Although empathy is one of the qualities of compassion, yet there is a significant difference among them. Empathy is a widely used word but with a variety of meanings, depending how it is used. Such meanings may be, the capability of someone to intuit others' feelings, others reflect emotional conveyance, or even it may refer to the distinguished emotional experience which will motivate an altruistic action. That said, the word of empathy may serve as a mediator, a cause, or even as an outcome in several models of good behaviour, whereas compassion refers to the witnessing of someone else's suffering and subsequently impels an exertion to help. Even though it is usually experienced as a positive fortitude, it can also be described by a primary moderating influence as an answer to someone else's anguish [9].

Health Care Professionals Role in Providing Compassionate Care

HCPs provide care to patients and families, in a number of settings and communities, serving the ill and needy. Due to the continuous evolving of medicine, technology and medical equipment, their work has become increasingly complex and demanding. Furthermore, staff shortages, set barricades to care and overwhelms HCPs, making their routine and even emergency, direct patient care related tasks impossible to complete. Studies had shown that patients can feel lack of connection, lack of consideration, lack of compassion and can become alienated from nurses, relegating nursing care [3]. In that respect, compassionate care is considered as the

main ingredient in providing quality health care to patients and the most precious gift to them [10]. Compassion thus becomes the ultimate motivation to act to reduce suffering in oneself and others. Furthermore, it is also related to lower level of work-related stress and burnout [11]. Consequently, using compassion in everyday practice helps not only patients and families but also the HCP and by extension health care organisations and systems. Failing in using compassionate care in daily practice has been linked with increased patients and family complaints, health care costs and unfavourable outcomes [12].

Value and Goals of Compassionate Carer

The cornerstone of compassionate care lies in understanding the values of the patient and the family, a decisive factor in developing a healthy relationship with the care team that honours and dignifies the person [13]. This will be achieved through the constant reminder that HCPs care about unique human beings, who need to be heard and understood without judgement and be handled in a gentle way. Who also need to be believed when they express physical or emotional distress, without belittling what they feel and how they express it [14]. HCPs must also accept that a patient or a family member has their unique life story, their own—frequently complex and at times conflicting—feelings, their own cultural beliefs and also their own way of thinking that originate from their life experience.

There is a vast literature describing that due to the ICU environment and the critical condition of patient's health, feelings of anxiety, uncertainty, post-traumatic stress disorder (PTSD), depression and many other psychological issues are risen among family members. Many of them are experiencing such feelings in such intensity, that it ends up with their debilitation, many of them being unable to continue their life [15, 16]. HCPs have the most interesting and most demanding role in order to prevent and also manage the patients and family's symptoms, taking into consideration people's relationships, contemplating the patient and his family as a unit and putting them at the centre of the care process [17].

Enhancing Communication Between HCP, Patients and Family

Communication is the process of sending and receiving information with verbal or nonverbal means between individuals and such a skillset in effective communication is imperative for HCPs. Communication between HCPs, patients and families should be established right from the beginning in an effective and seamless way. The information delivered to both patient and the family should be clear, frequent, structured and in understandable terms. In order to achieve this, HCPs should assess their health literacy, cultural understanding and language of understanding [18] in order to convey information about medications, the use of medical equipment, invasive procedures, etc. This process can have an indirect impact on outcomes as

effective and timely decision making in critical illness can sometimes make the difference between life and death.

Effective communication is facilitated when patients and family understand current health problem(s). Furthermore, giving time to patients and family to unravel their thoughts and concerns about health problems, outcomes and wishes, without interruptions is advisable and essential part of CCC [19, 20].

Maintaining CCC and Preventing Fatigue in ICU HCPs

According to the Code of NMC 2015 nurses must prioritise people, practice effectively, preserve safety and promote professionalism and trust [21]. It seems that compassion has a set place in the above code. Nurses who provide compassionate care describe feeling joyful and experience personal indulgence. Despite experiencing those feelings, there are times that could be feeling compassion fatigue which includes manifestations of anxiety, depression and emotional distress [22].

There are strategies which could be embodied to sustain compassionate care, including acknowledging the limitations of provided care in the environment, setting and date. Such advice could be:

(A). Estimation of self-care importance in managing the compassionate care provision ability, checking if personal values are proportioned with HCPs and code of practice in workplace.
(B). Clarification of the most important values, deploying self-care strategies and habits to enhance compassionate ability.
(C). Identifying the source of upholding personal values and acknowledging self-care needs and strategies in order to meet them.
(D). Understanding human values diversity as well as adaptness, while reflecting on how personal values may prejudge interactions and relations between patients and co-workers.
(E). Encourage staff to engage with sustainment and mentor peers.
(F). Secure a safe place/time for sharing personal experiences and cases maintaining confidentiality and data protection.
(G). Explore which strategies could be introduced in workplace and could enhance the procedures in care provision, while understanding and accepting the variety of personal and professional values.
(H). Furthermore, bethink creatively how current practice, thoughts, or actions may deform ideal values and behaviours [23].

Into Practice
Medical and nursing students

1. Integration of CCC in the curriculum of critical care teaching/basic nursing teaching as well as teaching of critical care nursing (MSc programmes).

2. Learning of compassionate care skills and behaviours as essential part of clinical skills.
3. Compassionate care testing in the context of end-of-life OSCE stations.

Doctors and Nurses in Training

1. Professional Development Courses on Compassionate care and prevention of Compassion fatigue and burnout.
2. Include CCC in the assessment model and skills required to sign off for the Certificate of completion of specialist training (CCST)—for doctors, and corresponding certification for nurses.

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7 Communicating Genuine Empathy for Compassionate Care: A Case for Identity Exploration, Congruence, and Inclusive Organisational Cultures

Alice Araujo

Learning Objectives

1. Highlight the challenges related to and benefits of communicating genuine, meaningful empathy to patients.
2. Encourage medical trainees and professionals alike to engage in identity self-exploration in a manner to help them bring their authentic selves into their interactions with their patients.
3. Underscore the need for healthcare organisations to explicitly adopt and foster cultures of inclusion and psychological safety for all its members in order to facilitate their authentic expression.

Introduction: The Expression of Genuine Empathy in Healthcare

> Seek out that particular mental attribute which makes you feel most deeply and vitally alive, along with which comes the inner voice which says, 'This is the real me,' and when you have found that attitude, follow it.
>
> William James, American philosopher, 1842–1910.

The central role of empathy in the provision of optimum healthcare and an understanding that multiple factors can facilitate and impede its effective expression have been clearly established in the medical education and clinical communication literature [1–4]. It is also commonly accepted that empathic understanding and the

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expression thereof can be effectively learned [5–9]. Yet medical students and physicians alike often struggle to recognise empathic opportunities and to compassionately communicate understanding of patients' perspectives in a manner that they themselves and their patients, respectively, feel and perceive to be genuine [10–13].

In my experience training medical students in clinical communication skills, the verbal and nonverbal expressions of genuine empathy can often be experienced as by far one of the most challenging aspects of a patient-centred medical consultation, particularly in the early stages of medical training but arguably for seasoned medical practitioners alike, particularly when most of the latter may not have had the opportunity to undergo training in clinical communication skills. When prompted for potential challenges and desired areas of feedback from their peers and facilitator in preparation for role plays, medical students often identify the expression of empathy among those. Similarly, in both formative and summative exams, otherwise successfully performing students are nonetheless sometimes puzzled and discouraged by the empathy deficit feedback from simulated patients and examiners. Stilted, not uncommonly unconvincing, though well-intended expressions of empathy and altogether missed empathic opportunities can confound those who earnestly attempt to convey their concern about the well-being of their patients, actual or simulated. At times, one can almost detect the proverbial "wheels turning" as trainees eagerly work at striking the difficult balance between effectively structuring their consultation and integrating learned clinical content while responding to concerns elicited from their patients in a manner that helps them build needed rapport with them. In the process, key empathic opportunities are routinely missed.

Sometimes lacking in confidence and consequently engaging in "doing empathy"—as in an item to be crossed off a checklist of duties—many students may understandably and unwittingly focus on the structural aspects of a consultation and on accurately covering relevant content relating to the clinical aspects of a case at the expense of equitably attending to those of the relationship with the patient. In doing so, they may inadvertently overlook the importance of patient-specific, meaningful verbal feedback to patients which transcends textbook-like statements and inappropriately brief acknowledgements that can come across as contrived and sometimes irrelevant (e.g. "I understand" and "I'm sorry to hear that"), or (e.g. "Okay" and "Right") when a much more helpful response to the information elicited about a patient's concern might sound more like, "I can see why [this potential diagnosis] has been on your mind because of your parents' medical history"/ "because of what you have come across in your online search". Accompanied by nonverbal expressions consistent with new understanding of the patient's perspective, these statements can then much more genuinely and successfully contribute to establishing a fruitful and rewarding interaction for patient and practitioner alike.

Research in medical education has indeed uncovered difficulties with the expression of empathy as an area of weakness for medical students, particularly in the early stages of training, when their own perceived ability to convey care, concern, empathy, and sensitivity has been found to be lacking [8–11]. Similarly, skills involved in managing the emotional aspects of interviews with patients were found to be primarily those medical trainees believe themselves to use least often and least

successfully [11]. In a study of third-year medical students' handling of challenging encounters with difficult patients, trainees found themselves resorting to less effective "reductive" behaviours that did not meet the needs of their patients as a result of feeling overwhelmed and frustrated by the difficult situations and in spite of otherwise behaving empathically towards them [13].

Further research elicited simulated patients' and volunteer outpatients' perceptions of the expression of empathy along with first-year medical students' own experiences practising those [10]. Several challenges that can impede their ability to convey empathy during the early years of their training were reported. Among those were handling anxiety about multitasking while conducting patient interviews, which made it more challenging to identify empathic opportunities and appropriately respond to them while managing the structural aspects of the consultation and tracking the content of patient responses; and scepticism over the need and usefulness of formal training to express the intrinsic compassion they felt for patients—which was positively transformed in the course of their studies. Moreover, students in the study emphasised verbal aspects of their communication with patients whereas the latter identified nonverbal communication as even more important to them in conveying the true meaning of an empathic response.

Additionally, and crucially, simulated patients identified the ability of a provider to take on the perspective of the patient as essential to their sense of being truly understood. Students who recognised empathic opportunities that others had not and extrapolated the impact of a symptom or experience beyond what they as patients had shared, positively stood out to these patients. In setting aside their own concerns to fully step into the patients' shoes, they were able to accomplish what many of their peers had not yet managed. This meant "avoiding becoming emotionally compromised such that they would be unable to think rationally, or becoming too removed such that empathetic statements would seem disingenuous" (p. 4). As a result of these findings, the authors singled out the healthcare provider's skill at working through their own sense of vulnerability as a central element in establishing a therapeutic relationship with patients.

Being able to convey genuine empathy in a manner that was received by patients as such hinged upon students' ability to more mindfully stay in the moment while interviewing them. As they responded to empathic opportunities and became more comfortable with their own expressions of empathy, trainees reported finding themselves relaxing and experiencing those responses as more natural to them. As argued elsewhere in countering the notion of conveying empathy as excessively time consuming, when embedded in the medical professionals' *attitude* towards the patient, it does not detract from but instead enhances a routine medical consultation [14].

In spite of the significant success in communicating with patients authentically and meaningfully experienced by trainees who adopted an openness to the experience of staying present and embraced empathic opportunities, some students nevertheless reported finding a sense of safety in the idea of having "back pocket" phrases in mind. Relying on such phrases during intensely emotional moments with patients or when genuine responses were not emotionally available to them served to cognitively free them to communicate empathy more effectively [10].

The expression of empathy has been regarded as part of healthcare professionals' "emotional labour" [14, 15]. The term, coined by Hochschild in her influential 1983 *The Managed Heart: Commercialization of Human Feeling* [16], refers to the management of emotional affect that organisations often require of workers—such as flight attendants and bill collectors—for job-related purposes, such as to enhance customer satisfaction and profits through the presentation of a given desired image or style. Applied to healthcare, the assumption is that, because it is not always possible for a physician to empathise with a patient, by practising a combination of "deep and surface acting" techniques s/he may, over time, learn to convey empathy in a manner that is more likely to be felt and perceived as more authentic. In deep acting, in turn, healthcare professionals would attempt to actually modify their internal experience to then respond according to actually experienced emotions; in surface acting they would simply fake their emotional displays by forging facial expressions, voice, and body language prior to and while interacting with patients [15].

Notably, although used as a defence against stress and possibly done with what is perceived as the patient's best interest in mind, this brand of "fake it till you make it" interaction was viewed by Hochschild as an occupational hazard that came at a cost for the obliging employee, who became estranged from his/her feelings. Moreover, as Hochschild pointed out, it is through feelings that we connect with others. The idea of acting to artificially affect perceived required emotions in the medical consultation stands in direct contradiction to the notion of coming to grips with one's own sense of vulnerability and opening oneself at the moment to the specific experience of the patient in order to understand their perspective as fully as possible.

