A review of the literature on compassion prepared for the Cultivating Compassion Project 2014 -2015

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1. Introduction

Compassion is an essential component of care. The Mid Staffordshire NHS Foundation Trust Public Inquiry Report, however, clearly indicated that compassion values are not always enacted on. In many instances, this had catastrophic consequences for patients and families. This literature review examines aspects of compassion in the NHS. It begins by providing a brief overview of some of the key drivers behind compassion initiatives. The review then moves on to consider what compassion means, to discuss different perspectives on compassionate care, to examine the relationship between leadership and compassion within NHS organisations and to explore the ethical nature of compassion. Following this, the practicalities of delivering compassionate care, which involve knowledge, skills, ethics and emotion, are explored by analysing the role emotional labour plays in bringing these components together. From this analysis, strategies to promote compassionate care are discussed, culminating in a critical analysis of the ‘train the trainer’ model advocated in this project. This is not a systematic literature review but rather a critical appraisal of a selection of pertinent literature that contextualises the project and demonstrates its underpinning knowledge bases.

2. Background

Health Education Kent, Surrey and Sussex (HEKSS) note in their call to bid (HEKSS Jan 2014) that “compassion is a critical element of all aspects of care and needs to be a common thread through all learning and education activities”. They suggest that compassionate care is required in care tasks in combination with knowledge and skills and “expressive caring which involves the emotional aspects of the relationship”. This background from HEKSS highlights the centrality of the values in the NHS Constitution, and the significance of the Francis reports (2009, 2013) in drawing attention to deficits in the NHS. Whereas a focus on healthcare ethics is not new, the publication of the Francis reports (2009, 2013) resulted in compassion
entering the political agenda. As these disturbing reports of lack of compassion at Mid Staffordshire emerged, it became clear that patient experience and compassion needed to be prioritised alongside safety and effectiveness in care, as outlined in the Darzi Report (DH 2008). The final report of the Next Stage Review states that compassion was to become one of the values of the Health Service and this is now clearly embedded in the NHS Constitution: “We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person’s pain, distress, anxiety or need (DH 2013a: 5)”.

Government recognition of the role which nursing and midwifery plays in the provision of compassionate care is demonstrated in a range of policy documents. The Prime Minister’s Commission Report on the Future of Nursing and Midwifery (DH 2010) reaffirms the call for high quality compassionate care as part of its vision for nurses as practitioners, partners, leaders in future healthcare provision. The Government’s agenda for compassion as a required component of education for the healthcare professions is clearly stated in their mandate for Health Education England (DH 2013b). More recently, the Chief Nursing Officer’s campaign for the “6 Cs” in nursing and midwifery practice (DH 2012), echoes the work of Roach (1987), in a clarion call for care, compassion, competence, communication, courage and commitment to underpin practice. A critical analysis of this policy emphasises the importance of organisational initiatives and introduces the idea of the ‘compassionate organisation’ (Dewar & Christley 2013 p.48).

However, the market driven economy of the NHS with its associated target requirements and heavy workloads, engenders a culture, which is perhaps not conducive to compassionate care (Austin 2011, Flynn and Mercer 2013). This creates stress for staff as identified in the Kings Fund Point of Care Programme (Firth Cozens and Cornwell 2009). It is now recognised that organisations need to consider the wellbeing of staff in their efforts to enhance high quality compassionate care for patients (Maben et al 2009, West and Dawson 2012).
Compassion is not a new concept within the discipline of nursing, whose scholars have placed the concept of caring at the heart of nursing values and beliefs. The contribution of so many nurse theorists to the vast range of literature on caring in nursing is evidence of its longstanding and continued importance to the profession (Roach 1987, Benner and Wrubel 1989, Swanson 1991, Eriksson 1992, Watson 1999, Boykin and Schoenhofer 2000, Brilowski and Wendler 2005).

