



Compassion is central to the work of practice nurses. Yvonne Sawbridge and Dr Alistair Hewison explore the emotional labour involved in providing compassionate care

‘Compassion costs nothing’—the elephant in the room?

The successful delivery of compassionate care is generally attributed to the actions of individuals. This article widens this discussion to explore the responsibility of organizations to create compassionate cultures and outlines a number of approaches to supporting staff with their emotional labour. There are a number of models of support, at varying stages of development, and showing promising results in terms of enabling nurses to deliver compassionate care. However, none of these have been targeted at general practice nursing. Hard emotional work is a role requirement for nurses, and the invisibility of this concept mitigates against it being recognised. This may leave emotional labourers unsupported within their work environment. General practice nursing is an area significantly under researched in relation to emotional labour, and this gap needs to be addressed.

The 6Cs and the supporting Department of Health (DH) strategy ‘Compassion in Practice’ (Chief Nursing Officer et al, 2012) were discussed recently in this journal (Moger et al, 2014). This article focuses on compassion, the absence of which has been the subject of much media coverage since the poor care uncovered at Mid Staffordshire NHS Trust, reported by Francis in the public inquiry he chaired (The Mid Staffordshire NHS Foundation Trust Inquiry, 2013). While general practice nursing rarely features in the public narrative of nursing, particularly in relation to the widespread concerns about care, compassion is as central to the work of practice nurses as it is for all nurses.

This article argues that compassion needs to be nurtured, and therefore the debate must encompass the role of the organisation, as well as that of the individual, in delivering compassion. The concept of emotional labour is applied as a means of demonstrating the need to consider the importance of supporting staff if compassionate organizations and services are to be developed. A number of

models that support nurses in their emotional labour are described, illustrating approaches that may be worthy of consideration for implementation in general practice nursing. This is an under explored area which warrants further attention.

Compassion costs nothing

‘Kindness and compassion cost nothing’ (Care Quality Commission (CQC), 2011: 4). This statement was made by the chair of the CQC. Instinctively, many people might agree with this observation and reason that if patients are treated without compassion, the failure lies with a particular individual—in short a ‘bad’ nurse.

However, an alternative view exists, captured in this statement by Robin Youngson (2012: 41): ‘When health professionals are abused and de-humanised by an uncaring system, how can we expect them to show compassion?’ This perspective shifts the focus of discussion from a simplistic, reductionist approach centred on individuals, and re-frames the debate to encompass the complex array of factors in the wider health system that influence the provision of compassionate care.

Compassion is a word that most people recognize, often based on an assumption that it is a quality you either have or not. Crawford et al (2011: 42) define compassion as: ‘... sensitivity to the suffering of others with a deep commitment to try and relieve it’. It involves a sense of awareness of others’ needs and paying purposeful attention to them. It also requires a motivation to act, and is a combination of skills and attributes. They argue that these skills can be taught, and that organisations need to create compassionate settings in which they can flourish.

However, Reason (2000: 768) states ‘blaming individuals is emotionally more satisfying than targeting institutions’ because the solution can appear to be deceptively and thus appealingly straightforward—simply remove/retrain/blame an individual, even though this

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takes no account of how competition, targets and threat can destroy compassion (Crawford et al, 2011). While some individuals fall short of their professional responsibilities and need to be removed from practice, this should not detract from the level of scrutiny that needs to be directed to the role of the wider organization in the creation of systems which nurture compassion.

Valerie Iles (2011: 37) states: 'Pressure to improve the transactional aspects of care, ... is leading to a withdrawing of care as a covenant between care giver and care receiver... This happens at all levels in the system and results in stories of patients feeling (and being) emotionally abandoned by care staff; in stories of staff feeling (and being) bullied by their managers; and in stories of Boards feeling (and being) bullied by the NHS management hierarchy'. The harrowing events at the Mid-Staffordshire Trust where it was found that there was an engrained culture of tolerance of poor standards, focus on finance and targets, denial of concerns, and isolation from practice elsewhere (Francis, 2013), underline the impact of such pressure. This creates an environment in which staff are fearful of raising concerns and so are constrained in their efforts to deliver care. If the best care is to be delivered staff need to be engaged and feel their contribution is valued (Ham, 2014).

Compassion therefore requires a purposeful and systemized approach, which the whole system needs to pay attention to.

What is emotional labour?

