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1st NZ Conference on Compassion in Healthcare
16th March 2019

Tena koutou tena koutou tena koutou katoa

Ko Shehy te maunga
Ko Blackwater te awa
Ko Celtic te iwi
Ko Ani toku ingoa

Nga mihi nui ki a koutou

Good morning everyone

I was finalising this talk as news of the Christchurch shooting appeared on my watch from a Guardian alert. I heard the shock in the voice of the RNZ reporter as events were unfolding and the compassion in his voice when he said to the principle of Linwood Avenue school, in lockdown **"I am sending love your way from all parents round new New Zealand**". I was reminded of a line I had read the previous day in Joan Halifax' book Being with Dying in which she describes ***great loss being transformed into a piercing tenderness towards everyone who has ever suffered.*** Some of you will have had other experiences of profound loss when it seems impossible to believe that other people could be carrying on with their lives as if nothing had happened and you might not have not known to whom you could entrust your tender heart. It is in the spirit of this piercing tenderness that we can honour all those affected by the Christchurch shooting and all people suffering.

I am a palliative care physician at Auckland Hospital and have therefore spent much of my work life alongside people who are dying soon or witnessing others dying. People facing death, fearing death, welcoming death, asking for death. Slow death, sudden death. People surrounded by love, people alone, people regretful and people grateful. People overwhelmed by death and people facing death with equanimity, people going gently and not going gently into that good night. I have been alongside families, whanau, secret lovers, and heard stories, confidences, confessions. I have seen communication go badly and heard about communication that went badly years ago. I have seen it go well and transform suffering for the dying and those who live on. I have seen those who are doing the communicating agonise about uncertainty, how to

make healthcare recommendations and how to tell people things that may break their heart whilst holding onto their own sometimes fragile hearts.

I have also witnessed the small compassionate acts of kindness that sometimes make the unbearable bearable. I have seen that often only connection matters in the end and that connection can happen very quickly. People can sometimes talk about their fears and hopes within a few seconds of meeting because of this capacity to connect quickly when time is short or energy is failing, when people cannot spare breath for anything that is not essential.

This has all given me many opportunities to learn about and reflect on compassion and communication in healthcare. First however I am going to tell you a story on a lighter note. I was brought up in the kind of household where most things were either homegrown or homemade, including birthday and Christmas presents. There was always a homemade cake when we got home from school. As a result we longed for shop-bought gifts and cakes…

When I was about 9 one of my aunts told me, I had the gift of compassion. I was horrified. I didn't really know what compassion was, but I felt like almost any gift would probably be better than that. Bought cake for example…

Because of my catholic upbringing I knew all about the Father, the son and the Holy Spirit. I had heard of the gifts of the holy spirit and thought compassion must be one of those. But compassion wasn't on that list. I tried the fruits of the holy spirit, but compassion didn't make it to that list either. I tried the fruits of the flesh – that list was a lot more promising but still no compassion….

I packed away this thing my aunt had said along with most of the other things that came from her generation during my teenage years….. Ironically when I failed to get into vet school at 17 and was very upset, that same aunt was the one person who seemed to understand what was going on for me. A year later when her husband dropped dead I went to stay with her. I remember feeling strange about being there and being relieved that she talked about him all the time because it saved me from having to find words that I could not find. Later she told me how much that had helped, which shocked me because I had no idea I had actually done anything. She mentioned the compassion thing again.

When I studied medicine instead of veterinary medicine I had no idea that the discourse of suffering, meaning and what it means to be an authentic and loving human, that I found in literature and poetry, would hardly be present in

my profession. By the time my mother died during my last year of medical school, however, I understood that none of my medical student friends had any idea how to be alongside me in my pain.

In my first house officer job in Coventry in the UK I was grateful that had the sense to ask the nurses for help. Especially the terrifying sister in the emergency department who made your life hell if you got on the wrong side of her. On-call happened every third night and every third weekend. An average week was 86 hours, every third week was 123 hours. I calculated that a weekend on call was eleven consecutive nursing shifts without sleep. How does compassion survive exhaustion, fear of making a mistake and sense of being totally unsupported by seniors or institutions? I distinctly remember a nurse once saying I looked tired and offering me a cup of tea and feeling overwhelmed by kindness and gratitude. On that day I am sure I was more compassionate towards my patients. The little things….