More recently, a number of significant studies on compassion in the context of caring relationships have been published in the nursing, care and ethics literature. Torjuul et al (2007), for example, conducted a qualitative study of nurses and physicians regarding compassion and responsibility in surgical care in Norway. Van der Cingel (2011) investigated compassion in relationships between nurses and older people in the Netherlands. Curtis (2012,2013) researched student nurses’ socialisation in relation to compassionate care in the UK. The most significant UK study relating to compassion was conducted in Scotland (Adamson et al 2012). The study ‘Leadership in Compassionate Care Programme’ had four strands: the establishment of Beacon Wards to ‘showcase excellence in compassionate care’; the facilitation of leadership skills in ‘key individuals’; influencing the undergraduate curriculum by ‘embedding relationship-centred compassionate practice’ for nurses and midwives; and providing support for newly qualified nurses. Insights from this project and strategies employed inform the development of the ‘cultivating compassion project’ training initiatives. Dewar’s (2011 p.263) relational perspective on compassionate care is one that the Cultivating Compassion (CC) Team are sympathetic towards. She writes:

*Compassion…..” is defined by the people who give and receive it and therefore interpersonal processes that capture what it means to people, are an important element of its promotion”.*

It can be seen from this brief overview that there is both a long held and newly articulated deep-seated recognition of the importance of compassion to health care and an urgency to ensure that compassionate care is embedded within the
organisational culture, its leadership structures as well as in the day to day care activities between health care workers and patients.

3. What is Compassion and What Defines Compassionate Ethical Practice?

Defined simply, and taken from the Latin ‘com’: together with, and ‘pati’: to suffer, compassion means ‘suffering with’. Compassion is understood to involve emotion, such as empathy or sympathy, and a rational understanding of the suffering that enables identification with it, i.e. the ability to deliberately and altruistically participate in another’s suffering (von Dietze and Orb 2000). Compassion therefore involves an emotion and thought that relates to the suffering of another that results in an action that acknowledges that suffering and seeks where possible to alleviate it. This suggests that recognition of suffering precedes the feeling/action of compassion.

The Dalai Lama reminds us that ‘the importance of cultivating love and compassion’ is emphasised by all major religions. ‘The ethics of compassion’ from Buddhist teaching argues that compassion has relevance to all aspect of life including ‘the workplace’. Without compassion, work activities can become ‘destructive’ because the impact of our actions on others may be ignored and people will be hurt, pointing out that:

“The ethic of compassion helps provide the necessary foundation and motivation for both restraint and the cultivation of virtue. When we begin to develop a genuine appreciation of the value of compassion our outlook on others begins automatically to change” (The Dalai Lama 1999 p.128).

A connection can be made between these insights from Buddhism and Iris Murdoch’s discussion of moral perception and ‘attention’ in the moral life. She writes of the importance of a ‘just and loving eye’ (Murdoch 1971). The suggestion is
that, when we come across people we find it difficult to relate to, we look more deeply, fairly, and lovingly to better understand their predicament and behaviour. Bennett (1993) suggests that the parable of the Good Samaritan (Luke 10v25-38) epitomises the Judeo Christian view of compassion in which

‘Our neighbour’ is the ‘one who needs the help that we can give him, whoever he may be’ (ibid p.141).

O’Connell (2009:4) notes that for Christians, compassion is the central mark of discipleship as “compassion can be an effective moral disposition with the capacity to challenge privatised, individualised and paternalistic responses to suffering at the hands of others”. The call to discipleship is not just to suffer with, but also to address unjust suffering. As Austin et al (2013 p.13) suggest:

“The most important sense of compassion that is carried through from biblical tradition to English is the sense that compassion leads to action. It seems to be more than a simple feeling or sentiment”.

In applied ethics, compassion is generally discussed as a virtue or moral disposition of the person. In one of the most popular texts Principles of Biomedical Ethics (Beauchamp & Childress 2013 p.37) compassion is identified as the first of ‘five focal virtues’. It is described as ‘a prelude to caring’ and as combining:

“an attitude of active regard for another’s welfare with an imaginative awareness and emotional response of sympathy, tenderness, and discomfort at another’s misfortune or suffering. Compassion presupposes sympathy, has affinities with mercy, and is expressed in actions of beneficence that attempt to alleviate the misfortune or suffering of another person. Unlike the virtue of integrity, which is focused on the self, compassion is directed at others”. (ibid)
Virtues can be thought of in relation to vices, that is, that virtues and vices come in triads with each virtue ‘flanked by two vices (vicious disposition) – one representing excess and one deficiency’ (Banks & Gallagher 2009). In thinking of compassion, then, as a virtue or ethical quality of the person and a disposition to help in response to the suffering of others, it is helpful to consider the vices of excess and deficiency. In terms of deficiency, Comte-Sponville (2002 p.103) writes of the ‘antonyms’ of compassion as ‘ruthlessness, cruelty, coldness, indifference, hard-heartedness, insensitivity’. In terms of excess, we might consider over-involvement, making assumptions about the suffering of, and appropriate responses to, others. There is risk in making unfounded assumptions about the suffering of others and of perhaps responding to others in ways that are paternalistic or infantilising.

