



The 2nd Annual Memorial Lecture of the Elizabeth Bryan Foundation Trust

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LISTENING TO NHS STAFF

What they say about Compassion and Care

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This lecture draws on material I have used in previous speeches, conferences and writings.

Thank you. It is a great honour to be here today, and to give this lecture named after such a dedicated doctor. Elizabeth Bryan was a charismatic leader with formidably energy and a gift of being able to encourage others. I wish I had met her, but am deeply honoured to be remembering her today.

I am going to talk about compassion and healthcare, something, that as a GP I am deeply concerned and interested in. I want to start by telling you two stories both are personal to me and both are true. One of them I gave at my first College conference speech in 2011 at the start of my fight against proposed NHS “reforms”. The stories are from difference perspectives; they resonate with the theme of compassion – something that Elizabeth so espoused.

The first happened a few years ago when I was on holiday with friends. All doctors, between us covering a range of medical specialties: radiology; pathology; psychiatry; general practice. We were having dinner with our children at an open-air opera in Germany. The place was packed. Everyone was having a good time - when the dreaded happened. Out of the corner of my eye I saw an elderly man fall headfirst into his plate. The four of us looked at each other. We knew our meal was over and we swung into action. Each working to type: the psychiatrist tending to the man’s wife and son; the radiologist searching for a defibrillator; the pathologist pounding on the poor man’s chest and me giving mouth-to-mouth. From the way he keeled over, it was obvious that he was dead. But we knew there was still plenty for us to do. We had to comfort his distressed family. And we had to keep the crowd calm for thirty minutes, until the paramedics arrived. When it was over my fifteen year old son turned to me and said, *“I want to be able to do that.”* *“Do what?”* I asked him. *“Care for people”*, he said. His reply surprised me. Not just because impressing teenage children isn’t easy, but because what impressed him wasn’t the glory and the drama of our public display of medical skill. No, what impressed him was our simple act of caring. Caring for a sick man. Caring for the man’s wife. And caring for the people in the crowd. That’s what inspired my son.

The second story is more recent and occurred in the middle of my Chairmanship of the Royal College of General Practitioners. My mother-in-law was newly diagnosed with throat cancer. I accompanied her and my father-in-law to her first appointment post diagnosis. This was to meet the surgical team to see what the treatment options were. My father-in-law is blind from glaucoma. They had been married for fifty years. I went not just to be there with my family, but also as a general practitioner. I thought that I would be able to translate any medical jargon into something more understandable. The young registrar began to talk. He spoke of the diagnosis, of what the site of the tumour meant to the prognosis. He talked about the cancer having spread to the local nodes. He spoke of treatment options: surgery; surgery and radiation; surgery with radiation and chemotherapy; or palliation. I listened and felt increasingly anxious. I knew that despite my elevated position and experience in general practice I could not translate the options to my mother in law. I did not know what was best for her. There were too many factors to take into account. My medical-self vanished, and I became in that room a frightened concerned "other", wanting only the best for someone I loved dearly. There was a moment's silence. My mother-in-law broke the silence as she asked "*What would you do if I were your mother....doctor....?*" This young doctor (they all seem young nowadays), held my father-in-law's hand, looked at his patient, drew his chair to close the circle, and told them what he would do. And we took his advice.

Both of these stories illustrate compassion. The first, a public display, but hidden from view, except spotted by my astute son, was the act of caring for the public and the relatives. The second, a compassionate exchange between a young doctor and us in the room.

Compassion emerges in the experience of a personal interchange between, in these cases sick and frightened individuals and a care giver. In my mothers in laws case the doctor took the time, had the empathy and skills to deal with three frightened people in the room, to address all the players together, but making us all feel that we mattered. He was treating our family as he would treat his own which is the essence of compassionate care.

Compassionate care, as with kind individuals, comes with a sense of shared humanity and seeing in the patient someone who is (as written by Ballatt and Campling in *Intelligent Kindness*, 2011) "*part of the flow of life and essentially the same as ourselves.*"

This theme, of treating others as you wish to be treated yourself has been brought out by Iona Heath, the past President of the Royal College of General Practitioners, Iona Heath, in her essay *Loves Labours Lost* wrote "*the only real certainty is the moral challenge of The Otherthe stranger*". She goes on to quote Zygmunt Bauman where he reminds us that to take a moral stance means to take responsibility for the Other "*To act on the assumption that the well-being of the Other is a precious thing calling for effort to preserve and enhance it. The essence of compassion therefore is "being for" (or equally being present) to suffering.*" (Bauman, 1994). For each patient we are expected to serve, and particularly for those who are most vulnerable and most damaged.