Indeed, while recognising that further research is needed to shed more light on particular behaviours that may or may not lead to genuine empathic interactions with patients, Halpern [17] cautions physicians against what she regards as a "trend toward encouraging superficial acting or other routinized approaches to substitute for genuine empathy" (p.305). Instead, in arguing that doctors may not be able to experience "full blown affective-cognitive empathy" as this experience is not entirely under their direct control, she advocates for the cultivation of empathic practices that are clinical context-specific and practical, such as the acknowledging and correcting of "interpersonal errors". An awareness that doctors' "unconscious emotional processes" may affect what they may believe to be professional judgements and decisions and will better protect patients from projections of their healthcare providers' own personal issues and concerns such as feelings of anxiety and discomfort. To that end, she proposes the cultivation of "engaged curiosity"—in line with what Guidi [18] subsequently named "empathic concern"—through which "affectively engaged communication" can facilitate the clinician's cognitive goal of understanding the patient's unique perspective in a way that will better serve both doctor and patient [17].

The practice of active, "skillful empathic listening" [17] involves attending closely to patients' communication to be able to repeat back to them using their own words rather than trying to impress them with the command of their field. It requires

a clinician to be truly present and open to learning about the perspective of the patient. Training in mindfulness can facilitate multitasking during the clinical consultation, but also enhance clinician's awareness of one's own nonverbal communication and emotional state, aid in developing deep listening skills, as well as help alleviate physical and psychological symptoms that can adversely impact the quality of patient care. Mindfulness skills, which are increasingly and credibly being promoted in medical schools, are seen as essential in helping clinicians negotiate challenging situations in healthcare and free them up to more genuinely experience and express empathy to patients by allowing them to bring a higher quality of attention/presence in their interactions with patients [17, 19].

This paper argues that the ability of medical care providers and trainees to express empathy that can be perceived as genuine hinges on a sense of provider authenticity, both as experienced by the self as well as perceived by the other—simulated patients and actual patients alike. Taking the time to explore the psychosocial experience of patients in relation to their symptoms and expressing genuine and meaningful empathy to them is often assumed to be an unrealistic ideal in the context of the high-pressure demands of healthcare institutions, and therefore taxing to medical professionals. Research instead suggests that as doctors tune in to patients' feelings, this form of communication, if combined with competence and in the appropriate setting, can also serve as a potentially protective factor against burnout [20].

Authenticity, Identity Development, and Congruence in the Communication of Genuine Empathy

Effectively expressing genuine empathy that will be interpreted by patients as such requires from the self-reflective medical practitioner both professional and personal self-awareness [6]. The experience of an authentic self is necessarily anchored on an identity development process that allows an individual, typically starting in adolescence but potentially continuing throughout the lifespan as a result of inevitable changes, intended or otherwise, to explore meaningful alternatives about who they are and what they believe. In James Marcia's view of identity development, although role-specific in its timing, such a process is necessary before individuals show a personal investment in the direction of their future by making a commitment to values, goals, and behaviours. As one negotiates various choices, an often unsettling but nonetheless healthy period of crisis or conflict (also known as exploration) ensues. In an attempt to avoid the discomfort of crisis or exploration, some individuals choose safer, and more predictable traditional paths without more independently considering which ones they might forge in their lives, thereby prematurely committing to an identity and foreclosing it. In doing so, individuals miss the opportunity to reach the more authentic experience of what Marcia termed identity achievement, which follows rather healthy and open-minded exploration [21]. Lacking enough identity exploration latitude, one may be left to uncritically and passively accept an ascribed identity that does not necessarily express one's authentic self.

This is not to suggest that medical students and professionals who experience difficulty in conveying empathy in a manner that resonates with their authentic sense of self or/and that is perceived as genuine by patients have not appropriately explored career options. Although this might be the case for some, Marcia's theory may rather provide a framework for considering how their own expressions of empathy to patients might be perceived and experienced by the latter, as in their capacity as healthcare providers they may prematurely foreclose their identity as more authentic communicators by adopting an externally generated style of "professionalism" that they experience as false and that similarly rings hollow to patients, simulated or real, alike.

It is this discrepancy between one's true ideal self and how one may express oneself to a patient that psychologist Carl Rogers (1957) identified in the context of the psychotherapeutic process as incongruence. Along with empathic understanding and what he termed "unconditional positive regard" for the client, Rogers argued that congruence or genuineness was essential for a constructive and meaningful therapeutic relationship with positive outcomes for those seeking help. Crucially here, he nonetheless did *not* consider therapist complete and constant congruence as a prerequisite for establishing genuineness in the therapeutic relationship: "It is not necessary (nor is it possible) that the therapist be a paragon who exhibits [a full] degree of integration, of wholeness, in every aspect of his life. It is sufficient that he is accurately himself in this hour of this relationship, that in this basic sense he is what he actually is, in this moment of time". The process of genuinely accepting the client and his/her experience with unconditional positive regard thus begins and unfolds in mindful presence and as an organic extension of therapist self-acceptance—"unconditional positive self-acceptance" [22, 23].

In his person-centred approach, the therapist's congruence communicates a façade-free sense of authenticity to the patient that allows both parties to be themselves in one another's presence. The more congruent the therapist is, the more emotional space is freed to accommodate the client and the better one is able to genuinely empathise with the other and communicate such empathy accordingly [24]. More than a set of skills ("listening, accepting, understanding, and sharing"), Rogers' approach can be understood as an orientation more than a prescriptive set of guidelines [25].

Regarding therapist congruence as a primary component to the expression of genuineness, Rogers considered the ability to bring into the therapeutic relationship a quality of presence that would allow for the expression of feelings and attitudes to the client as appropriate to be key to congruence. In that sense, he clearly identified the therapist's quality of communication with clients as a reflection of one's internal feelings such that authenticity entailed a balancing of individuality and interrelatedness. Others have subsequently likewise regarded the source of the authentic self as both self-referential and other referential so that dimensions of each can contribute to how we interact with others and view ourselves, including when views of one's authenticity are involved. Regardless of how others appraise someone's authenticity, our own sense of congruence or feeling true to one's true and ideal self will have an impact on how we relate to others [26, 27].

In interpreting Rogers' approach to the therapeutic relationship, Proctor [24] concluded that achieving congruence ultimately serves to free the provider of care to present themselves in an authentic presence with the other: "The more our awareness is open to ourselves, freely, the more a freedom and a capacity will exist to listen to others in a way that might be unusual or rare. It is as if openness to ourselves, in a state of congruence, takes less cognitive energy than incongruence, and in turn, this energy then becomes available to be used in a relationship with others" [24]. In line with Hochschild's work on the expression of inauthentic emotions [16], resisting the expression of one's more authentic self can be exhausting. Instead, genuine relationship building with patients should ideally energise and fuel the work of care rather than drain the healthcare worker by the compassion fatigue of emotional labour.

The importance of healthcare practitioners communicating with their patients in a manner in line with what they experience as their authentic selves—including their values and communication style—cannot be underestimated but it requires exploration in the Marcia vein and a sense of self-acceptance. Rogers' person-centred theory suggests that feelings of inauthenticity and maladjustment are experienced when individuals act in a manner inconsistent with their perception of themselves. A foreclosed sense of identity (Marcia) will therefore predispose a professional to lack the confidence to express him/herself in a manner that they experience as genuine and devoid of "front".

For most in the medical profession, training both implicitly and explicitly promotes a framework of neutrality rather than authenticity, rendering practitioners "frequent abettors of [an] imagination of professionalism that, for [them and for their] patients (…) supplants a 'who' with a 'what'", in the process risking the erasing of their authentic selves [28]. The author regards this ethic of neutrality as a paradox, promoting both objectivities in medicine and what she terms "an individualistic distortion of authenticity". In an optimum work environment, a "work self" version sharply distinct from that which one will display to others in the company of close ones such as friends and family will not be present [29].

Bringing someone else's prescribed sense of professionalism into consultations will invariably fall short of establishing a genuine connection with a patient and over time drain the medical professional. Given healthy and contextually appropriate boundaries, expressing one's more authentic version in light of potential vulnerability may in fact protect one from the common experience of burnout among healthcare professionals [29]. Empathic care and professional behaviour need not function in mutually exclusive modes, particularly in the context of patient-centred care.

Halpern [17] argues for the importance of physicians to cultivate "empathic curiosity" about their own emotional reactions and about what they might be missing about their patients' experiences of distress since both have an impact on professional judgements and decisions. In addition to that, doing so can help doctors avoid projecting their own personal issues and concerns onto patients. Based on Gordon's (1998) notion that one's sense of authenticity emerges from a belief that one's private and public lives reflect one's true self, Vannini and Franzene [26] concluded

that individuals may conversely enact behaviours that commit to identities that may not feel authentic to them.

Among graduate and undergraduate medical students, as well as matriculating medical students earlier on, a highly prevalent form of inauthenticity known as impostor phenomenon (IP) was identified. This was observed particularly, but not exclusively so, among first-year women [30] and among female, feminine, and undifferentiated individuals [31]. In research on women in science, among other male-dominated fields, it has been found that, regardless of gender, sacrificing their authenticity by acting "like a man" placed them at an advantage in becoming a leader in their fields [32]. Rosenthal et al. found that the incidence and degree of imposterism only increased throughout the first year of medical school. Defined in the study as inappropriate feelings of inadequacy among high achievers who struggle to "internalise their accomplishments and take ownership of their success" [30], this maladaptive aspect of one's self-concept has been linked to personality traits associated with psychological stress. Notably in both studies, higher IP scores were significantly associated with lower scores in the areas of self-compassion, sociability, self-esteem, but higher scores on anxiety. However, as a "malleable personality construct" [30], IP has been shown to be successfully addressed through interventions that include supportive feedback, collaborative learning, faculty mentoring, as well as those that facilitate self-compassion, such as individual counselling and support groups, along with mindfulness [30, 31].

Training in the practice of mindfulness, sometimes promoted to help medical trainees deal with multitasking-related anxiety [19], has received increased attention as it is being integrated as an important part of training in medical schools such as the University of Rochester Medical School in the USA and Monash University in Australia in a variety of formats [19, 33]. As a practice of conscious cultivation of non-judgemental awareness, such training has been found to be effective in lessening negative emotions and stress while boosting mindfulness, empathy, and self-compassion. Mindful training thus also has the potential to benefit those afflicted by stressful feelings related to imposterism by promoting greater self-compassion and therefore self-acceptance.

Cultivating a Culture of Inclusion in Healthcare Organisations

> When we hire a diverse population of caregivers, then we're able to learn from one another. Once a person knows that their truth is going to be respected, then we can be in each other's space and not have to hide significant portions of ourselves [34].

A focus on the importance of the authenticity of self for the communication of genuine empathy should not be inferred to minimise the key role healthcare organisations can play in creating normative cultures of compassion [35] and inclusion. An inclusive culture not only accepts but also values and regards as a strength the difference that each member contributes to their institution [36–38]. At the heart of inclusion is the extent to which all members feel that they belong, have a voice in

their organisation and are treated equitably [39]. This means that they feel connected to one another and to their institution and believe they can bring their full, authentic selves to work and feel safe to express themselves without fear of judgement [37, 38]. In the same way that authentic expression is predicated on one's commitment to self-exploration and congruence, a sense of belonging is predicated on the organisation's unwavering commitment to inclusion.

Organisations that foster inclusive work environments hire individuals representing a wide range of aspects of human diversity, visible and otherwise, and clearly communicate to employees, both through stated policy, practice and uncompromising espoused values, that each person is valued, respected, and appreciated for their unique and individual strengths, their lived experience and perspectives [37, 40]. In addition, the key to an inclusive organisation is that its members are encouraged to have a voice on topics that matter [41]. The most inclusive teams have been found to be those that reward thoughtful contributions and encourage collaborative behaviours [42]. These ideals can only be actualised to the extent that members feel comfortable speaking up and sharing new ideas, anchored in a climate of psychological safety [38]. In a study on what makes teams most effective, Google [43] found psychological safety to be by far the most important factor [36, 38, 43]. In such an environment, members are comfortable being and expressing themselves in congruence with their own sense of authenticity and shared belief that they can take interpersonal risks—including asking questions, sharing ideas and admitting mistakes—without feeling insecure or embarrassed or fearing failure or retribution [32, 38, 44, 45]. Longitudinal research on workplace engagement around the globe by Gallup [37, 38, 46] further revealed that the most productive workplaces share a common trait—a culture where each person feels that they belong, in that their unique and individual strengths are valued. The research group also found that encouraging people to be themselves is the most important factor in inclusive environments [46]. A culture of belonging and inclusion, therefore, supports authentic expression in a climate of psychological safety [36].