Nussbaum (2001), who distinguishes between compassion and mercy, proposes a ‘cognitive notion of compassion’ requiring three judgements: first, that the suffering is ‘serious’; second, that it is ‘undeserved’ (that is, not person’s own fault); and third, ‘that the suffering can be imagined to be ones’ own and that it has some bearing on one’s own flourishing’ (Hordern 2014 p.93). Nussbaum’s (1996) suggestion that compassion involves judging whether the suffering is deserved is not without criticism (Van der Cingel 2009; Carr 1999). Van der Cingel (2009) argues that in healthcare compassion should involve withholding judgement. This position is particular to healthcare because, as Curtis (2013) points out, the right to equal treatment can be found in the majority of all healthcare professional codes of conduct. Whilst non-judgemental compassion is the ideal, it is interesting to note that sociological research around health inequalities suggest that in respect to lifestyle diseases, healthcare workers do make moral judgements. This is well articulated through Jeffery’s (1979) notion of the ‘Rubbish Patient’ and more recent developments around the concept of the ‘sick role’. For example, Varul (2010: 89) notes that the sick role has been influenced by an increase in “chronic illness and disability” and “a rejection of behaviours and attitudes that are suspected of being part of their aetiology”.
Von Dietze & Orb (2000: 169) argue that compassion transcends difference, and that this characteristic is what distinguishes it from pity – which implies condescension and/or paternalism. They argue that “compassion deliberately seeks to avoid paternalistic care”, it is about solidarity – it is therefore “not so much what we choose to do for other people but what we choose to do together with them. Thus, compassion is based on rationale thought and emotion that requires understanding and deliberation, it is therefore a moral action because if reaches beyond the self to others.

It may be considered short-sighted to consider that recognition of, and appropriate compassionate responses, should only be directed towards ‘suffering’. Scheler (cited by Austin et al 2013 p.19), for example, writes of ‘fellow-feeling’ described as involving ‘not just sharing in suffering but also in joy’. Many health care episodes require that staff members join patients in celebration and rejoicing also. Consider, for example, childbirth and a clear scan following cancer treatment.

The Dalai Lama writes of some of the other risks of compassion as follows:

“Constant exposure to suffering, coupled occasionally with a feeling of being taken for granted, can induce feelings of helplessness and even despair. Or it can happen that individuals may find themselves performing outwardly generous actions, merely for the sake of it – simply going through the motions […] when left unchecked, this can lead to insensitivity towards others’ suffering” (ibid p.129).

The phenomenon of ‘compassion fatigue’ is now frequently reported in the international literature. Austin et al (2013 p.1) describe this, in relation to health professionals, as their being ‘too weary to be with the suffering of others in the way they once were’. The term was first used in relation to public fatigue towards global problems such as famine and poverty. In relation to the care professions’ ‘compassion fatigue’ was first used in the early 1990’s. The experience is related to others such as burnout, moral distress and secondary/vicarious trauma. Based on
their research, Austin et al (2013 p.173) write of the importance of hope in such situations:

“Without exception, the experience of compassion fatigue is painful. The journey into and through compassion fatigue is unexpected, unclear, uncertain, and unfamiliar. During such times, the need for hope is most apparent”.

There are also critiques regarding the focus on compassion in healthcare. Gallagher (2013), for example, cautions against ‘monoethics’ and argues that compassion may be necessary for healthcare practice but it is not sufficient. Other virtues or values such as justice, courage and trustworthiness etc. are also required to practice ethically.

In a recent paper, the philosopher Paley (2014) challenges the idea that recent care deficits were due to compassion failure in individuals. He draws on a substantial literature in social psychology and argues that care deficits were due rather to ‘an interlocking set of contextual factors that are known to affect social cognition. These factors cannot be corrected or compensated for by teaching ethics, empathy, and compassion to student nurses’. Mindful of this critique and of other research that highlights the importance of attention to micro (individual), meso (organisational) and macro (societal) factors (RCN 2009), the CC team’s engagement with compassion goes beyond individual behaviour.