We have learnt a lot about the lack of compassion in healthcare since the Francis Report (2013). We have learnt where compassion has failed. Failed between the

giver - the health professional and the receiver, the patient. But what we are also becoming increasingly aware of is the failing of compassion at organisational level.

In this ever changing industrialised health service, with the focus on production and quantity of care rather than its quality, this “being for” at the level of the organisation, is becoming increasingly difficult.

I have been working with the psychologist Joanna Wilde on trying to develop our ideas and thoughts about compassion in the work place. All organisations are emotional arenas, with pain and suffering generated from outside (as part of normal living) and from within – through inevitable tensions and conflicts inherent in working collaboratively. Not surprisingly the sense of being valued at work is created (or destroyed) day to day in the way people interact with each other. This is especially important where the worker is a care-giver as positive experiences can help mitigate against the emotional labour of our work. More compassion in the work place leads to less anxiety amongst staff and better attachment between staff and the organisation. And the virtuous cycle continues.

But, sadly, the NHS is far from a compassionate organisation and the psychological environment that NHS staff work in is not safe. Over a quarter of NHS staff report physical and psychological violence from patients. The same levels of psychological violence from other NHS staff members. That is 300,000 NHS staff being bullied or hurt by patients, managers and colleagues every year. When asked about raising concerns, 72% do not believe that anything would be done if they spoke up about their concerns. Of these, 14% believe they would be punished for speaking. I find it deeply surprising that these figures continue year on year, and in fact are getting worse, and yet the level of reporting and outcry is minimal. When we contrast this state of affairs for our staff with the service they deliver it adds further concern to the mix.

This complex NHS system works 24/7 and delivers exceptional levels of service to our society. One million people are seen every thirty-six hours with an astounding 81% of patients giving a very positive (“always”) response to the question *“are you treated with dignity and respect?”*

These headline figures indicate a substantial “compassion gap”, whereby greater compassion is shown to patients than is shown to NHS staff. I believe if the NHS were a factory, so psychologically toxic is it, so damaging to those who work in it, that it would be closed down. The reasons for this dissonance are complex but arise from the dual forces of increasing marketisation coupled with constant and unrelenting reorganisations.

Over the last three decades we have moved from a national state funded, state owned, and state managed organisation to a fragmented system of multiple competing providers. The role of medicine is also changing from *“a craft concerned with the uniqueness of each encounter with an ill person, to a mass manufacturing industry preoccupied with the throughput of the sick”* (Illife, 2008).

Iona Heath described the commercialisation of my profession, general practice as one of the *“dark forces at work behind the subversion of professionalism”* (Heath, 2007) and she bemoans the changes in her own career which have led to the disappearance of *“any idea of a gift economy, where professionals could be knights but recipients could be queens—once altruism wasn’t recognised, it began to disappear.”* (Heath, 2012). Nitsun (2015, p.44), a group analyst and psychologist,

talks of the NHS moving from a *“Labour inspired institution to a highly competitive culture”*.

During my work in the NHS over the years, I have had to work in an ever-changing landscape. It seems that given any difficulty, the first course of action is to reorganise in the apparent magical belief that reorganisation will address deep-rooted financial or social problems.

Just as within functional families, those working as nurses, doctors, and managers require stability, security, and safety to be able to deliver compassionate care, rather than wasting time, managing the personal impact from this constant state of transition. Stability provides the safety for change and experimentation – paradoxically, allowing for change, but safe change. For decades, governments across the world have used reorganisation and policies of “destructive innovation” to juggle the clinical and financial priorities of health services. Each attempt to fashion a new order produces a new state of disorder and activates the “survivor syndrome”. Repeated reorganisation fractures relationships and promotes anxiety in the organisation.