If it is accepted that the responsibility for the provision of compassionate care lies with the system as well as the individual, then an important aspect of the work of nurses that organisations need to acknowledge is emotional labour. Hochschild first coined this phrase (1983) and used the work of air stewards as a case study, illustrating their need to present a professionally appropriate appearance, which involves suppressing their own emotions (Smith, 1992; 2012). Sawbridge and Hewison (2012) and others describe nursing as hard, emotional work, and that this is often overlooked in current management practice, and rarely discussed in these terms. When nurses discuss their professional role they use the terms 'face', 'mask' and 'act', which signifies their awareness that they must actively work on their emotions to present the recognisable face of the carer (Bolton,

2001). Similarly achieving neutrality through initially distancing themselves emotionally assists nurses in determining whether to remain distant or to engage emotionally with patients (Hayward and Rae Tuckey, 2011). This is necessary because as Menzies (1960: 97) described 'Nurses are confronted with the threat and the reality of suffering and death as few lay people are. Their work involves carrying out tasks which, by ordinary standards, are distasteful, disgusting and frightening', which involves a high level of emotional labour, as noted above. Mastracci et al (2012) interviewed emergency call handlers in USA (equivalent to our 999 staff) and identified emotional labour as a role requirement. In the same way a chauffeur needs to be able to drive, nurses need to have the ability to undertake emotional labour. Once recruited, however, nurses also need support to help them continue to deliver compassionate care by recognizing that their emotional 'bank account' can become overdrawn, and needs topping up. Yet, little systematic support is accessible to nurses in the course of their daily work to help them do this. Without support, there is a danger that nurses protect themselves from the anxiety that care-giving often induces by suppressing their own emotions over a sustained period of time, which can render them less able to withstand the emotional toll of care, resulting in burn-out (Maslach et al, 2001). This can be manifested in part as an unhealthy detachment—which means that nurses no longer notice, let alone act on, the distress of others (Vaughan and Pillmoor, 1989).

Supporting emotional labourers

While physical labour is understood and generally accounted for in management practice (manual handling sessions and equipment for example), emotional labour is largely invisible. However, work is underway to raise the profile of this issue and to explore potential solutions. One approach sought to test the feasibility of using a staff support model developed in the voluntary sector in the NHS (Sawbridge and Hewison, 2014). The Samaritans organization provides a confidential listening service for people in distress and has a peer-based approach to supporting the volunteers who provide the service. This system of peer de-briefing enables them to manage the emotional impact of the calls they take. A research project testing the feasibility of adapting this approach on hospital wards

found significant challenges; however, it did identify that emotional labour is an issue to be managed (Sawbridge and Hewison, 2014).

A follow up project is in progress, working with two different organizations to introduce a model of support that best fits the different environments and situations. One of the key learning points from the first project was the importance of ensuring the staff teams had ‘ownership’ of the system and this is a key feature of the second action research project which is scheduled for completion later this year.

Other models of support include restorative supervision which has been introduced to all health visiting services in the West Midlands (Wallbank and Preece, 2010; Wallbank, 2013). This involves a co-coaching approach focussing on the impact of practice on the individual practitioner, which reduced stress levels among the health visitors and increased their effectiveness when making difficult decisions about safeguarding children for example. There is also a national project, led by the Point of Care Foundation, to implement Schwartz rounds in a number of organizations (Goodrich, 2011). These are multi-disciplinary group meetings which generally use a case study to stimulate discussion about the emotional impact of the care of a patient on the professionals involved. Early evaluations have produced some promising results and a large scale evaluation is now taking place (Goodrich, 2011).

However, little if any of this work has been undertaken in general practice nursing. Nurses play a greater role in general practice than in the past. There are 23 833 practice nurses working in England, an increase of 375 (1.6%) since 2012. This equates to 14 943 whole time equivalents, an increase of 248 (1.7%) since 2012, which represents one full time practice nurse for every 3748 registered patients, a decrease of 1.2% since 2012 (HSCIC, 2014). The working environment for many practice nurses means that there is often no nursing team to support them so accessing even informal support may be more difficult than for nurses in the acute setting. For example a practice nurse providing bereavement support to an elderly lady, when her own father has just been diagnosed with the same condition this lady’s husband died from, may have no outlet for sharing her thoughts and feelings about having to manage her own emotions in this situation. The ‘lone’ nature of much general practice nursing

can exacerbate personal feelings of distress arising from the demonstration of compassion.

In view of this, developing a model that supports general practice nurses in their management of the emotional impact of care, which could be made available to every practice nurse, is an area ripe for further research. The models discussed earlier may represent some promising areas for this type of work.

Conclusions

Compassion is important to patients, and the delivery of compassionate care is as dependent on the system, resources, culture and environment as it is on individual care givers. The ‘elephant in the room’ is that far from costing nothing, the emotional labour involved in sustaining kindness and compassion can exact an immense toll on nurses and have an adverse impact on their ability to deliver compassionate care—in whatever setting they are employed. West and Dawson (2012: 20) found ‘that cultures of engagement, positivity, caring, compassion and respect for all—staff, patients and the public—provide the ideal environment within which to care for the health of the nation. When we care for staff, they can fulfil their calling of providing outstanding professional care for patients.’ The importance of compassion in the role of the practice nurse may not have attracted widespread attention or comment in the past—perhaps it is now time to start the debate?