Inclusion is increasingly being viewed as a prerequisite to organisational excellence—what Harvard University terms "inclusive excellence" [47]. Organisations that foster inclusion enjoy advantages such as increased job satisfaction, higher retention rates, greater organisational commitment as well as higher levels of trust, well-being, creativity and innovation. In addition to these benefits, lower levels of conflict, intention to quit, stress, job withdrawal and organisational turnover have further been documented [46, 48]. A culture of inclusion can thus serve as a resilience factor for individuals in the context of the conspicuously intense pressure from numerous stressors in medical training as well as problematic work environments in healthcare organisations.

Operating in a medical culture that may implicitly assume professionalism and authenticity to be mutually exclusive, many healthcare providers may conceal their anxiety about effectively empathising with patients. They may do so by putting on a front and donning a "professional" façade in an attempt to convey the desired empathic response and embody the professional attitude they may have come to believe displays compassionate care.

Healthcare organisations can actively promote a climate of psychological safety that may influence how clinicians are expected and able to acknowledge not only medical and technical mistakes [45] but also "interpersonal errors--like being too abrupt or blunt with a patient, which [one] need[s] not fear acknowledging" [17]. Rather than implicitly managing the emotional displays of employees in the service of organisational efficiency, healthcare organisations can instead choose and some have already chosen to invest in the promotion of a more inclusive and a compassionate approach to care as part of their uncompromising core values [49]—what they commit to standing up for and practising on a daily basis [39, 48, 50].

In spite of the cultural shift challenges of pivoting from a workplace culture of incivility to one of compassion and inclusion, healthcare organisations that do not embrace and promote inclusion implicitly signal to practitioners that less collaborative and even non-collegial approaches to care and co-worker interactions are acceptable. Different scholars have proposed organisational interventions and approaches that promote cultures of compassion, inclusion, and an ethic of hospital(ity) in healthcare. In recognition of the increased rates of workplace bullying and disharmony in healthcare organisations which alienate and demoralise members and detract from optimum performance, Simpson [51] proposed an organisationally positive approach to consciously promoting compassion across the organisation in order to re-humanise it. His supportive mechanism-specific model details a range of individual and institutional processes and practices for the systemic enactment of compassion throughout the organisation and by all of its members, employees and leaders alike. Others have similarly addressed the role of organisations in cultivating cultures of empathic, compassionate care. In arguing that the responsibility for compassionate care must be shared by the organisation rather than being left to the individual to fulfil, Dutton et al. [35] offered a 5-mechanism model of socially coordinated compassion organising as a healing response to members' pain and trauma. The model promotes the deployment of existing organisational structures designed for daily work in the institutional social architecture in support of individual agencies for dealing with these issues. Tracing back the history of faith traditions of hospitality from which healthcare institutions originated, Ellis [28], in turn, argues against the push for neutrality as good patient care as an individualistic distortion of authenticity. She favours a "welcoming of strangers" patient care ethic of hospitality as a "communal and normative pursuit", part of the institution's core values that every member abides by and that can also be activated in times of stress and crisis.

A commitment to the kind of inclusion that encourages the authentic expression of empathy must be part of the company's uncompromising core values embraced by all levels of leadership and enacted by all members on a daily basis [35, 38, 49]. The inclusion commitment must be intrinsic to the organisation, not only in a "this is who we stand for" fashion but also as a "this is who are" explicitly verbalised commitment [50] that guides and reflects healthcare professionals' lived daily experiences.

As a leadership-driven goal but one of shared responsibility at all organisational levels, making empathy central to company culture has been identified as the most

important inclusive leadership skill [40, 52, 53]. A dedicated Inclusion (or Inclusion & Diversity) Office with assigned officers who regularly assess and monitor progress towards measurable goals with built-in accountability is considered essential in the process. Caution has been recommended against hiring outside consultants to set up benchmarks, as the involvement of those who work in the organisation, have a better understanding of it and can share their perspectives on relevant topics of interest is needed [41]. Other interventions healthcare organisations can offer in support of their goals of meaningful inclusion include eliciting regular anonymous feedback, coaching and mentoring, instituting confidential private helplines, and conducting regular educational programmes such as unconscious bias training, as well as forming coalition employee groups to avoid isolation and to facilitate approaching leadership with suggestions with an enhanced sense of empowerment [54]. Healthcare organisations such as the Cleveland Clinic and the Moffitt Cancer and Research Institute have been repeatedly recognised as high-performing inclusive cultures [39] using a variety of approaches to the cultivation of inclusive organisational cultures.

The complexity of bringing one's authentic self to work in the absence of a truly inclusive climate of psychological safety must not be underestimated. In a Harvard University research study, 37% of African Americans and Hispanics and 45% of Asians said they "need to compromise their authenticity" to conform to their organisation's demeanour or style. Another study that included women in science revealed that no matter the gender, "acting like a man" can improve one's chances of advancement [32]. As noted earlier, a climate of psychological safety is a prerequisite to authenticity in the workplace and therefore requires one to place oneself in the vulnerable position of trusting others. As put by Brene Brown in the context of discussing systems of exclusion and oppression, "when we ask people to 'take off their armour' we may be asking them to do something that is not emotionally or even physically safe in all environments (…). Everyone deserves brave and safe spaces to be [able to be] vulnerable" [55]. In an inclusive healthcare organisational context, members can more safely communicate with genuine empathy in their interactions with patients and colleagues in a way that, rather than saddling them with a sense of depletion leading to compassion fatigue and disillusionment, instead infuses their work with the vibrancy of authentic presence.

Conclusion

In this paper, attention to inclusion serves as a means to highlight the foundational role of institutions in cultivating an inclusive healthcare organisational culture in which all individuals feel safe to express themselves in ways that resonate as authentic to them and is perceived by their patients as intended. An ongoing process of identity exploration that rejects premature foreclosure in the interest of the achievement of identity authenticity is an important developmental component to enable healthcare providers to experience a sense of congruence more often than not. Ultimately, the communication of genuine empathy in patient-centred care must

necessarily make room for as broad a diversity of styles and lived experiences as there are individual healthcare professionals.

Into Practice

Individuals

1. Engage in self-reflection regarding authentic expression not only with patients but also in daily life in order to bridge existing gaps.
2. In the same vein, explore one's own communication of empathy in all personal and professional interactions alike.

Educational Institutions

1. Integrate self-reflection into the application process for educational programmes in the various areas of healthcare.
2. Encourage self-exploration and self-awareness as part of continuing professional development of healthcare practitioners.
3. Emphasise and encourage individual differences of style and lived experience and encourage authentic expression in communicating with patients.

Healthcare Professional Training

1. Conduct/take advantage of clinical communication and basic counselling skills training to home in medical practitioners' ability to effectively communicate genuine empathy.
2. Conduct/take advantage of mindfulness skills training in order to enhance self-awareness, and self-acceptance, listening skills, along with quality of attention and stress management skills.
3. Engage in consultation recording as well as constructive peer feedback and private viewing for additional perspective contingent upon patient informed consent.
4. Embrace training opportunities as part of one's professional development.

Organisations

1. Explicitly promote a culture of psychological safety where all employees and trainees are appreciated for their individual differences and encouraged to be their unique authentic selves.
2. Make a culture of inclusion an explicit value and mission in the organisation and capitalise on it as a distinguishing strength: "This is who we are".
3. Offer educational programmes in areas such as cultural competence and unconscious bias as well as conflict management, intercultural communication, and clinical communication skills more broadly.
4. Regularly solicit anonymous feedback from employees to safely facilitate the sharing of relevant individual experiences.

5. Promote employee empowerment to fend off individual isolation by establishing resource groups to approach the leadership in support of the development and maintenance of a more inclusive and productive work environment.
6. Institute an Office of Inclusion/Inclusion and Diversity to evaluate current practices, as well as to identify systems to be put into place for the daily practice of inclusion and to establish specific, measurable goals and accountability, then monitor their progress.

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Organising Compassionate Care with Compassionate Leadership

8

Ace V. Simpson, Tamara Simpson, and Jane Hendy

Learning Objectives

1. Define compassionate leadership and its implications for healthcare practice.
2. Contrast healthcare delivery supported by compassionate leadership as compared to the toxic healthcare environment that arises in its absence.
3. Reflect on examples of efforts to promote compassionate leadership in the UK's NHS.
4. Advance a research agenda by considering the implications of different theoretical lenses (power, paradox, conservation of resources) for compassionate leadership research and practice.

Introduction

The aim of this chapter is to provide an account of the significance of compassionate leadership for healthcare practice. Compassionate leadership can be defined as a process wherein a leader *Notices* signs of suffering in their reports, *Empathises* with it, *Appraises* the suffering to understand its circumstances and *Responds* to address it (NEAR) [1–3]. The UK's National Health System (NHS) and the effects of the COVID-19 pandemic provide a context for our discussion. Generalising from this context, we hold that the issues considered here are relevant more broadly to healthcare systems across the world even outside of the pandemic context. Research on the effects of COVID-19 on NHS staff suggests a view that "the pandemic had

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exposed a deficit of 'softer' people skills" in NHS managers [4]. It has been further identified that to date "leadership development programmes often neglected the tools and techniques that managers needed to identify, address and resolve challenging people issues". The NHS has been seeking to address these concerns at a national level by investing more resources in staff occupational health and wellbeing, equality and diversity initiatives, working closely with the unions and improved communications to ensure employee voice and engagement [4].

The experience of COVID-19 has reinforced changing leadership expectations in healthcare that were developing even prior to COVID, where there were growing calls for compassionate leadership that is less concerned with efficiency and budgets and more concerned with the resilience and wellbeing of those impacted by leadership decisions [5, 6]. COVID-19 has precipitated a shift in power relations in working lives, making the usually invisible labour of minimum wage and casual (including in healthcare) workers more visible as "essential workers" [7]. For the NHS, the disruption imposed by COVID-19 has been seen to represent "a limited window of opportunity" for developing "improved communication, greater organizational agility, creative use of new technology, enhanced employee voice and deeper stakeholder partnerships" [4]. Bringing in a new working environment advancing compassionate leadership requires reimagining leadership as a co-created enactment reducing power distance by advancing inclusiveness, dialogue and feedback loops. We explore some of these implications in this chapter.

We structure the chapter by initially providing a background of the general poor work culture often found in the UK NHS (and healthcare more broadly even outside of the UK). We include within this review a description of efforts that have been made to address this in the NHS by promoting compassionate leadership. Next, we discuss the existing limited literature and theory on compassionate leadership. In this context, we also consider the more developed research literature on organisational compassion, whence theorising about compassionate leadership tends to draw. Acknowledging that current research on compassionate leadership is limited, we explore some implications and research questions that emerge from viewing compassionate leadership through theoretical lens of power, paradox and conservation of resources. We conclude with final reflections on the importance and significance of further researching and cultivating compassionate leadership in healthcare.

The Need for Compassionate Leadership in Healthcare

The need for cultivating compassionate leadership in the NHS is reflected in the consistent overrepresentation of bullying and harassment over many decades [8], with the latest findings reporting that in 2020 12.4 percent of NHS staff reported having been bullied by managers and 18.7 percent reported bullying by colleagues [9]. These findings are not isolated. Outside of the UK research has found that, relative to other occupations, bullying and workplace harassment tends to be more prominent amongst healthcare workers [10, 11]. A survey of 762 registered nurses conducted in the Australian healthcare context suggested that 61 percent of

respondents had experienced at least two bullying instances in the prior 12-month period [12]. Whilst nurses appear to bear the brunt of bullying behaviours in healthcare, they are by no means the only victims. In a study involving 747 Australian doctors, 25 percent reported experiencing some form of bullying within the 12-month period prior to the study [13].

These findings are surprising considering that a motivating factor for healthcare workers entering the profession is the virtuous intention of serving humanity with compassion [14]. The need for upholding strict standards is sometimes given as an excuse for bullying in the healthcare context. Where lives are at stake there is no margin for error. Interestingly, counter to this justification, research suggests that a key variable in enhanced patient outcomes is carers feeling psychologically safe, with psychology safety defined as "a shared belief that the team is safe for interpersonal risk taking", or "a team climate characterized by interpersonal trust and mutual respect in which people are comfortable being themselves" [15]. For Worline and Dutton the psychological safety research suggests the importance of a workplace culture of compassion in contributing to superior performance [16].

Returning to the NHS context, a series of reports commissioned in the 2000s, including the Francis Report [17], the Keogh Review [18], and the Berwick Review [19], sought to identify the underlying cause of the endurance of poor relational issues in the NHS. These studies (and others like them) have underscored systemic issues of resource constraints, a leadership focused on meeting quantitative targets and balancing budgets over listening to staff concerning their needs in doing their jobs, and a toxic blame culture amongst managers and staff as underlying causes of constrained employee voice, low trust and overall poor work relations [20, 21]. These factors were also seen as contributing to high levels of employee absenteeism, sick leave, compensation claims and turnover, all of which are known to erode staff morale, wellbeing and the quality of patient care [22]. In other words, bullying and compassion are not just considerations of individual character, they are also informed by organisational practices of leadership, culture, values, routines and resourcing [23].