4. Compassion in the Organisation and as a Component of Leadership

The organisational context in which compassionate care is practiced is fundamental to cultivating compassion (Paley 2014; Goodman 2014; Rynes et al 2012). Greenhalgh (2013: 481) points out that despite the Francis Report identifying a lack of compassion as the root source of the neglect encountered at Mid-Staffordshire Hospital Trust, ‘almost all [Lord Francis] recommendations relate to documents or procedures’. She argues that what is needed is a compassionate organisation because it ‘supports and shapes behaviour by its members, partly through appropriate incentives, rewards and procedures but mainly by recognising that
emotions – feeling, caring, loving, yearning – are an integral component of our rationality, not something that distorts or detracts from it (ibid)’. Goodman (2014: 1268), in her exploration of nursing care experiences amongst older people argues that:

“Poor quality care occurs often enough across care organisations (structures) to warrant analysis beyond simply vilifying and blaming failing individuals (agents). If only one nurse was abusive and neglectful we would properly look to the character of that nurse. However, when many instances of poor quality care arise we should undertake a political and social analysis for a fuller understanding”.

Rynes et al (2012) ask the question what then does the compassionate organisation look like? In their review on care and compassion in the organisation they suggest ‘that care and compassion should be the responsibility of everyone in the organisation’. To achieve this requires a radical shift, for rather than the usual organisational objectives of profit and efficiency, the organisation should focus on the ‘health, happiness, well-being and sustainability of the organisation, their members and those they serve’. When compassionate care is embedded within the organisation, it recognises the importance of the receipt of compassion and what the workforce requires in order to sustain and extend compassion to patients and their family and friends.

Youngson (2011) contends that compassion must be defined as a management and leader

“The leaders of the very best healthcare organisations provide role models for the values and principles underlying people centred care: they are deeply respectful, humane and compassionate towards their employees, they celebrate diversity, they act fearlessly against bullying abuse and discrimination, they listen deeply, they role model openness, integrity, and they are not afraid to say sorry (2011:9)”.

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A significant contribution to our knowledge of the impact of interventions on compassionate practice come from data collected as part of the Leadership in Compassionate Care Programme (Adamson et al 2012), a 3 year appreciative action research project run by NHS Lothian and Edinburgh Napier University which emphasises the centrality of developing leaders who can embed compassion within effective, relationship centred care. Three interventions developed during the project inform our intervention: use of emotional touchpoints; ‘Knowing who I am and what matters to me’; and ‘Caring about caring’.

The King’s Fund report ‘Seeing the person in the patient’ (Goodrich and Cornwell 2008) suggests that improvement in patients’ experience of care requires the cooperation and effort of all staff with direct contact with patients with encouragement and support from the wider organisation. This operates at 4 levels, the individual, the team, the institution and the wider health system and is a function of both organisational and human factors, which interact in complex ways. Leadership for improvement at team and institutional levels becomes critically important in the support of compassionate care in the light of evidence which suggests that staff wellbeing is an antecedent to patient care performance (Maben et al 2012, West and Dawson 2012).

It can be seen so far that compassionate care is linked to the nature of suffering, underpinned by wider ethical issues, and requires a compassionate organisation with leadership role modelling compassionate behaviour. A major theme running through all the section so far is that compassion is also linked to staff wellbeing and compassion fatigue. In the following section this will be explored in more detail.

5. Compassion and Emotional Labour

Curtis (2013:212) points out that the giving of compassionate care involves an emotional endeavour that can take work to achieve. Essentially the carer must be
“able to understand another’s suffering, empathise with their situation, think that suffering is terrible and therefore want to relieve the suffering by doing what is best for that person”. Yet, in relating to and empathising with the patient, the carer must also be professional - thus an emotional balance between utilising feelings of empathy with professionalism in the face of suffering is required – this involves emotional labour. Emotional labour is a term coined by Hochschild (1983) where the induction or suppression of emotion is required of the carer in order to ensure that the person being cared for feels comforted and safe.