- Bolton SC (2001) Changing faces: nurses as emotional jugglers. *Sociology of Health and Illness* 23(1): 85–100
- Care Quality Commission (2011) Dignity and nutrition inspection overview. National report. CQC, Newcastle-upon-Tyne
- Care Quality Commission (2014) State of Care report. www.cqc.org.uk/content/state-care-201314 (accessed 10 March 2015)
- Chief Nursing Officer, Department of Health Chief Nursing Advisor, NHS Commissioning Board (2012) *Compassion in Practice: Nursing, Midwifery and Care Staff: Our Vision and Strategy*. www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf (accessed 10 March 2015)
- Crawford P, Gilbert P, Gilbert J, Gale C (2011) The Language of Compassion. *Taiwan International ESP Journal* 3: 1–16
- Goodrich J (2011) Schwartz Center Rounds: Evaluation of UK Pilots. www.kingsfund.org.uk/sites/files/kf/field/publication_file/schwartz-center-rounds-pilot-evaluation-jun11.pdf (accessed 13 March 2015)
- Ham C (2014) *Improving NHS Care by Engaging Staff and Devolving Decision-Making. Report of the Review of Staff Engagement and Empowerment*

KEY POINTS

in the NHS. King's Fund, London

Hayward RM, Tuckey MR (2011) Emotions in uniform: How nurses regulate emotion at work via emotional boundaries. *Human Relations* 64(11): 1501–23

Health and Social Care Information Centre (2014) General and Personal Medical Services: England 2003–13. www.hscic.gov.uk/catalogue/PUB13849/nhs-staf-2003-2013-gene-prac-rep.pdf (accessed 17 March 2015)

Hochschild AR (1983) *The Managed Heart: Commercialization of Human Feeling*. University of California Press, Berkeley

Iles (2011) Why reforming the NHS doesn't work: The importance of understanding how good people offer bad care. www.reallylearning.com/Free_Resources/Really_Managing_Healthcare/reforming.pdf (accessed 13 March 2015)

King's Fund (2011) Improving the quality of care in general practice. www.kingsfund.org.uk/sites/files/kf/improving-quality-of-care-general-practice-independent-inquiry-report-kings-fund-march-2011_0.pdf (accessed 13 March 2015)

Maslach C, Schaufeli WB, Leiter MP (2001) Job burnout. *Annu Rev Psychol* 52: 397–422

Mastracci S, Guy M, Newman M (2012) *Emotional Labor and Crisis Response. Working on the Razor's Edge*. M.E Sharpe, New York

Menzies IEP (1960) A case-study in the functioning of social systems as a defence against anxiety: a report on a study of the nursing service of a general hospital. *Human Relations* 13(2): 95–120

Moger A, Nicholson W, Storey K (2014) Three national leads appointed in England to support practice nurses. *Practice Nursing* 25(11): 530–532 doi: 10.12968/pnur.2014.25.11.530

Reason J (2000) Human error—models and management. *BMJ* 320: 768. doi: 10.1136/bmj.320.7237.768

Sawbridge Y, Hewison A (2012) Time to Care? Health Services Management Centre, Birmingham

Sawbridge Y, Hewison A (2014) Time to care research. www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/publications/2014/Time-To-Care-FINAL-March-2014.pdf (accessed 13 March 2015)

Smith P (1992) *The Emotional Labour of Nursing*. Macmillan Education, Basingstoke

Smith P (2012) *The Emotional Labour of Nursing Revisited: Can Nurses Still Care?* Palgrave Macmillan, Houndmills

The Mid Staffordshire NHS Foundation Trust Inquiry (2013) *Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005–March 2009*. Chaired by Robert Francis QC. 3 vols. The Stationery Office, London

Vaughan B, Pillmoor M (1989) *Managing Nursing Work*. Scutari Press, London

Wallbank S (2013) Maintaining professional resilience through group restorative supervision. *Community Practitioner* 86(8): 26–8

Wallbank S, Preece E (2010) *Evaluation of Clinical Supervision given to Health Visitor and School Nurse leadership participants*. NHS West Midlands and Worcester University

West MA, Dawson JF (2012) Employee engagement and NHS performance. www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf (accessed 13 March 2015)

Youngson R (2012) *Time to Care*. Rebelheart Publishers, New Zealand

- Compassion is crucial for patient care
- The current narrative focuses on compassion as an individual responsibility and blames those who do not meet it
- Organizations have a role to play in developing a compassionate culture
- The toll of emotional labour on nurses can hamper the delivery of compassionate care
- Models of support for staff exist, though their implementation in general practice nursing is limited