Efforts to improve work experiences in the NHS over recent years have included the development of internal mediation services, cultivating a learning culture, and working with staff and unions to quickly resolve tensions, as well as highlighting the need for more compassion, including compassionate leadership, in interpersonal dealings. Regarding the latter, in 2012 Jane Cummings, Chief Nursing Officer for England NHS Commissioning Board and Director of Nursing Department of Health, along with Viv Bennett, Lead Nurse, Public Health England, responded to these findings by launching "Compassion in practice" as a 3-year vision [24]. Their report, based on engagement with 9000 nurses, midwives, care staff and patients identified "Action Area 4: Building and strengthening leadership" as one of six action areas critical for cultivating an organisation wide culture of compassion. A follow-up 2014 report "Building and strengthening leadership: Leading with compassion", also by the Chief Nursing Officer for England NHS [25], sought input from influential nurse leaders from across England to "identify key areas that we needed to progress in relation to leadership" (p. 3). The report recognised the development of leadership that supports a culture of compassion in healthcare as a

complex "wicked problem" (p. 10), one that cannot be solved with a single "attribute, force or mechanism". It recommended that interventions for cultivating compassion ought to target four levels: "(i) the self; (ii) the manager/leader; (iii) the team; and (iv) the organisation, and usually must be targeted at all four for compassion to truly thrive" (p. 7). A "Developing People – Improving Care Framework" was subsequently launched by The National Improvement and Leadership Development Board (2016), which has representation from 13 healthcare-related organisations including the Department of Health, Public Health England, NHS England, NHS Health Education England, NHS Leadership Academy, NHS Improvement, National Institute for Healthcare Improvement (NICE), Local Government Association and the Care Quality Commission. One of four critical capabilities the framework focused on was developing: "inclusive and compassionate leadership, so that all staff are listened to, understood and supported, and that leaders at every level of the health system truly reflect the talents and diversity of people working in the system and the communities they serve". The relational tensions that surfaced in the NHS by COVID-19 despite the release of various strategy documents and frameworks for developing compassionate leadership over the years, reinforce that enacting culture change is not easy in practice. It also begs the question, what is compassionate leadership?

What Is Compassionate Leadership?

Understanding of compassionate leadership builds on the theorising and findings of the broader discipline of *organisational* compassion research over the past couple of decades (for a review see Dutton et al. [26]). Organisational compassion scholars discuss compassion as something that arises within a context of suffering [27]. Intrinsic to the human condition, suffering can manifest from any number of causes including personal circumstances of grief on the death of a loved one or a relationship break up; personal loss or injury from natural or human-made disasters or workplace accidents; or emotional pain experienced from relational conflict, including in the workplace. Compassionately addressing workplace suffering, through efforts in which leadership frequently plays a significant coordinating and sanctioning role [28–30] is generative of significant positive physical, emotional, relational and professional performance effects (Fig. 8.1). Amongst these are the hastening of post-trauma healing [28, 31]; enhancing connection, altruism, motivation, pride and loyalty [32–34]; promoting perceptions of leadership effectiveness and superior decision-making [35, 36]; and boosting organisational performance levels [37]. Within the healthcare context research has found that individual experiences of compassion are associated with higher levels of affective staff commitment and positive emotion [33], improved sleep quality and subjective health, reduced work-related stress and reduced workplace bullying [38]. Organisational compassion research has identified that compassion from a leader, signals that those with the power to provide resources that might facilitate coping and recovery are attentive to situations of distress [29].

Fig. 8.1 Some effects of workplace compassion and by inference compassionate leadership

Compassionate Leadership as a NEAR Process

Organisational scholars approach compassion not merely as an emotion or even as a virtue but rather as a collective process that comprises four NEAR subprocesses: *noticing* the suffering of a colleague, *empathising* with their pain, *appraising* their circumstances to understand their situation better, and *responding* in the most appropriate manner to alleviate their suffering [39]. Drawing on this definition, compassionate leadership has accordingly been defined as a process wherein a leader enacts these NEAR practices to address their follower's suffering (Fig. 8.2) [3].

Noticing

In noticing, a leader (manager, supervisor) pays attention to signals of suffering amongst those under their charge [30]. Suffering may also be signalled through an explicit call for help, but more often the signals are implicit, indicated through changes in mood, energy, routines, language or behaviour [26]. Outbursts, mistakes and missed deadlines can be blamed on the individual and further compound feelings of inadequacy, burnout and turnover. They can also be taken as implicit cries for help. A respondent cited in a research project on the effects of efforts to develop compassionate leadership capabilities in the NHS observed that emotional intelligence is important for noticing the suffering of their rapports: "Emotional intelligence is vital, and the ability to sense verbal and non-verbal patterns of behaviour – to see when people are with you, and when they are not, or when they have concerns" [25].

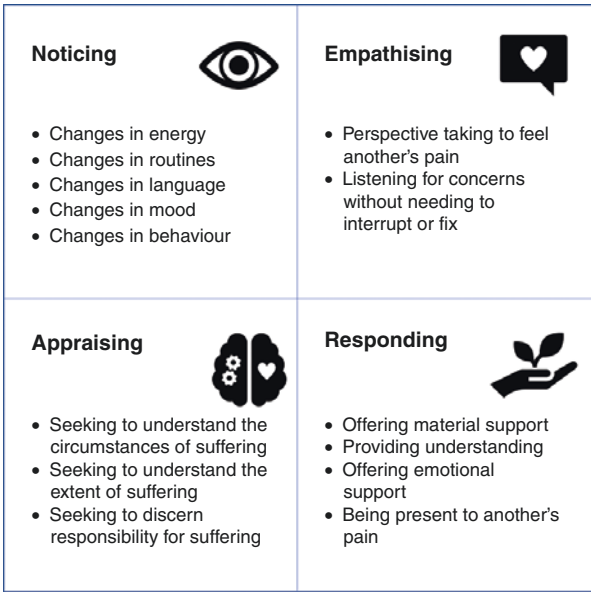

Fig. 8.2 Compassionate leadership can be defined as a leader engaging in NEAR behaviours to address the suffering of their followers

Empathising

A leader empathises with their followers by feeling their struggles, identifying with their followers' sufferings as their own. Figuratively, empathy entails the ability to imaginatively place oneself in the follower's "shoes" or "skin" through perspective taking [26]. Capabilities of self-compassion, mindfulness—or moment-to-moment awareness of feelings or events without passing judgement, as well as active and reflective listening skills can support a leader in empathising with the suffering of those they lead [40]. Empathy can be built into organisational routines through regular team check-ins, as one NHS leader explained: "I run a 'communication cell' each week. It reduces the opportunity for things to get out of control: 'What's gone well or was difficult that you need time from the group on?', 'What are your challenges coming up?' There are some operational bits but the majority is task-related mutual support" [25].

Appraising

Leaders appraise the struggles of those under their charge through an active curiosity about the specific circumstances and causes of difficult work situations that underlay staff suffering [40]. The practical end of effective appraising by a leader is an understanding of the follower's needs and a sense of what can be done to address their distress. Vital to such a process is active listening. Behind individual outbursts of anger, on-the-job mistakes and missed deadlines, there may be personal struggles with systemic issues of under-resourcing, over work, unrealistic time pressures, and

even experiences of harassment and bullying [41]. West, 2019 suggests that compassionate leaders initiate their appraisals with a "default positive assumption that others are good, capable and worthy of compassion – offering the benefit of the doubt" [40]. Even where the leader's appraisal concludes that their report is personally responsible West observes that: "Leaders can withhold blame by steering conversations toward learning".

Responding

Leader's response to the suffering of their followers by acting [29]. When leaders act, it sets the tone for expected behaviour within the organisation, translating precepts into an example that can be emulated by others [30]. A respondent to an NHS study offered this view on the importance of compassionate action by leaders: "Compassionate leadership is as needed amongst commissioners and throughout arm's length bodies, assurance and oversight bodies as their actions can either reinforce and encourage collaborative leadership at the front line or significantly undermine it" [25]. Leaders taking action often entails improvising to provide material resources, including by increasing staff numbers or the procurement of equipment or technology that lessens workloads and time pressures. At a personal level, it might entail approving sick leave, compassionate leave or professional support, or even advance pay. Offering flexible work arrangements is another way that a leader might intervene to address a follower's struggles with work and family responsibilities. Frequently, all that a follower is looking for from their leaders is the emotional support being listened to and understood. A leader can provide emotional support through their presence, standing with followers during their times of individual and struggle.

A Systems View of Compassionate Leadership

Generalising existing organisational compassion research and the NEAR definition to the leadership context is a helpful starting point. However, it has its limitations, particularly for larger organisations such as the NHS where the structures may resist a leader or caregiver's compassion capabilities. As such compassionate leadership must be conceived from a systems view, where compassion is integrated systemically within organisational processes (1): "The 'organisation' establishes the infrastructure, the systems and mechanisms to support (or thwart) managers to enact desired values and behaviours, such as compassion, as they in turn support and guide teams and individuals" (24Of vital importance here are mechanisms of organisational culture, routines (including hiring, promotion, training and development), social structures as well as organisational discourse and communication [29, 42]. In a chicken and egg situation, compassionate leadership is important for championing, initiating, and facilitating such system-wide integration.

Despite the growing literature on *organisational compassion* and an abundance of leadership theorising and models, there still is little academic research on *compassionate leadership,* including within the NHS [1]. Aside from work generalising existing organisational compassion research and the NEAR definition to the leadership context, specific components or testable hypotheses of compassionate leadership have not yet been articulated.

A point of departure outside of the healthcare context is a case study of Jacinda Ardern [43], a world leader who "proudly" self-describes as "an empathetic, compassionate leader" [44] and who has been recognised as such by other leadership scholars [45–49]. Analysis of Ardern's leadership through several crises revealed four characteristics of her compassionate leadership that can be generalisable at a broader level (Fig. 8.3): (1) Compassionate leadership is *idealistic,* based on humanistic values that inform a vision of addressing suffering through societal improvement that provides an authentic purpose to leadership as a calling. (2) Simultaneously, it is *pragmatic* in recognising that leadership is performed as the art of possible, requiring a preparedness to negotiate, to be adaptive and to be decisive when opportunity arises or when swift action is called for (as in a crisis). (3) Further, compassionate leadership is *inclusive* in empathising with and speaking to the concerns and needs of followers and promoting solutions as a collaborative endeavour co-enacted by the leader and followers. (4) Finally, it is *rational* in that initiatives need to be embedded within policy guidelines and operational systems including those of accountability, and to be informed by science. Individually, each of these four areas has their own logic and might be seen to represent an individual leadership style (authentic, autocratic, democratic or bureaucratic). Combined, they involve tensions between idealism vs. pragmatism and inclusivism vs rationality. Whereas tensions

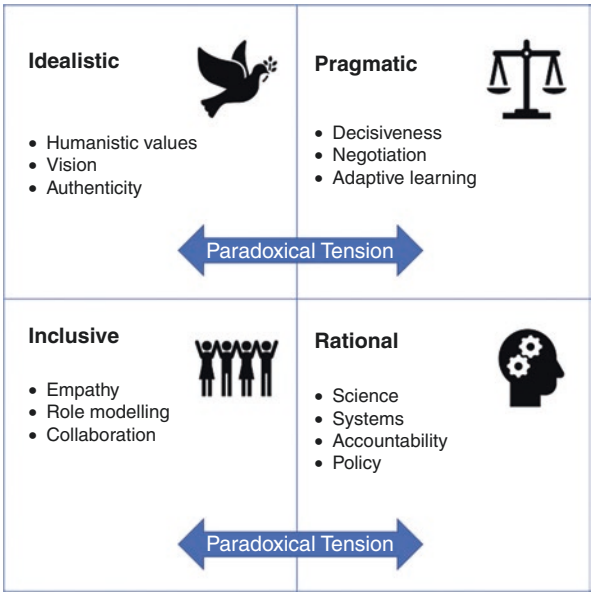

Fig. 8.3 Compassionate leadership, drawing upon and navigating paradoxical tensions between idealism vs pragmatism and inclusivism vs rationality

such as these can act as barriers to compassion [3, 16], effective compassionate leaders embrace these tensions as paradoxes and navigate them through inspirational rhetoric and effective communication.

In the absence of existing models of compassionate leadership derived from longitudinal studies following the intentional development of compassionate leadership capabilities in healthcare contexts, it can be helpful to explore compassionate leadership by viewing it through various theoretical lenses. Such analysis is not only helpful for practice but may also provide insight for developing research programmes. To support such an agenda, we next consider three theories: power, paradox and conservation of resources.

Three Lens for Viewing Compassionate Leadership

Viewing a topic through a relevant theoretical lens opens new angles of vision that contribute richness to an inquiry, as stated by Saunders, Lewis and Thornhill [50]: "Qualitative research conducted through the lenses of interpretivist philosophy will affect the nature of the data produced, with implications for their analysis". O'Brien accordingly compares theoretical lens to a kaleidoscope: "we can see social theory as a sort of kaleidoscope – by shifting theoretical perspective the world under investigation also changes shape" [51]. The three selected lenses discussed below have all been drawn upon in the academic literature to contribute novel perspectives on organisational and leadership phenomena, including compassionate leadership [1] (Fig. 8.4).