Through my 'terminal' cancer diagnosis, surgery and complications it was a nurse in her first year on the wards who showed me true compassion, when senior doctors and nurses ignored my paralysed legs and told me I could not be in pain. The flashbacks I still have are still helped by the memory of her kindness. Following a tragedy in my personal life a prominent New Zealander whom I knew personally and respected, ignored me in the street. When confronted he judged me without any attempt to understand and left me once again raw with grief. It was the kindness of the bus-driver that made the difference. I know you will have had these experiences. Different sure, but the same.

Like you through the difficulties of my life I have experienced striking examples of compassion and lack of compassion. What has helped me survive and then thrive, has often been the small moments of kindness and compassion that have been enough to get me through the next hard bit. The compassion has often come from the most unlikely of places. Not from the people I thought would have my back. Rather from people who would have no idea that they had had a transformative effect on my life. **To know that these small acts of connection, recognition and unsolicited kindness can transform suffering is of immense value to us as human beings. What a great and hopeful thing this is!** What if we all did this a bit more of the time. What if we personally put great value on doing this in our lives. What if we practiced it in the supermarket, on the bus, with strangers and what if we could increase the amount of time we spend being truly present, with strangers, with colleagues,

with patients and even our families. What if there were practices that could help us with this?

So let's move back to the world of healthcare. Albert Jones is a 76-year-old man who arrived at the front desk of a ward and told the ward at 9.30 one morning and told the ward clerk he was here to see a particular medical team for a follow up. She asked for his name and typed it into her computer. Without looking up she went into the ward office and talked to one of the nurses. Albert could see them discussing him. The ward clerk came back and told him he was early and to take a seat. After forty minutes when the same nurse walked past he asked when someone might see him. She told him the doctors would see him when they were free. He became angry and said that no one was telling him anything. After a heated discussion whilst they were standing in the main ward corridor he asked to see someone else. The nurse found the clinical nurse specialist and explained that Albert was becoming angry and could she help. This nurse took Albert into a small office and they sat down. She started by apologizing profusely that no one had yet seen him, she told him she was here to help sort things out but first could he tell her what had happened. Albert explained that he had left his disabled wife at 5am in order to catch the bus from Hamilton to get to the hospital at the time he had been told he had to be there. All he wanted was some information about what was likely to happen as he would need to make plans for his wife. The nurse found out a little more and told him she would find the doctors and come back and let him know. She showed him where the tea and coffee was. She found the doctors on the ward round and told them that he was here and what had happened. The registrar said he could leave the round now and see him. He too apologized to Albert, addressed the issues and helped him book a taxi back to the bus stop.

Put your hand up if you have seen this kind of thing happen at work.

We watch this kind of scenario unfold every day. And it affects us. I feel relieved someone finally listened, understood and helped that man. If I am not careful - care- ful – full of care -I can feel anger towards the people that did not help him and judge them. I can create a story in my head about what kind of people they must be. And then I can judge myself for feeling like that and for judging them.

OR…. If I can pay attention in that moment and open up a small small space I might be able to attune to my own feelings and to what might be going on for

another person. And I can choose to instead to be kind to the ward clerk and the nurse even if just by wishing them well in my head and in the process save myself from my own critical storyline. So somehow a smile or a kind word or thought might send a different kind of ripple through me and through the whole institution.

So what is this thing called compassion? You have already heard a definition and a lot about compassion. You know it is different from sympathy and empathy. You know from healthcare literature and policy that patients want healthcare that is more compassionate and that compassion improves patient reported outcomes and patient satisfaction. It also It is therefore helpful to look at how patients themselves conceptualize these terms.

A study that does this is a 2016 grounded theory study by Sinclair et al where a group of patients with advanced illnesses were asked about how *they* perceived sympathy, empathy and compassion. The researchers put together definitions based on the patients' responses.