There are some inherent difficulties and complexities involved in the emotional labour in compassionate care. First, in drawing on the self it requires the individual to relate to the suffering of others. In doing so they need to enter into that suffering. As Nouwen et al (1982: 4 cited in Von Dietze & Orb 2000: 169) powerfully write:

“Compassion asks us to go where it hurts, to enter into places of pain, to share brokenness, fear, confusion and anguish. Compassion challenges us to cry out with those is misery, to mourn with those who are lonely, to weep with those in tears. Compassion requires us to be weak with the weak, vulnerable with the vulnerable, and powerless with the powerless. Compassion means full immersion into the condition of being human”.

This ‘entering into’ needs to be balanced with making the patient feel safe and comforting them. Where possible this will also involve the alleviation of that suffering through action, such as treatment, as well as empathy. Here the emotional labour involves using compassion as a motivator in inducing the expression of reassurance, of being in control, rather than weeping with tears or sympathising in fear; it may also involve suppressing confusion and anguish in order to have a still hand, or to objectively argue for the individuals care needs in order to get the required support mechanisms in place. Emotional labour is a balancing act that requires a high degree of self-awareness, emotional dexterity and clinical knowledge and skill. As Hochschild (1983) notes, this takes work and is hard to achieve.
Smith (2012) in her book Emotional Labour in Nursing argues that the skill of emotional labour needs to be taught and refined, that an assumption that it is inherent is detrimental to its development. This is particularly the case when the individual carer does not naturally feel compassion for their patient. Hochschild (1983; 2003) describes two processes through which the emotional labourer can both induce and suppress their emotions. The first is surface acting, this is where the labourer expresses an emotion they do not really feel, but know that they are only acting it out. The second is deep acting, which is where the labourer uses their imagination or memories to work on their feelings so that they come to feel the required emotion.

Compassion fatigue and burnout is particularly linked to high levels of surface acting (Erikson 2009; Mann 2004). Conversely, when deeper relationships are forged, the emotional labour results in a deep attachment, making it harder for the carer to hide their emotions when they deeply relate or to detach when the relationship comes to an end (Kelly et al 2000).

Over exposure to suffering presents a particular dilemma to healthcare workers. Curtis (2013:217) notes in her research with student nurses that they considered it important to ‘harden up’ or develop a ‘thick skin’. For the difficulty in relating to one patient, is that one has to move on to the next and be just as available and connected to them. “Students could see the need to preserve their emotional well-being alongside the need to be compassionate”. Curtis (2013) suggests that one way in which this can be enhanced is through promoting discussions on moral courage and self-compassion. But as Gilbert (2009:xxi) notes this is not always easy. This is largely due to concerns that self-compassion is linked to ‘letting ones guard down’ “If they started, to feel self kindness or compassion it could ignite feelings of grief”. There is, however, a growing body of research (Weng et al 2014; Morgrain et al 2011; Leiberg et al 2011) that suggests that the practice of compassion increases happiness and that training individuals in altruistic behaviour enables emotion regulation and results in emotional rewards such as increased satisfaction. Indeed Gilbert (2009) points out that evidence suggests that feeling love and compassion for
ourselves is deeply healing and soothing. In their research, Hefferman et al (2010) found a positive correlation between high levels of self-compassion in nurses, and their ability to relate to the suffering of their patients. Self-compassion is therefore important to supporting and sustaining compassionate care (Gilbert 2009; 2010).

Birnie et al (2010), drawing on the work of Neff (2003:224) suggest that:

“\textit{Self-compassion entails three fundamental components: (1) extending kindness and understanding to oneself rather than harsh self-criticism and judgment, (2) seeing one’s experiences as part of the larger humanity rather than as separating and isolating; and (3) holding one’s painful thoughts and feelings in balanced awareness rather than over-identifying with them.}"

To support self-compassion, many authors are increasingly advocating Mindfulness as a means of reducing stress and encouraging self-empathy (Gilbert 2009; Birnie et al 2010; Hefferman et al 2010). Kabat-Zinn defines mindfulness as “paying attention in a particular way: on purpose, in the present moment, and non judgmentally’ (cited in Black 2011:1). The CC team has taken in to consideration mindfulness activities as a means of supporting self-compassion in the workforce.