Power

COVID-19 has shifted power relations in working lives, bringing attention to the limitations of leadership imposed as domination "power *over*" someone, where only a single managerial voice is considered as valid [52]. Power theorists suggest that leaders can just as well deploy power as empowerment, where people are given

Theoretical Lens	Focus	Applied to Compassionate Leadership
Power	Power is concerned with an agent's capacity to act in a particular manner, to influence as "power over", to empower as "power to" or co-create communal shared "power with".	Compassionate leaders share power by including staff in decision making and empowering staff to voice their concerns and ideas.
Paradox	Paradox are made salient by competing but interdependent tensions. They are manifest in healthcare as hybrid identity were two or more identities or roles are fused.	Compassionate leaders effectively navigate tensions between kindness and professionalism in staff relations.
Conservation of Resources	Conservation of resources posits that suffering arises from threats to resources, actual loss, and a failure to replenish lost resources. Resource caravans are where resource loss/enrichment is followed by further resource loss/enrichment.	Compassionate leaders are attentive to staff/co-worker resource needs (as appropriate) to minimise or address staff suffering.

Fig. 8.4 Viewing compassionate leadership through the lens of power, paradox and conservation of resources offers nuanced insight

the "power *to*" take initiative in following managerial directives. Most effective, however, is when agents create "power *with"* each other as a co-actants in expressing voice and setting the managerial agenda, as envisaged by Mary Parker Follett [53], a female management theorist who was ahead of her time. Follett's [54] circular theory of power espoused replacing bureaucratic institutions with networks of people voicing their views in analysing, producing and taking responsibility for outcomes at each stage of organisational processes. Circular power updates facts in an evolving context, accommodating new interpretations, experiences and insights across time. In leadership, however, the focus has traditionally largely been on *power over* that suppresses employee voice, including within the NHS [20, 54]. Even when voice is encouraged in the NHS, it has often been within limited parameters defined by managerial authority [55, 56]. The same frequently occurs in organisational compassion relations purported to be grounded in a discourse of *power to* [57]. Follett's ideas suggest that addressing suffering with organised compassion in the NHS requires co-active *power with,* co-created initially by listening to the voices of NHS employees and partnering with them in agenda setting [58]. Research on compassionate leadership in the NHS informed by power theory would ask questions such as: *to what extent are staff being more included in decision-making and agenda setting, do they feel empowered to voice their concerns and insights* [1]?

Paradox

A focus on compassionate leadership as co-active *power with* might suggest a leadership style that is weak, sentimental and ad hoc [59]. In contrast, a paradox lens would acknowledge that compassionate leadership often involves navigating interdependent yet contradictory demands of a hybrid identity in a complementary manner by being simultaneously both professional and kind, strong and empathic [23, 60]. Another example of this is the case of Jacinda Ardern's compassionate leadership discussed in more detail earlier [43]. Research suggests managing conflicting hybrid roles is part of what it means to be a healthcare professional [61]. What makes this process manageable is when these role expectations are made salient, and the value differing roles are recognised. Applying a paradox lens to compassionate leadership can bring attention to the tensions that compassionate leaders must navigate and may even leverage to harness the power of oppositional forces towards a unified objective. Compassionate healthcare leadership informed by paradox theory would ask: *to what extent are healthcare managers and staff able to navigate sometimes competing demands for professionalism and compassion in interpersonal dealings*?

Conservation of Resources

Compassionate leadership is primarily concerned with alleviating suffering [1, 28]. The primary cause of suffering, according to conservation of resources theory, is a

loss of resources, defined as anything perceived by individuals that help them to attain their goals [62]. Resources are described as "objects, personal characteristics, conditions, or energies that are valued in their own right" [63]. Internal human resources include "vigour, hope and self-efficacy" providing "energy and motivation to seek and maintain external resources such as supportive relationships" [64]. Other relevant resources include internal locus of control [65], supervisor support [66, 67] supervisory and co-worker support [68], as well as task complexity, personal decision-making and individual autonomy [69]. These resources can enhance followers' resilience and coping and promote physical, emotional and social wellbeing [70]. Conservation of resources further posits resource caravans where resource loss, or loss enrichment, follows further loss or enrichment. Theorising compassionate leadership in healthcare as a process of mitigating suffering by conserving, developing and replenishing staff and patient resources is a helpful way of operationalising the practice and objectives of compassionate leadership. Research on compassionate leadership informed by conservation of resources theory would ask: *to what extent are managers and co-workers attentive to the resource needs of their dependents, colleagues and patients to minimise their suffering*, or *to what extent has addressing resource needs enriched staff and patient wellbeing?*

Discussion

Preliminary research suggests that when healthcare staff are supported by compassionate leaders who provide an opportunity for staff to voice their needs and concerns and are attentive to the resources (including emotional, social, relational, physical) staff require to properly perform their roles, staff commitment, engagement and wellbeing will likely improve [2, 33]. To date, however, we know more about the absence of compassionate leadership than its presence. Less is known about whether compassionate leadership can be learned through staff training and development programmes. If compassionate leadership training is found to deliver significant improvements in developing healthcare managers "'softer' people skills" (Soundry [4], pp. 2–3) by equipping them to "identify, address and resolve challenging people issues", this outcome would constitute a significant research contribution and source of great hope. It would also contribute towards realising the determinations and recommendations of the Francis Report (2013), the Keogh Review (2013), and the Berwick Review (2013), as well as various internal NHS studies, strategies and policy frameworks for developing compassionate leadership [24, 25, 71]. In the meantime, generalising existing *organisational* compassion research to the compassionate leadership in healthcare context is a good starting point. Theorising about compassionate leadership by viewing it through the lens of well-established organisational theories such as power, paradox and conservation of resources can also be helpful.

Conclusions

In this chapter, we have sought to broaden understanding of compassionate leadership in healthcare, using the UK's NHS and the COVID-19 pandemic as a context for our discussion. We structured the chapter by initially providing a background of the poor workplace relationships often found in the UK NHS (and healthcare more broadly even outside of the UK) where workplace bullying and harassment tend to be overrepresented as compared to other sectors and the workforce more broadly. Several NHS reviews commissioned in the 2000s found that even if carers enter the profession with a compassionate intention to help others, if they are not supported by a leadership that values care over efficiency and productivity, it can precipitate a work culture of scarcity and blame and limit the resource of care and kindness that carers have for each other, with patients ending up paying the highest price with poorer health outcomes. This description was followed by a review of various NHS policy and planning initiatives to address this highlighting the need for compassionate leadership in healthcare. We then considered the limited existing research and theorising on compassionate leadership. What does exist at a more developed level is a research literature on organisational compassion describing the positive effects and contingencies of compassion in the workplace, including the finding that leadership plays an important role in promoting and role modelling workplace compassion. It is from this literature that compassionate leadership tends to be conceived of as a NEAR process aimed at addressing the suffering of their rapports. Acknowledging limitations to the current body of research on compassionate leadership we explored some novel insights and relevant questions that emerge from viewing compassionate leadership through various theoretical lenses. We conclude by reinforcing that in healthcare, it is important to provide an organisational environment where leaders are seen to role model compassion and to integrate compassion within organisational policy and practice alongside any efficiency and performance agendas. Compassion like charity begins at home, unless carers are supported with compassion, it undermines the compassionate care they can provide to their patients.

Into Practice

1. Healthcare leaders and managers view addressing staff suffering as part of their responsibility.
2. Leaders can be trained in developing compassion capabilities related to the NEAR subprocesses.
3. A systems view of compassionate leadership must also be maintained, where leaders integrate compassion within organisational culture, routines, social architecture and communication.
4. Resources are required for funding research on the practice, effects and development of compassionate leadership in healthcare.

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Compassionate Care and Health Economics

9

Michela Tinelli and George Samoutis

Learning Objectives

- Understand the importance of evaluating compassionate care to inform decision-making.
- Outline the main approaches to measuring outcomes in economic evaluation.
- Propose discrete choice experiments (DCEs) as an innovative way to evaluate dimensions of compassionate care.
- Provide an example of DCEs to inform health economics for compassionate care.

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Introduction

Healthcare costs are not only growing faster than other costs in economy, but they are outpacing them at an alarming rate [1]. Compassionate care models have been proposed as an effective antidote and they can drive lowering costs through motivating self-care and improving adherence to medication [2]; reducing employee absenteeism [3]; reducing healthcare professionals' burnout [4]; improving self-efficacy, relieving psychological pain [5]; improving patient outcomes [6]; affecting the quality of care [7]; reducing medical errors [8]; and improving patient centredness [9]. As discussed in the introduction chapter, compassionate care creates patient-centredness delivering top ratings.

Debate in the literature on how we can get better at providing person-centred care [10] (such as shared decision making (SDM) and self-management) reports that services must be well coordinated and structured in a way that supports and empowers people to take charge of their health and long-term conditions. However, for it to be person-centred, medical, and social care must show people '*dignity, compassion and respect*'.

From a policy decision-making perspective, the recurring questions to be answered in healthcare service developments would be 'who should do what to whom', 'with what health and social care resources', and 'with what relation to other health and social care services'. The answers to these questions depend on estimates of the relative value of alternative services in terms of patient, but also clinical and economic outcomes. Health economic evaluation uses a range of approaches whereby these estimates of relative value can be estimated and interpreted.

Some instruments have been developed to measure compassion [11]. But, unfortunately, most of them are associated with significant limitations, such as lack of clinical relevance or psychometrically robustness. Also, they usually fail to consider any notion of opportunity cost and constrained choice or strength of preference. Since preferences are usually collected from people with experience of the healthcare received, they cannot be regarded as a societal valuation of the service and therefore employed in economic studies with a larger societal perspective. They also fail to produce any summary measure of utility to be compared across alternatives in an economic evaluation.

The incorporation of a preferences-based measure [12] within an economic evaluation framework is possible and can place a value on compassionate care beyond health outcomes (e.g. QALYs, quality-adjusted life years) into the evaluation and compare results with the standard cost-per-QALY approach.

This chapter describes current practice when measuring outcomes in economic evaluations, comments on its application to compassionate care and provides an example of a preference-based measure developed and applied to evaluate compassionate SDM for diabetes patients. We conclude with final remarks on policy and practice.

The Status Quo: Measuring Outcomes in Economic Evaluations for Compassionate Care

Three main approaches exist to measuring outcomes of use in economic evaluation: clinical effectiveness, quality-of-life measures, and willingness to pay (WTP) [13]. The outcome measure used to showcase the clinical effectiveness of an intervention is usually either mortality or clinical end points, such as reduction in the number of strokes or changes in blood pressure. Health economists use such measures to construct incremental cost-effectiveness ratios (for use in cost-effectiveness analysis, CEA) and measure the incremental cost to be invested per unit of effect (e.g. cost to be invested per death avoided, cost to be invested per stroke avoided or cost per unit reduction in systolic blood pressure).

An example with application to end-of-life care is provided here to illustrate its application to compassionate care. The success of providing compassionate care for patients with cirrhosis and ascites in their last period of life could be measured in terms of cost to be invested per patient month saved. But in case the intervention is proven to be both more effective (reduces 12-month mortality) and cost saving (reduces the global healthcare costs for their management), decreased mortality rates and costs are presented as separate figures [14].

Measuring outcomes in terms of clinical effectiveness has the disadvantage that comparisons between different healthcare treatments (using different clinical effectiveness measures) are difficult. Also using mortality data can be challenging as few studies are powered to detect mortality differences and many treatments affect morbidity rather than mortality. Lastly, even when survival is a relevant measure, it is worth noting that a gain in survival rate may be at the expense of a loss in quality of life.

Measures of quality of life, capturing impact on health-related outcomes (beyond both clinical and mortality end points) are becoming more common. Quality-of-life measures may be condition generic, specific, or generic and specific utility based. All these four categories of health status instruments have their own place in the evaluation of healthcare interventions. In the field of health economics where there is a focus on the evaluation of relative benefits from competing alternatives, the main requirements for an instrument are to be applicable to a range of conditions and patient groups (generic) and to produce a numerical score for overall health status (an index) comparable across alternatives. And usually, economic evaluation focuses on Quality-Adjusted-Life-Years (QALYs) utility-based measures as the main valuation method. According to the National Institute of Health and Care Excellence [15], QALY is defined as '*a measure of the state of health of a person or group in which the benefits, in terms of length of life, are adjusted to reflect the quality of life. One QALY is equal to 1 year of life in perfect health. QALYs are calculated by estimating the years of life remaining for a patient following a particular treatment or intervention and weighting each year with a quality-of-life score (on a 0 to 1 scale). It is often measured in terms of the person's ability to carry out the*

activities of daily life, and freedom from pain and mental disturbance'. Health economists use such measures to construct incremental cost-utility ratios (ICER; see cost-utility analysis, CUA), by dividing the difference in total costs by the difference in QALYs.

$$\text{ICER}\left(\begin{array}{l}\text{representing the economic value of an intervention } i,\\ \text{compared with an alternative}\left[\text{comparator } c\right]\end{array}\right) = \left(\text{total costs } i - \text{total cost } c\right) / \left(\text{total QALYs } i - \text{total QALYs } c\right).$$

Benefits of healthcare interventions can go beyond clinical or quality of life changes and include non-health benefits (e.g. being treated with dignity and respect) or process benefits (e.g. care coordination or continuity care) all important to patients and the public.