These are examples of patients responses to sympathy…

"Sympathy is I think you are feeling sorry for that person. I don't want somebody to feel sorry for me I want you to help me"
"Sympathy is like flattery, its sounds pretty but it goes nowhere and does nothing"
"If you're thinking of looking for sympathy you will find it between shit and syphilis in the dictionary"

Sympathy was generally seen *as 'a pity-based response to a distressing situation that is charactersied by a lack of relational understanding and self-preservation of the observer.* It was acknowledged as well-intended but was unwanted and in some cases despised by the recipient. It made them feel worse about themselves. Sympathy was seen as motivated by pity, ego and obligation

Unlike sympathy which was seen as emotional distancing, empathy was seen as approaching the suffering in a vulnerable manner which was connecting. This is what patients said…

"Empathy enters into another's suffering …it's the ability to be there"
"Empathy is personal connection"

"When you've empathised with people you've crawled right into their moccasins"

Empathy was defined as '*an affective response that acknowledges and attempts to understand an individual's suffering through emotional resonance or putting themselves in their shoes .*

Compassion was identified as the preferred care medium …

"it's being tender"

"it's hard to explain…that extra smile, that extra, you know, hi, how are you? Hand on your shoulder, you know, we're here for you"

"Sympathy is words and you know 'jeez I hope you feel better' and 'ts terrible you got this' and compassion is running over and getting a barf bag"

Compassion was defined a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action.

Compassion was seen as less motivated by a sense of duty, less dependent on the emotional state of the observer and less influenced by the perceived deservedness of the patient. It was thought that although compassion engendered relationship is was not dependent on relationship and there was an unconditional acceptance even when the patient was at their worst.

Thus in addition to the acknowledging, understanding and relating emotionally of empathy compassion had the defining qualities of being motivated by love, the altruistic role of the responder, it resulted in action and was often associated with small acts of kindness. They spoke of people with compassion being **instrumental in the relief of their suffering in a way that had an enduring impact.**

So empathy and compassion are experienced differently by patients. A really important finding in neuroscience is that empathy and compassion affect different parts of our brain with empathy lighting up areas associated with aversion and producing a negative effect whereas, compassionate thoughts open up areas in the brain associated with reward love and affiliation. This is consistent with research being compassionate appears to engage us rather

than exhaust us and requires a reframing of the notion of compassion fatigue as perhaps empathic distress.

What about healthcare professionals – how compassionate are we towards each other?
So here is another story – it was written as part of a reflective exercise by a registrar working in a NZ hospital and I have permission to share it.

I was called to a resus in ED – the emergency department as the medical registrar on call. The ED consultant and ED registrar were at the bedside with an ultrasound probe on the belly of an elderly man. He had a history of an abdominal aortic aneurysm that had been rapidly enlarging over the years and his surgeon had previously told him there was nothing they would be able to do about it, and one day it would rupture, resulting in his death. His numbers were terrible, and the ultrasound showed free fluid in the abdomen, essentially confirming the diagnosis – that the aneurysm had ruptured. We spoke with the surgical registrar, who agreed that he would not survive surgery. I decided with the ED consultant that we would do everything we could do to ensure he was comfortable. I went back to explain this to him and ask him what was important, given that time was short.

For some reason, the medical consultant on-call had heard there was someone in resus and and arrived in ED. She saw me writing my note and charting some medications to ensure the man's symptoms were controlled. She started yelling at all the various staff members to tell her what was going on, why weren't we actively treating this man and why hadn't the consultant vascular surgeon come and reviewed the patient. We explained our logic. She started examining the dying patent, whilst berating the nurses in the room. During this period, the ED consultant was nearby in a waiting area explaining to the family that the patient was dying. The medical consultant started making phone calls to a various people as everyone became more anxious and distressed. Eventually the ED consultant took the medical consultant aside and explained how the decisions had been made. After much arguing, the medical consultant finally acquiesced to the management plan.

She then took me aside (for what reason, I'm still unsure) and proceeded to give me a piece of her mind. Afterwards, the ED consultant came up to me and asked if I was OK. She was clearly shocked by the behaviour and the treatment of the teams involved.