The skill base underpinning emotional labour therefore is fundamental to supporting and sustaining compassionate care in practice. It is required in simple acts of kindness through to complex acts in which the practitioner relates yet also holds back in order to both empathise and alleviate the suffering; in addition, emotional labour is crucial where carers do not naturally feel compassion and use their imaginations or own memories to induce such feelings in order to provide the proper compassionate care required of them. Theodosius (2008) notes that emotional labour is based on reciprocal interaction – that is in entering into the suffering of the patient, the carer receives back from the patient gratitude and from a job well done, a sense of satisfaction. These emotions are important in sustaining emotional labour in the long term giving of compassionate care to the many, and go a long way in protecting against compassion fatigue.
It is important to note here that resource issues also significantly impact on the quality of care. Research on emotional labour suggests that low resources negatively impact on the quality of emotional labour given (Bone 2002). The higher the staff:patient ratio the more likely nurses will use surface acting, which is directly linked to compassion fatigue and burnout (Ball & Catton 2011; Erickson 2009; Rafferty et al 2007). They were also more likely to report low/deteriorating quality of care on the ward.

It is important that the CC team recognize the pressures staff are under, and the impact this may have on the delivery of compassionate care.

6. The Evidence Base for Compassion Training

Weng et al’s (2014) research ascertained that compassion training does increase altruistic behaviour. Their participants were divided into two groups: those who received compassion training and those who received re-appraisal training. The results showed a significant increase in altruistic behaviour in the compassion training group demonstrating that compassion training that involved cultivating feelings of compassion for different groups of people, does work.

The idea of cultivating compassion across the whole workforce poses educational questions concerning the best means of achieving this. There is a little evidence to suggest that delivering training in standard one off lectures by outsourced educationists has the desired effect. Indeed, Levine et al (2007) found that traditional lecture style training was not effective so introduced the ‘train the trainer’ model. The aim of their training was to change physician behaviour in the management of common geriatric conditions. Experts from the University Faculty trained 60 non-expert peer-educators based in the geriatric practice setting. These peer-educators then trained up their fellow geriatricians in the practice setting using a purposefully designed toolkit by the Faculty educators. Follow up research on the impact of this method showed statistically significant increases in self-reported knowledge and attitudes six months after the peer sessions. Levine et al’s
acceptance of the role and responsibility of providing compassionate care in a variety of settings. This is in line with the concept of care being at the heart of the role of the healthcare professional (Haynes et al., 2007: 1281) found that the tool kits were important factors in enabling their peer-educators to facilitate learning.

"Findings suggest that modest positive changes in practice in relation to common geriatric problems can be achieved through peer-led, community-based sessions using principles of knowledge translation and evidence-based tool kits with materials for providers and patients”.

The ‘train the trainer’ model has been most successfully used in public health initiatives where large numbers of people spread across a range of community settings need to be reached. Eresk et al (2006: 42) found in their study examining the effectiveness of the model in the community hospice setting in America that “confidence in teaching end-of-life content increased significantly for participants who used the course materials to prepare and present in service”.

The evidence supporting the train trainer model is not conclusive (Trabeu et al 2008) but would appear to be the most appropriate model when aiming to raise awareness across the wider workforce in a variety of clinical settings. The development of the toolkit is essential to this process. The CC Teams notion of the ‘toolkit’ on the move’ has been designed to enable training by peer-educators to take place in the clinical setting as well as in bespoke workshops. There is no robust evidence regarding the impact of compassion awareness training over time. Our proposal provides an opportunity to generate such evidence.

7. Conclusion

The nature of compassion and the delivery of compassionate care is complex. From this review it can be seen that compassion can be understood as a virtue, that it is rooted in moral and ethical thinking; compassion requires the carer to relate to the suffering which may involve making difficult judgements that are framed within current socio-political discourse. In order to empathise with those they care for in a
constructive way so as to alleviate suffering as well as to suffer with them, compassion requires emotional labour. Compassion needs to be embedded within the organisation as a whole and be visible in leadership behaviours. In order to raise awareness of compassion within the workforce these complexities need to be taken into account.

The **project aims** to:

- Develop a sustainable programme of compassion awareness training that enhances patient safety and experience and promotes ethical healthcare practice;
- Engage effectively with healthcare staff building on existing values-based initiatives and encouraging creative compassion promotion projects; and
- Facilitate the development of organisations and teams that respect, reflect and promote the values of the NHS Constitution.
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