Stated preference techniques [13, 16] (such as contingent valuation (CV) and discrete choice experiments, DCEs) can be used to capture all forms of benefits and provide a measure of the benefits in monetary terms (see cost-benefit analysis CBA). With both approaches, individuals are asked to compare different hypothetical situations about the intervention under investigation. For example, with the former, they could be asked directly to state their WTP for in vitro fertilisation (IVF) treatment when presented with different probabilities of success (e.g. *'Assume that you are infertile and can be treated with IVF treatment cycles, while the success rate of treatment is 10%, so how much are you willing to pay for it?'*) [17]. With the latter, they are asked to choose between different service combinations (service A, where effectiveness (probability of success) is 10%, risk of complications is 2% and there is no shared decision making (SDM) vs. service B, where effectiveness (probability of success) is 40%, risk of complications is 5% and there is SDM). The DCE methods can be used to obtain WTP estimates indirectly by including an additional cost attribute (i.e. cost per cycle, Euros) [18].

It is recognised that CV may have a few limitations. For example, it is unable to capture the individual value attached to each attribute of care, since respondents value the service (as a whole) rather than discriminating across specific aspects of care [19]. Information about the importance of individual attributes relative to each other could enable policymakers to adjust new services before their enrolment in practice, or to adapt services already in place to people's preferences avoiding more radical and costly changes to alternative systems. The DCEs technique can help to address this.

Proposal for a Change: DCEs to Inform Health Economics for Compassionate Care

DCEs were introduced into health economics to value aspects of healthcare beyond health outcomes [20, 21]. Since then, their use has increased to address a broad range of applications [22–24] and it can be used in different ways to inform economic analysis in health [25]. DCEs is a quantitative method increasingly used in

health and social care to elicit preferences from participants (users, providers, payers, commissioners) without directly asking them to state their preferred options. Each alternative is described by several attributes or characteristics and the choices subsequently determine how preferences are influenced by each attribute and their relative Importance. It has the potential to provide outcome measures to inform both CUA (utility measures to construct incremental cost-utility ratios) and CBA (WTP estimates for net benefits calculations). Whilst many studies have generated monetary values from a DCE (as part of WTP approach), the application of such values within an economic evaluation is limited, with only four studies identified (none of them with application to compassionate care) [26–29].

But DCE is largely used to elicit preferences and reveal how far people are willing to accept compromises on some outcomes to gain more of other outcomes. It can also help predict uptake to inform policy development and analysis. The technique has been applied to evaluate dimensions of compassionate care with application to hepatitis C testing services in primary care [30], care for older people [31], and more [32]. An example of their use to capture patient preferences for compassionate SDM and inform health policy for diabetes care in England and Cyprus is presented below.

Case Study: Application of DCE to Value the Implementation of Compassionate SDM for Diabetes Care

SDM, as described in the introduction chapter and defined by Coulter et al. [33] as '*a process in which healthcare professionals and patients work together to select tests, treatments, management, or support packages, based on clinical evidence and patients' informed preferences*', is embedded in the English National Health Service (NHS) Constitution as leading person-centred care practice [34]. The Shared Decision Making Collaborative [35] was created by NICE to support the wider health and care system to embed SDM into routine practice. Their action plan includes working with Health Education England (HEE), the Academy of Medical Royal Colleges (AoMRC) & General Medical Council (GMC) to support compassion and encourage the delivery of undergraduate and postgraduate professional training programmes on compassionate care.

In other countries, such as Cyprus, there is an awareness that patients play a crucial role in decision-making, and SDM practices could be considered innovative strategies to promote person-centred health services delivery [36]. Although the implementation in Cyprus proceeds at a pace slower than desired, the participation of patients in the decision-making is now mandated by law. And patients' representatives are now contributing to the NHS board of directors and the public health sector hospitals' board of directors. There is also recognition that encouraging compassion through teaching and learning is crucial to support the humanistic nature and personal values of care, but discussion about the actual development of compassionate-based SDM practices is still in development [37].

A DCE was adopted to understand the preferences of people with diabetes when choosing their care, and how they value compassionate SDM compared to their 'current' option [38]. Preferences were collected in 2014 from patients based in England, where SDM was already in place at national level, and Cyprus, where people were new to it.

This application demonstrated the complexity of patient decision-making when considering their care for diabetes in a community setting. Study findings suggested that people with diabetes value SDM services although the importance of the service features may change across healthcare systems. Cypriot patents valued choosing alternative SDM services compared to their 'current' option, whereas English respondents preferred their status quo (where they had already experienced SDM and shorter waiting times). Receiving 'compassionate care', support from the 'primary physician', 'detailed and accurate information about their care', 'continuity of care', 'choosing their care management and treatment', and reduced 'waiting time' were the service characteristics that Cypriots valued mostly.

The English cohort preferred similar factors, apart from 'detailed and accurate information about their care' or 'continuity of care' that were not valued. Compassion, as an example of a characteristic appreciated by both cohorts, was valued much highly by Cypriot than English respondents (Cypriots were willing to wait 8 more hours to 'receive always care and compassion for their personal situation' (compared with 2 hours for the English respondents). Everything else constant, Cypriot patients valued more an alternative SDM compared with their current one, whereas English patients preferred their current experience to other services.

Further analysis of the Cypriot data set showed that older respondents already receiving SDM from the private sector, valued their 'current' option and they did not want to change it with other services [39]. Younger people from the public sector valued a change in policy and wanted to move from their 'current' to alternative diabetic care services where the waiting times were shorter, they could not only manage their care but also choose their treatments (together with compassionate care, receiving information, and continuity of care). Innovative initiatives on this front have been implemented as the healthcare professionals' education on compassionate care programmes [37] and the teaching of healthcare students on contemporary compassionate care approaches [40].

Conclusion

There are issues with the (economic) evaluation of initiatives promoting compassionate care, mainly related to the lack of utility measures able to capture the benefits of interventions against compassionate dimensions and compared between alternative options. DCE can be applied to evaluate compassionate care and the DCE-based model presented here does appear to be a successful framework to elicit patient preferences for its application to compassionate SDM for diabetes patients. This evaluation confirmed that patients value approaches offering a collaborative

process (through which a healthcare professional supports a patient to reach a decision about a specific course of action) and making sure that people are always treated with dignity, respect, and compassion; the value they place on compassion in delivering of care was scored high across nations. This case study offers an example of the successful application of DCEs to measure compassionate care and can provide common ground for developing a framework to fit the needs of multiple settings and the management of multiple conditions.

Into Practice

- Prospective Medical Students: Short courses on the importance of economic evaluation to inform clinical decision-making online and/or face to face in secondary school.
- Medical Students: Integration of economic evaluation teaching in the curriculum (practical experiments as part of project assessments).
- Junior Doctors: Professional Development Courses on economic evaluation and its application to inform compassionate decision-making.
- Senior Doctors: Professional Development Courses on economic evaluation and practical application to inform their practice.

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Compassionate Spiritual Care

10

George Samoutis, Andreas Anastasiou, and Christos Lionis

Learning Objectives

1. Understand the definition of Compassionate Spiritual Care.
2. Describe the role of Spiritual Care Services in Clinical Practice.
3. Describe the skills and attitudes for effective Compassionate Spiritual Care.
4. Describe the impact of Spiritual care in healthcare.
5. Describe the five key spiritual virtues for compassionate healthcare professionals and Spiritual Care Services personnel.
6. Outline key Compassionate Spiritual Care interventions that can be applied in clinical care.

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Introduction

Before we begin, we would like to present two remarkable and notable case studies.

Androulla's Spiritual Transformation During Cancer Pain

Case 1

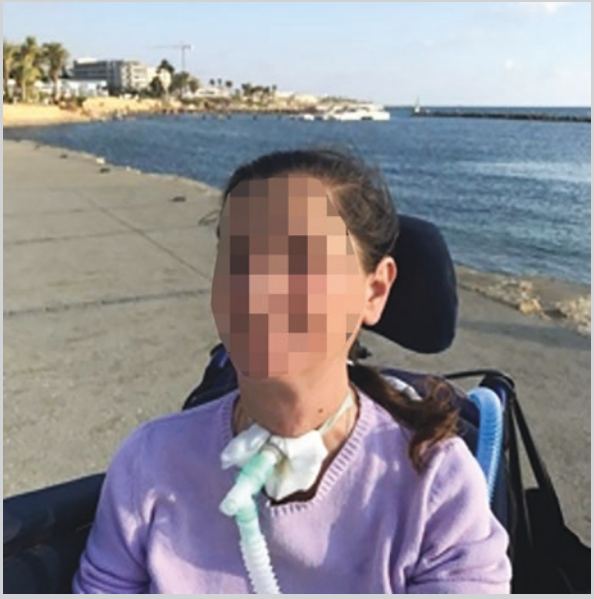
I knew a sixty-year-old Cypriot lady who had cancer. She came to the monastery and told me, "I have cancer. The doctors told me in six months I shall die". I said to her "Androula, then go for the meeting with the Lord, hold on to his word: whether we die or live we are the Lord's (cf.Rom.14:8) and prepare for this meeting. You have six months. Wonderful! It is the moment of your life." She was a woman of prayer. I never console people, "Ah, you will live, it will pass." I say rather, "Prepare for the meeting," even if they live afterward. The woman accepted it and started saying, "Glory be to Thee, O Lord," all the time. One day she said to me, "I want you to promise me just one thing: when I will not be able to come to the monastery anymore, you will come to see me once in the hospital before I die." I agreed, and before she died I went twice. The first time I went she was in a pretty bad state, but very peaceful, and I asked her how she was. She said, "Thanks to God, I am well," even though she was not well—she was dying. She kept saying, "Glory be to Thee, O Lord," and she was saying another prayer that I had asked her to say, "Lord, I am Thine, save me" (cf. Ps. 119:94). "Just surrender to the Lord with this prayer," I said to her, "you do not need any other prayers." After a while, I went to see her again. Her situation had worsened. They phoned me, and I left for the hospital taking Holy Communion with me, although I was not sure if she would be able to partake. I arrived and I saw her: her tummy was like a balloon, from cancer. The only part of her body that was free from cancer was from the throat up. I asked her, "How are you, Androula?" Her face was pale but luminous. She started crying. I was thinking, "Oh, my God, I hope she is not fainthearted." I said, "Why are you crying?" Do you know what she told me? "Am I worthy to be given such a grace to bear this monstrous thing? Who am I? Glory be to the Lord!" She was in such deep humility. She could not thank God worthily for the grace that she had been given to bear that terrible cancer. She added, "My relatives come here thinking to console me, and they disturb my prayer and do not understand it. And the Lord is there – she pointed to the corner of the room – waiting for me." And her soul departed like that, like lightning. After that, I returned to the monastery, and the next day celebrated the Liturgy. During the Liturgy, these words were sounding in my heart: "She is saved." "She is saved." "She is saved." I could hear these words sounding in my heart. And I was crying and could not control myself.

Zacharou, Archimandrite Zacharias.
The Enlargement of the Heart: "Be ye also enlarged" (2 Corinthians 6:13) in the Theology of Saint Silouan the Athonite and Elder Sophrony of Essex. Mount Thabor Publishing

Mirantas Compassionate Spiritual Care from Angels

Case 2

Miranta was diagnosed in 1993 with motor neurone disease completely changing her life and transforming her spiritual state. Miranta is tetraplegic and speaks only via the movement of her eyes. She is the president of the Cyprus Motor Neuron Disease Association helping and supporting an array of patients and more explicitly those with motor neurone disease. She describes her experience in the ICU in the book namely 'the revelation of my life' illustrating her adversity-activated spiritual development and the interconnection between spiritual/compassionate care with high-quality clinical care. "*When I was in the ICU, I considered the two intensivists that were offering me compassionate spiritual care as my angels. They were firstly true human beings and then physicians. Their presence brought me trust, peace, and joy. They never looked down on me, they had peace and compassion and they prayed for me*."



Miranta Symeonidou
The revelation of my life, 2007.

How much we learned by reading both stories; *"My relatives … disturb my prayer and do not understand it"* from the first case. How important it is to listen to patients and respect their ideas, concerns, expectations, beliefs and values. Moreover, involving the family in clinical and spiritual care services is of paramount importance.