Around twelve months ago I set up a network of like-minded individuals called *The Founders Network*. Its remit was ambitious: to remove the systems and structures that are preventing us from delivering compassionate care – not just compassionate care to patients, but compassionate care to staff. I wanted to capture the voices of staff working in and around the NHS and in so doing elucidate an argument to improve the system, structures and policies that inhibit the delivery of compassionate care to patients and ensure that staff who work within the health (and social care) system are themselves the recipients of compassionate care by their employers. The events used group-analytic techniques to enable free-floating dialogue with participants with the intent to make them feel safe to speak in confidence and anonymously about their experiences of working in the NHS. Voice after voice, from the student nurse, the ward porter, senior hospital manager or general practitioner told of their intolerable working conditions. They talked of high work load (at times expressed as unsafe), intolerable working conditions, disempowerment and the toxic effect this was having on their personal and professional lives. Fear was the overwhelming emotion, fear of annihilation – be that loss of job, status, department, or even of life. Fear appeared to have become part of the fabric of many of the delegates day to day working lives. Fear of litigation, of saying *“I don’t know”*, of admitting to having a problem and that when admitting failure they would be punished rather than supported. Some described fear of blame, fear of the NHS disappearing and with it free healthcare. Many felt impotent to bring about any change. Attendees expressed feeling unsafe and in constant fear of retribution and of being named, shamed and blamed should any error occur:

Senior Manager: *“Culture in the NHS is like a garden full of weeds – we need to pull them out”*

Nurse: *“There is a sense of annihilation, a fear of some sort of destruction rather than productive thinking and creativity.”*

Consultant: *“Scapegoating and bullying are rife in the NHS. I see a lot of over-tired people, structures are oppressive and seem to be getting worse. There is no time to share compassion. The system fails to grasp this.”*

Nurse: *“There is almost a normalising of toxicity and distress that we are willing to accept. ...The organisation is not safe.”*

The attendees used words that, in a psychiatric assessment, would lead to a diagnosis of depression. In fact many described early morning waking, anxiety, feelings of demoralisation, hopelessness and a lack of joy in the work that they did. Many felt depressed and demoralised working in the NHS and that it became increasingly difficult to lift themselves up to participate in compassionate care. This led to resentment as they were expected to “give their all” to their patients. This feeling is attuned to the evidence that, whilst individuals always bring their own pain and distress into the workplace, the organisations that are best able to cope with this are ones where compassion is integral to the working environment. Group members described not feeling valued or cared for and that the culture of consumerism was feeding into a “them and us...hero and villains” divide, creating a massive barrier between themselves as health professionals and the patients they treated. The findings of the “listening events” resonate with Ballatt and Campling (2011) as they talk about kindness – saying:

“For it is easy to forget the appalling nature of some of the jobs carried out by NHS staff day in, day out – the damage, the pain, the mess they encounter, the sheer stench of diseased human flesh and its waste products.”

What next?

We have to work to change the system, as if we don't our patients will suffer and not receive the compassionate care they deserve, and which staff want to provide, but in changing I believe we have to grasp some nettles: the first is about putting patients first. The recommendation in the Francis Report (2013) that healthcare workers should put their patient's needs above their own health needs is understandable but troubling. Given the causal evidence around work environment and serious ill health, this suggestion is not consistent with the Health and Safety obligations enshrined in law for people at work. Further, a damaged carer cannot give high quality compassionate care. To put patients first should not mean putting yourself last; even the airlines tell us to pull our own oxygen mask down first before helping others. My view is that is ethically unacceptable to require any healthcare worker to act in a way that causes damage to their psychological or physical health.

Second: we have to address the psychological resource gap in the NHS. If we leave this resource gap in place then we are accepting a system that is draining compassion from those working within it. In turn, if we accept that we are draining our staff and continue to do this, by giving them less compassion than they provide to us on a daily basis, we also accept that issues like those reported in Mid Staffordshire will occur again. As we know this and know what we need to do to improve it, if we choose to do nothing, then we all become culpable. Rather than blaming those that are already drained, we must take collective responsibility for these outcomes and for the investment required and difficulties associated with NHS culture change. Our emerging focus given ongoing conversations through the Founders Network is that there is a pressing need to reconsider the approach to regulation. This we characterise as “compassionate regulation”. Creating this requires a new design that (from the top) role models what is required for care, compassion and concern to flourish. Further it needs to use insights about how to operate in a complex workplace such as the NHS to enable compassion. We need interventions that change the regulatory tone. The challenges in our care system are not technical or even financial but human – in essence how to ensure that we focus on the quality and compassion of care rather than merely measuring its quantity and speed of delivery.

Our capacity to think about and care for others is inherent to this change. Health systems now need to re-engage with their human side.

There is good news. Simon Stevens, the new Chief Executive of the NHS is addressing. This is the first sign of good news in a desert of bad. I hope that it signals the start of a compassionate NHS, not just for patients, but for the staff who work in it as well.

Thank you.

For further reading see

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