Please put your hand up if you have come across this kind of behaviour at your place of work. Maybe like this or maybe in a milder form. So from a place of compassion we know that no-one goes into healthcare to behave in this way. We do not set out to wound each other in the process of trying to do the right thing by a patient. I know that this person is suffering and that they are causing others in the system to suffer. What a tragedy. But who is responsible? That consultant, the busy ED department, the hospital, our leaders who prioritise throughput and outputs over the conditions for engagement that enable human beings to heal and flourish, the ministry that sets the targets and makes funding dependant on compliance, the voters who voted them in. Where does it stop and what is my role in it. It can all feel rather overwhelming.

So how and why are we communicating with each other and our patients in ways that are sometimes quite unhelpful? I think communication and compassion go hand in hand. Effective communication is compassionate. We know that when we have good communication skills, healthcare outcomes improve, satisfaction goes up, complaints go down, consultations are quicker and we all do better with less 'burnout'. We know the skills that enhance healthcare communication and these are the skills that also enhance compassion, whether that is explicit in the teaching or not. There are also conditions in our work teams that enhance or impede healthy communication. First let's look at communication skills.

My teaching and learning in relation to communication skills was initially largely through the VitalTalk team in the US. On their courses they teach healthcare professionals how to communicate and also how to facilitate the learning of others. Their teaching involves learning specific skills with mentored practice, feedback and reflection in a safe space.

The learning provides skills to connect with patients or learners as people, to find out what is happening to the them from their perspective, recognize and respond to their emotions, and impart information based on what that person needs at that time.

As we were mentored whilst we learnt facilitation skills, we realized we were becoming more compassionate towards the learners in our groups and in turn as their skills improved they become more compassionate towards the patients and families they were communicating with. None of this will be of any surprise to you – it is all obvious. But it is only rarely that it happens in healthcare. Let me give you an example of compassionate communication.

Moana was a 46-year-old woman married to Anna. She was the CEO of a small NGO supporting women who had experienced domestic violence. Between them they had four children between 5 and 16. Moana had been diagnosed with myeloma 3 years previously. She went through various forms of treatment including a stem cell transplant. Her disease was in remission for a while, but then progressed again. Further treatment improved things for a while but then she developed increasing bone marrow failure as the myeloma cells once again filled up her bone marrow and caused pathological bone fractures. After being hospitalised with pneumonia it became clear that she had only a short time left to live.

The doctor who came to speak with Moana in hospital knew that she had only a short time to live, maybe only days, and that she might want to be out of the hospital if she was dying. She also knew that Moana had always been keen to pursue any possible treatment options to give her longer with her family. She sat down next to Moana and asked her how she was. Moana said she was tired and weak. She didn't have much energy. She asked when she might expect to feel better and what the next step would be with treatment. Carefully and gently the doctor said *Moana I really wish that things were going to improve ……and …… I am worried that time is now short.* Moana looked shocked. Tears trickled down her face. The doctor stayed quiet. She pulled her chair in closer to the bed. She lent in and rested her hand on the bed near Moana. She stayed silent. After a while Moana looked up *How short? Maybe a few days, maybe a week or two*. Moana said forcefully. *Its been shit.* The doctor said *It has.* She stayed quiet again. Moana cried some more. Eventually her tears subsided. *Anna and the kids are coming in later. I want to tell them. Can you be here. Yes. And then I want to go home. Can we do that. Yes we can. Silence.* Moana looks up at the *doctor. Thank you.*

The interaction has taken six minutes. I know this because I was there. It happened last 2 weeks ago during a three-day course helping doctors and nurses enhance their communication skills. At the beginning of the course participants are often anxious and have some skills. By the end they are no longer fearful of opening a Pandora's box of emotions in patients but are able to find out what matters to them, respond appropriately to what is happening and sit in silence if needed. They notice what opens up when they leave a space and they hold the space with tenderness. They communicate with great care and compassion. And in the reflective space afterwards they consider

their own needs and their own self-care and self-compassion, which they may never have previously considered.

So this is an illustration of communication skills training in the postgraduate arena, learning in a safe space or maybe re-learning the human responses that have always been present and re-integrating them with their professional role.