"When I was in the ICU, I considered the two intensivists that were offering me compassionate spiritual care as my angels. They were firstly true human beings and then physicians" from the second case. For spiritual care to be truly person-centered, a foundation of compassion is essential. It reminds us that the definition of patient-centered care by the Institute of Medicine; it as includes "qualities of compassion, empathy, respect and responsiveness to the needs, values, and expressed desires of each individual patient. It is inclusive of care that ensures that patient values guide clinical decisions" [1].

The recent COVID-19 pandemic and crisis revealed the inadequacy of a cure-based, biomedical model in healthcare. The impact of this pandemic on the frontline healthcare providers and essential workers invited policy makers to propose a lot of recommendations to alleviate their mental health burden [2, 3]. Current guidelines and policies require healthcare professionals and organizations to focus on a whole-person approach to patients including the body, mind, and spirit [4] and a bio-psycho-social model has been proposed [5]. The findings of several studies support healthcare providers encouraging their patients to explore their spirituality as an effective resource for dealing with the physical and psychological responses to disease [6]. Compassionate Spiritual Care (CSC) can improve a patient's quality of life, satisfaction with clinical care, and even prevent or alleviate the negative psychological impact of hospitalization. Healthcare providers are also benefiting in terms of motivation, work efficiency, well-being, and reduction of burnout risk [7]. It is an actual reflection of the holistic approach, an independent core competence of the discipline of family medicine/general practice [8].

However, CSC and chaplaincy service is currently underestimated and underdeveloped although the benefits on patients' quality of care and providers' self-care are significant and clear. Moreover, communication between chaplains and physicians is rare. Chaplaincy service is primarily reserved for dying patients and their family members rather than providing proactive spiritual care [9]. Effective training of healthcare professionals and chaplains/volunteer spiritual care leaders is a critical success factor in eliciting a patient's spiritual needs and offering personalized spiritual care. Healthcare professionals feel unprepared to incorporate CSC for patients and families in their clinical care pathways [10, 11].

Compassion and Spiritual Care: A Focus on Definitions

Spiritual care is that care which recognizes and responds to the needs of the human spirit when faced with trauma, ill health, or sadness [12]. A person's spirituality is not separate from the body, the mind, or material reality, for it is their inner life. It is the practice of loving-kindness, empathy, and tolerance in daily life. It is a feeling

of solidarity with our fellow humans while helping to alleviate their suffering. It brings a sense of peace, harmony, and conviviality to all [13]. Spiritual care emphasizes the healing of the person, not just the disease. It views life as a journey, where positive and negative experiences can both help us to learn, develop, and mature.

Compassion is a virtue that is tightly connected with the provision of high-quality spiritual care. Compassion as a concept spans more than 2000 years, having a strong association with religion and spirituality. It lies at the heart of most religious, ethical, and spiritual traditions as one of the greatest virtues. It has also been well described by Aristotle (384–322 BC) [14, 15]. Spirituality seems to be a predictor of healthcare professionals' empathetic compassion [16].

Our proposed definition of compassionate spiritual care is a person-centred care that enables unconditional love, humility, gratitude, forgiveness, prayer, and altruistic behavior.

A plethora of studies show that a connection between religiosity, spirituality, and virtues indeed exists [17, 18]. A meta-analysis reveals correlations between religiousness and variables related to moral social engagement such as volunteerism, behavioral help, and gratitude. Additionally, spirituality affects the development of virtues and moral intuitions in medical students [19]. Moreover, an array of studies revealed that individuals who were more spiritual showed increased levels of empathy and were more readily able to forgive and improved their mental health i.e., reduction in depressive symptoms [20–23].

The Role of Spiritual Care Services in Clinical Practice

An array of spiritual care services can be provided via trained chaplains or volunteer spiritual care leaders inter alia crisis intervention, comfort and emotional support, spiritual consultations and guidance, support in decision-making and ethical dilemmas, prayers, blessings, rituals, and sacraments, making arrangements with patients' clergy or spiritual leaders, end-of-life support.

Healthcare organizations need to ensure an appropriate place for prayer, meditation, and reflection as well as spiritual care resources that can be used by patients, family, and team members. Spiritual care resources may include apps, audio offerings, videos, and websites that represent several religious and spiritual traditions and practices.

Additionally, several validated tools can be used to assess spiritual history and spiritual well-being. The Spiritual History Scale (SHS) is a 23-item four-dimensional measure of religious and spiritual practices over the life course [24]. To assess current spiritual well-being, the Functional Assessment of Chronic Illness Therapy Spiritual Well-Being Scale can be used [25].

Finally, professional training (i.e., clinical pastoral education) designed for spiritual care professionals, clergy/religious community leaders of all faiths, and healthcare professionals could be extremely useful in ensuring high-quality spiritual care services and interprofessional communication.

Skills and Attitudes for Effective Compassionate Spiritual Care

We proposed below in table 1 a model with four dimensions of compassionate spiritual care skills and attitudes (Table 10.1).

Table 10.1 Skills and attitudes for effective CSC

Cognitive	Emotional	Behavior	Organizational
– Understand – Enacting therapeutic relationship—promising never to abandon – Treat the other person along their diseased journey as wished to be treated – Effective interpersonal skills – Cultural competence	– Feel the other person's pain alongside them – Peacefulness – Presence during the patient's journey, cry, and laugh together – Resilience, adversity-activated development – Co-existing in the same "place": (physical, psychological, professional, intellectual, and spiritual) where two or more people are invited to enrich one's existential experience	– Respectful not judgmental behavior, acceptance – Attentiveness, good eye contact, body language, dress, manners – Small caring gestures – Self-care – Spending time with the other person – Physical alleviation of the patients suffering – Effective communication – *Prayer, gratitude, forgiveness, humility, altruism*	– Access to spiritual care services to healthcare professionals, patients, and their families, onsite (i.e., within the hospital) and offsite (i.e., via video calls, helpline) – Effective communication between spiritual care (i.e., chaplaincy) services and healthcare professionals (interprofessional learning activities) – Competent training of healthcare professionals and chaplains on compassionate spiritual care

The Impact of Spiritual Care in Healthcare

An array of studies showed that spiritual care is a critical part of providing whole-person care [26], subsequently having a beneficial impact on patient's quality of care [27, 28]. Furthermore, spiritual care seems to facilitate self-care, disease prevention, and improves chronic disease management [29–32].

Spiritual care can successfully impact a patient's mental health. Spiritual care programs decrease anxiety levels in patients suffering from severe diseases with the greatest effects on emotional and mental aspects of the patients [33] studies have suggested that spirituality can increase the patients' resistance to mental health crises following the diagnosis and treatment of cancer [6].

Additionally, patient satisfaction is strongly related to access to spiritual care. Patients tend to rate care more poorly if their spiritual needs are not adequately met [34, 35]. Finally, addressing spiritual issues of patients is required by national guidelines [36, 37].

It is very important that we "adjust" the dose of our compassion and our participation in the suffering of our patients based on our physical, psychological, and spiritual strength in order to avoid illness and compassion fatigue. Abundant evidence found spiritual care to be potentially protective against burnout and mental health problems. Competent training on compassionate spiritual care should be offered to reduce burnout and improve the well-being of HCPs [38–41].

Five Key Spiritual Virtues for Compassionate Healthcare Professionals and Spiritual Care Services Personnel

There are several papers that stress the capacity needed to provide spiritual care. In one of them, Julie Lepianka underlines that "*when we have the courage to contemplate, connect and collaborate, we can transcend the physical dimension of care*" [42]. It implies the existence of several skills or better virtues and this section highlights the following 5 key spiritual virtues that can provide broad guidance of a compassionate ethos for HCPs and Spiritual Care Services personnel (i.e., chaplains). It can be included in their relevant training courses and cultivated in clinical practice.

Humility is an extremely important virtue in spiritual and compassionate care. By learning to humble yourself, "going down," someone can overcome passions, become a better listener, improve empathy, and enact therapeutic relationships with patients. It is the opposite of narcissism to be shown to be prevalent among healthcare professionals, especially physicians [43–45].

Moreover, through humility, we understand better our limits and thus can better take care of ourselves and prevent burnout and compassion fatigue. If you are proud, you do not admit your mistakes, you do not ask for help and you try to cope with every case not appreciating its limitations. You aim to increase hope, faith, and love in the heart of his/her patients while at the same time he/she "go further down" becoming humbler. HCPs benefit more when they remain selfless and do not expect a reward from the patients/society.

Gratitude

> Once I went to the hospital to have an operation and I thought I would try what the Fathers say. In the week after the operation I was convalescing in the hospital, and all the time I was there I said no prayer but "Glory be to Thee, O Lord. I thank Thee, O Lord, for all things". And it was so beautiful there that at the end of the week I did not want to leave the hospital [46].

Gratitude is strongly related to eudemonic well-being [47] and its practice can help patients and HCPs to adjust, cope, and adapt positively to various life changes following traumatic experiences [48]. Moreover, gratitude reduces HCP's burnout as it is suggested to be a sufficient and necessary condition for workplace happiness [49, 50].

The role of gratitude is also vital in enacting a therapeutic relationship. The find-remind-and-bind theory of gratitude suggests that the positive emotion of gratitude serves the evolutionary function of strengthening a relationship with a responsive interaction partner. Gratitude is important for cultivating meaningful relationships, especially with our family, colleagues, and patients [51].

Forgiveness

A fundamental ethos in spiritual and compassionate care. Pride is the main obstacle to forgiveness. Forgiveness in interpersonal relationships is a spiritual need for patients with severe chronic diseases, i.e., cancer. Successfully addressing forgiveness concerns can improve mental health in chronic disease patients [52].

The role of forgiveness in the physical health of patients is also important and well-documented [53].

It is evident that there is room for forgiveness interventions that can be successful and positively change depression, stress, and anger. Forgiveness treatment can also improve satisfaction with life, subjective happiness, and psychological well-being [54]. Interestingly self-compassion is related to self-forgiveness. An array of studies suggested that self-compassion or self-forgiveness may weaken the relationship between negative life events and self-harm [55]. Moreover, evidence shows that forgiveness and compassion are effective in healthcare professional commitment [56].

Prayer

Spiritual care may help healthcare professionals to be able to listen to their patients prayerfully, console them, and switch their thoughts away from misery and hopelessness reducing, therefore, their suffering and misfortune in their health. Findings indicate that private prayer, when measured by frequency, is usually associated with lower levels of depression and anxiety, and appears to be a coping action that mediates between religious faith and well-being and can take different forms [57].

Furthermore, many anecdotal reports indicate that when a HCPs is purely praying for the suffering of their patients and feels in his/her heart repose and joy, which may be a positive predictive sign that his prayer may have a beneficial effect. If our prayer is to transmit therapeutic energy it must come from a "pure" heart, full of unconditional love, forgiveness, and compassion for our patient.

The HCPs seem to find it suitable to initiate spiritual or religious conversations during patient care. In a study with nurses, 90% of participants believed it appropriate to initiate a conversation about spirituality/religion and nearly three-quarters thought it appropriate to self-disclose spirituality/religion or offer prayer under certain circumstances or at any time [58]. A compassionate prayer for the whole world and for every created thing is considered to bring spiritual harmony.

Altruistic Behavior

Altruism was initially defined as "an unselfish regard for the welfare of others" incorporating two main ingredients empathy and prosocial behavior (altruistic behavior) [59]. Altruistic behavior (AB) is considered an important component of compassionate care and is connected with reduced aggression, better physical and mental health, longevity, and improved well-being [60–63]. AB in clinical practice is about going the extra mile and doing things that the patient has not asked the HCP, or the organization is inadequate to provide to patients or HCPs. HCPs with a low level of altruism do not demonstrate adequate care regarding the well-being of others [64].

Altruism can induce positive emotions such as kindness, compassion, and other regarding love by removing negative emotions [65].

Conclusion

Provision of CSC is part of national guidelines and is tightly connected with better quality of care, increased patient satisfaction, primary and secondary prevention of chronic disease, improved self-care, and reduction in HCPs burnout.

Moreover, the proposed model of the 4 dimensions of CSC can be taught and incorporated into the HCPs training (undergraduate and postgraduate). Effective communication between HCPs, patients and CSC services needs to be improved.

The key ethos of CSC namely humility, gratitude, forgiveness, prayer, and altruism can be used as broad guidance for self-care.

As we learnt at medical school first, we have a theory, we form a hypothesis and then we test and verify it. Experiential learning from good examples of CSC can be very didactic.

Into Practice

- Discuss the dimensions of compassionate spiritual care with your HCP team and patient representatives and identify didactic patient and healthcare professionals' cases that can be brought to the team meetings and openly discussed.
- Ensure access to spiritual care services to healthcare professionals, patients, and their families, onsite (i.e., within the hospital) and offsite (i.e., via video calls and helpline).
- Practice and experiment praying, gratitude, forgiveness, and altruism in everyday life not only during clinical work.
- Teach and integrate compassionate spiritual care training in HCPs curricula (graduate and postgraduate programs) and spiritual care leaders.