But what happens when these health professionals go back to work? We know that communication skills teaching in the undergraduate curricula of health professionals has already changed markedly over the last 20 years. We know that good communication improves patient experience and outcomes and improves our experience as clinicians. Why then do complaints about communication in healthcare remain so high along with rates of burnout and suicide in health professionals? What is going on here?

I asked this question during interviews with medical students and qualified health professionals during a six-year grounded theory study until I had a theory that provided one part of the explanation. Early in my research one of my participants told me that he said to one junior doctor who had just changed teams **"you were a nice guy yesterday, how come you have become a bastard today".** Over and over again the degree to which junior doctors could speak, get their needs met, and thrive varied according to attributes of the team they were working in and impacted on the patients they cared for. I called this team thing the relational landscape of the team. I found that teams could have engaging, good enough, undermining or disabling relational landscapes.

Let's take an example in relation to learning. Say a newly graduated doctor is asked to order a scan during a ward round but doesn't understand exactly what the scan is for. In **a team with an engaging relational landscape** that doctor can ask the consultant on the ward round for more information and then go and order the correct scan. In a team with a **good-enough relational landscape** they might not do that but could find a workaround by asking someone else later. In an **undermining relational landscape** they might not feel able to ask anyone and in a disabling landscape they might be mocked or humiliated for asking.

These four different types of relational landscapes in teams also determined other attributes of the team such as emotional wellbeing, interprofessional working and social cohesiveness. It turns out that behaviour is modified rapidly when people enter these teams. People pick up quickly on the relational cues –

all the things we say and do everyday- to learn the rules of how to behave round here and this in turn affects the cues that they add to that relational landscape resulting in reinforcement of that particular landscape.

It turns out the relational landscape is determined by the philosophical drivers of the team. Where these drivers were predominantly based on healthcare as **a service industry** concerned with getting patients through the system, hierarchy tended to be steep, the relational landscape undermining or disabling resulting often in misuse of voice. Where the philosophical driver for the team was nearer **healthcare as healing** teams had an engaging or good enough relational landscape a flatter hierarchy resulting in people being able to actively engage their voice. In these teams emotional wellbeing was valued, social cohesion and learning were prioritized and healthcare professionals and patients were more likely to thrive. Thus the environment in which we are immersed profoundly affects the way we are in the world. We pick up the cues in the relational landscape very quickly and adapt how we speak and behave in order to fit in with that environment.

So, in summary, this business of communication and compassion is complex. We have our own barriers and variable commitment to compassion. There are issues with how we ensure that our increased focus on communication, compassion and professionalism is not undermined by the relational landscape of the teams we work in. There are factors about patients and families that make it more difficult for us, complex barriers of language and health literacy, overwhelming social situations, poverty and abuse, and suffering that seems difficult to relieve. There are institutional factors – a strong focus on KPIs and dollars. We often work in conditions where we feel conflicted between our knowledge of what makes good patient care and our inability to provide it resulting in moral injury. Despite being some of the most resilient and resourceful people on the planet this moral injury takes a toll. We may fall over the edge of respect into disrespect and bullying. Even wanting to be perceived as compassionate can be a trap – we might feel our worth is measured by how compassionate we are whilst needing approval and validation.

The good news, however, is that we have many ways that we can improve the situation and remove barriers. First we can do our own personal work, we can develop self-compassion. We are so lucky to live in an era with access to such great teaching of contemplative practices such as mindfulness and meditation increasingly supported by scientific evidence to help those who need that. We

can learn from the wise people who have been here before us. I believe there are some fantastic workshops planned for tomorrow (!).

Second there are ways in which we can teach communication that opens up a precious space for noticing, that enhances compassion and can mitigate empathic distress, overwhelm, withdrawal and burnout. And thirdly we can challenge the philosophical drivers within healthcare that profoundly affect the degree to which we are able to act with compassion within our teams.

Whatever we do we need some sense of urgency for our patients, ourselves and our planet.

In the worlds of the Dalai Lama: **compassion is not religious business it is human business. It is not luxury ….it is essential for human survival.**

Thank you