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Conclusion: The Spirit of This Book

At a time of sometimes overwhelming worldwide discord, unbridled hatred, suffering, and uncertainty on social, psychological, and physical levels, the obvious need for compassion and empathy has become all the more evident and deeply felt.

Although this book has largely focused on the importance of compassion and empathy as they relate to patient outcomes, these concepts reflect basic and necessary needs for every human being in a much wider variety of contexts. Put simply, we all need to be heard, understood, and treated with respect and kindness. When we have that experience, we find ourselves relaxed and are more likely to meaningfully connect with others. In relationships of compassion and empathy, vulnerability is required, and trust is consequently developed. In medical settings, where the patient is intrinsically in a vulnerable position, the responsibility for the establishment of a meaningful therapeutic relationship lies overwhelmingly on the medical provider.

As we have emphasized here, compassionate care is associated with significantly better patient outcomes. Therefore, it seems imperative to consider and infuse training in counselling skills as well as in skills that promote the communication of genuine empathy and compassion in medical training. Additionally, it is imperative for interpersonal skills assessment to be adopted as a major criterion in admissions decisions in the way that graduate-level psychology programs do in acceptance decisions.

On an institutional level, administrators must take deliberate measures to consciously foster a culture of compassion on a daily basis in the ways we have described in this book. Eventually, over time, these qualities should become part of the identity of the institution and no longer require as much conscious effort or extensive training to be manifested in organizational life.

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Ultimately, it is at the individual level that most work should be done in developing self-awareness and self-care skills. Communicating compassion and empathy should not be just something that we do mostly or exclusively with our patients. It should be an important part of our identity as individuals and professionals, of who we are, and that reflects the way we relate to all others. The great American theorist Alfred Adler envisioned what he called "social interest" as an important characteristic of the healthy person, defining it as an innate need that we all have to take care of others. Being in touch with this need and conducting ourselves in ways that are consistent with our identity that integrates social welfare is associated with better mental, spiritual, and physical health.

The transcendent spirit of this book goes beyond any type of setting, medical or other, and focuses on the positive interpersonal, mental, spiritual, and physiological outcomes that result from the fulfilment of our very basic human need to communicate and receive compassion, empathy, understanding, and kindness.

Useful Chapter Conclusions and Key Recommendations

Chapter	Key conclusions/Objectives	Key recommendations for education, research, and healthcare services
1. Compassionate Care and Evidence-Based Medicine	1. Using the best evidence is essential in healthcare. 2. Applying evidence requires understanding your patient's views, fears, needs, and hopes. 3. High-quality evidence is generated using strict criteria to ensure validity. 4. Compassion includes empathy—Being able to understand suffering of others. 5. Shared decision-making does not mean simply devolving decisions to your patients. 6. Focusing simply on tasks rather than patients risks diminishing compassion and diminishing care.	• When using evidence, it is important to consider the individual needs, values, expectations, and hopes of your patient. • Decisions on care, other than in emergency and time-critical situations, should include a full discussion with the patient about benefits, risks, and alternatives. • When using clinical guidelines, take note of the processes used to derive them. Ideally, these should conform to the Appraisal of Guidelines for Research and Evaluation (AGREE) criteria.
2. Compassionate Self-Care for the Compassionate Health Care Professional: Challenges and Interventions	1. Prioritize and invest in meaningful, healthy relationships, especially those with your family members. 2. Be mindful of how you connect with but also how you might alienate others. 3. Acknowledge your capacity to be narcissistic and work on your ability to empathize. 4. Have a good listener in your life. 5. Acknowledge and express needs. 6. Exercise and take care of your physical health. 7. Remove from your schedule unnecessary sources of stress. 8. Seek psychological support when you need it and be aware of relapse. 9. Redefine success.	• Introduce mindfulness about self-care in medical school training. This must be infused into all aspects of medical school training and explicitly emphasized by instructors.
3. Compassionate Care in Crisis	1. Practicing compassion in times of crisis does not require time, but a mindset change on the individual level and a culture change on the organizational level.	• Compassionate leadership is fundamental to compassionate healthcare as exhausted employees need someone to guide them on the right path. Employees who are convinced that they work in an environment which is governed by compassion, tend to perform better in terms of quality of care provided. • Leaders who show a compassionate approach tend to build work environments that improve both the staff's as well as patients' lives.

Chapter	Key conclusions/Objectives	Key recommendations for education, research, and healthcare services
4. Cultivating Compassion in the New Generation	1. Developing compassion in the new generation of healthcare professionals is of utmost importance. 2. Compassion can be taught using the 3C model: Cultivate, Check, Conserve. 3. Compassionate care teaching involves the cultivation of virtues and skills through didactic, practical, and experiential teaching methods. 4. The delivery of a hybrid modular overarching theme in healthcare teaching across all years of study is suggested to be one of the strongest ways of teaching compassion. 5. Effectiveness of Compassionate care education be measured using the Sinclair Compassion Questionnaire (SCQ).	• Prospective Medical Students. 1. Short courses online and/or face to face in secondary school. 2. Experiential learning through work experience at nursing homes and hospitals. • Medical students. 1. Integration of CC teaching in the curriculum. 2. Experiential learning of CC skills and behaviors during clinical placements. 3. OSCE stations testing CC. 4. Testing of CC at end of a medical school exam. • Junior doctors. 1. Professional development courses on CC and prevention of compassion fatigue. 2. Shadowing role model physicians (1–2 weeks). 3. Development of CC and fatigue quantitative scales. • Senior doctors. 1. CC should be part of revalidation. 2. Professional development courses on CC and prevention of compassion fatigue. 3. Shadowing fellow role model clinicians (1–2 consultations). 4. Development of CC and fatigue quantitative scales.
5. Compassionate Care Within the Primary Health Care Setting: Before and During a Public Health Crisis	1. Be aware of unexpected crises that might occur, and how PHC delivery may need to adapt to meet the needs of patients and their families. 2. Promote listening skills which may prove crucial in situations whereby the advantages of observation and nonverbal communication may not be available. 3. Ensure recognition of the needs of healthcare practitioners so that occupational stress can be addressed, and a compassionate culture can be sustained. 4. Encourage care which is inclusive and promotes good teamwork. 5. Consider the individual's family and social networks as important supportive mechanisms to alleviate daily stress and enhance connection and compassion.	• Re-think the structure and organization of PHC and continue to monitor the effectiveness and problems associated with telemedicine. • Encourage an understanding of the local population, including respect for their prevailing beliefs and promote sharing of the fears and needs of the individual. • Consider the impact of any crisis on mental health and enhance the capacity of PHC to deal with mental health issues. • Overcome the issue of reluctance in raising sensitive issues such as loneliness or potentially prevailing negative thoughts. • Acknowledge the needs of vulnerable and hard-to-reach populations and—provide appropriate consultation and support. • Strengthen an integrated people-centered approach to PHC, which focuses on communication and compassionate care skills.

6. Compassionate Critical Care: A "3C" Model	1. Critical illness encompasses great and long-standing physical, emotional and spiritual suffering for critically ill patients and their families/carers who need a holistic therapeutic approach. 2. Suffering starts upon patient's admission to the ICU with a life-threatening condition and is peaked when end-of-life decisions are needed, or long-standing disabilities are sustained, but it does not end with patient's discharge or death. 3. All of the above impose a great deal of spiritual and psychological stress, also, to HCPs, which, if not relieved, can lead to burnout and can seriously affect fitness to practice amidst an unprecedented staffing crisis in healthcare. 4. CCC is a model of care that is posed to alleviate suffering using a holistic and human spiritual approach and is proposed as an advantageous model of care that addresses the needs of patients, families, and HCPs in parallel and in interaction.	• Medical and nursing students. 1. Integration of CCC in the curriculum of critical care teaching / basic nursing teaching as well as teaching of critical care nursing (MSc programs). 2. Learning compassionate care skills and behaviors as essential part of clinical skills. 3. Compassionate care testing in the context of end-of-life OSCE stations. • Doctors and nurses in training. 1. Professional development courses on compassionate care and prevention of compassion fatigue and burnout. 2. Include CCC in the assessment model and skills required to sign off for the certificate of completion of specialist training (CCST)—for doctors, and corresponding certification for nurse.

Chapter	Key conclusions/Objectives	Key recommendations for education, research, and healthcare services
7. Communicating Genuine Empathy for Compassionate Care: A Case for Identity Exploration, Congruence, and Inclusive Organizational Cultures	1. Highlight the challenges related to and benefits of communicating genuine, meaningful empathy to patients. 2. Encourage medical trainees and professionals alike to engage in identity self-exploration in a manner to help them bring their authentic selves into their interactions with their patients. 3. Underscore the need for healthcare organizations to explicitly adopt and foster cultures of inclusion and psychological safety for all its members in order to facilitate their authentic expression.	• Individuals. 1. Engage in self-reflection regarding authentic expression not only with patients but also in daily life in order to bridge existing gaps. 2. In the same vein, explore one's own communication of empathy in all personal and professional interactions alike. • Educational institutions. 1. Integrate self-reflection into the application process for educational programs in the various areas of healthcare. 2. Encourage self-exploration and self-awareness as part of continuing professional development of healthcare practitioners. 3. Emphasize and encourage individual differences of style and lived experience and encourage authentic expression in communicating with patients. • Healthcare professional training. 1. Clinical communication and basic counselling skills training to home in medical practitioners' ability to effectively communicate genuine empathy. 2. Mindfulness skills training in order to enhance self-awareness, and self-acceptance, listening skills, along with quality of attention and stress management skills. 3. Encourage consultation recording as well as constructive peer feedback and private viewing for additional perspective contingent upon patient informed consent. 4. Embrace training opportunities as part of one's professional development. • Organizations. 1. Explicitly promote a culture of psychological safety where people are appreciated for their individual differences and encouraged to be their unique authentic selves. 2. Make a culture of inclusion an explicit value and mission in the organization and capitalize on it as a distinguishing strength: "This is who we are." 3. Offer educational programs in areas such as cultural competence and unconscious bias as well as conflict management, and clinical communication skills more broadly. 4. Regularly solicit anonymous feedback from employees to safely facilitate the sharing of relevant individual experiences. 5. Promote employee empowerment to fend off individual isolation by establishing resource groups to approach the leadership in support of the development and maintenance of a more inclusive and productive work environment. 6. Institute an Office of Inclusion/ Inclusion & Diversity to evaluate current practices, as well as to identify systems to be put into place for the daily practice of inclusion and to establish specific, measurable goals and accountability, then monitor their progress.

8. Organizing Compassionate Care with Compassionate Leadership	1. Define compassionate leadership and its implications for healthcare practice. 2. Contrast healthcare delivery supported by compassionate leadership as compared to the toxic healthcare environment that arises in its absence. 3. Reflect on examples of efforts to promote compassionate leadership in the UK's NHS. 4. Advance a research agenda by considering the implications of different theoretical lenses (power, paradox, conservation of resources) for compassionate leadership research and practice.	• Healthcare leaders and managers view addressing staff suffering as part of their responsibility. • Leaders can be trained in developing compassion capabilities related to the NEAR subprocesses. • A systems view of compassionate leadership must also be maintained, where leaders integrate compassion within organizational culture, routines, social architecture, and communication. • Resources are required for funding research on the practice, effects, and development of compassionate leadership in healthcare.
9. Compassionate Care and Health Economics	1. Understand the importance of evaluating compassionate care to inform decision-making. 2. Outline the main approaches to measuring outcomes in economic evaluation. 3. Propose discrete choice experiments (DCEs) as innovative way to evaluate dimensions of compassionate care. 4. Provide an example of DCEs to inform health economics for compassionate care.	• Prospective medical students: Short courses on the importance of economic evaluation to inform clinical decision-making online and/or face to face in secondary school. • Medical students: Integration of economic evaluation teaching in the curriculum (practical experiments as part of project assessments). • Junior doctors: Professional development courses on economic evaluation and its application to inform compassionate decision-making. • Senior doctors: Professional development courses on economic evaluation and practical application to inform their practice.
10. Compassionate Spiritual Care	1. Understand the definition of compassionate spiritual care. 2. Describe the role of Spiritual Care Services in Clinical Practice. 3. Describe the skills and attitudes for effective compassionate spiritual care. 4. Describe the impact of spiritual care in healthcare. 5. Describe the five key spiritual virtues for compassionate healthcare professionals and spiritual care services personnel. 6. Outline key compassionate spiritual care interventions that can be applied in clinical cases.	• Discuss the dimensions of compassionate spiritual care with your HCP team and patient representatives and identify didactic patient and healthcare professionals' cases that can be brought to the team meetings and openly discussed. • Ensure access to spiritual care services to healthcare professionals, patients, and their families, onsite (i.e., within the hospital) and offsite (i.e., via video calls and helpline). • Practice and experiment with praying, gratitude, forgiveness, and altruism in everyday life not only during clinical work. • Teach and integrate compassionate spiritual care training in HCPs curricula (graduate and postgraduate programs) and spiritual care leaders.