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Link to publication

Total number of authors:
1

IJHPM
International Journal of Health Policy and Management

Commentary

Beyond Compassion: Replacing a Blame Culture With Proper Emotional Support and Management
Comment on "Why and How Is Compassion Necessary to Provide Good Quality Healthcare?"

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Abstract
The absence of compassion, argues the author, is not the cause of healthcare failures but rather a symptom of deeper systemic failures. The clinical encounter arouses strong emotions of anxiety, fear, and anger in patients which are often projected onto the clinicians. Attempts to protect clinicians through various bureaucratic devices and depersonalization of the patient, constitute as Menzies noted in her classic work, social defences, aimed at containing the anxieties of clinicians but ending up in reinforcing these anxieties. Instead of placing additional burdens on clinicians by bureaucratizing and benchmarking compassion, the author argues that proper emotional management and support is a precondition for a healthcare system that offers humane and effective treatment to patients and a humane working environment for those who work in it.
Keywords: Compassion, Emotional Labour, Emotional Management, Anxiety, Social Defences, Psychoanalysis, Blame Culture

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A compassion deficit has recently been identified as an explanation for some major healthcare scandals and failures, as Marianna Fotaki[1] has eloquently argued in her recent editorial. This, as she states, is reflected in the findings of public inquiries into such failings, but it also expresses public opinion on the causes of these failings. A compassion deficit as the core reason for healthcare failures is also currently beginning to infiltrate academic discussions. The combination of the terms 'compassion' and 'healthcare' resulted in only two articles on the ISI Web of Knowledge database in the early years of the twenty first century, a figure that rose to 23 in 2014. Compassion and its failings then are now centre stage in public discussions of health policy and increasingly academic discussions too.

At first sight, the plausibility of the idea that failures in healthcare are due to lack of compassion of clinicians for their patients seems incontestable. This is certainly the view of many patients and their relatives, but also many of those working in the health sector. Notice something else too – in public discussions nurses seem to be instantly placed in one of two extreme positions, either idealized as caring angels or vilified as uncaring functionaries filling forms and holding back from offering patients the one thing they desperately need: reassurance and human contact. This tendency to idealize or to vilify extends to doctors (messianic figures saving lives or uncaring technicians treating patients as throughput to their medical machines). It also extends to the National Health Service (NHS) system as a whole, where, at least in the United Kingdom it is portrayed as the nation's greatest institution, or conversely, as a Kafkaesque bureaucracy which people

enter at a huge risk to their dignity, their humanity and even their health.

It is worth reflecting on the centrality of compassion in different service relations, in other words in relations when a system staffed by professionals seeks to address the needs of its constituents or clients. Do patients need or deserve more compassion from those who serve them than do students or airline passengers? Do patients deserve more compassion than the compassion that nurses or doctors who look after them deserve from their own managers or the public at large? Emotion is central to every service relation, whether it involves clinical work, nursery work, teaching or even hairdressing. In all of these instances, people place themselves in a dependent relation to someone with superior expertise and are liable to feel vulnerable, exposed and anxious. As Fotaki rightly points out, a duty of care, is the corollary of this vulnerability: the undertaking, in other words, to provide an effective and safe service, but also to treat the other with respect and consideration. A safe and effective service, ie, a technically effective service that minimizes health risks and optimizes a patient's chances of survival and recovery, is not enough, unless it is complemented by a concern for the patient's psychological well-being in time of vulnerability and anxiety.

This is why 'emotional labour' becomes as important in the way clinical staff do their work as intellectual and manual labour. Emotional labour is a term proposed by Hochschild[2] and subsequently used numerous theorists to denote the work involved in responding to the emotional needs of clients in different service transactions. In the case of health

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service, reading the emotions of patients and their loved ones, responding to them and managing them becomes as important as drawing blood with syringes or performing mastectomies. However, working with patients' potentially explosive emotions (including fear, anger, despair, anxiety, disappointment, and physical pain) makes considerable demands on those who deliver the service, demands that are reduced if the clinical staff distance themselves from the patients and restrict themselves to providing a safe and efficient technical service. Hochschild[2] was aware that in some circumstances emotional labour can turn into the 'commercialization of human feeling,' where employees go through the motions of displaying suitable emotions, such as compassion, excitement or hope, without actually feeling them, a situation she described as 'surface acting.' This would certainly result in deficit of real compassion even if the pretence of compassion is displayed in a healthcare setting. What Hochschild's important concept did not consider is that emotional labour towards others requires a very considerable work on the part of health and other service providers with their own emotions. This is what Ian Craib, in a seminal contribution, described as emotional work:

"Individuals, people – men and women – are by definition engaged in at least two interlocking forms of emotional work: The 'internal' work of coping with contradiction, conflict and ambivalence and the 'external' work of reconciling what goes on inside with what one is 'supposed' or 'allowed' to feel" (p. 113).[3]

The internal emotion work carried out by professionals like nurses and doctors who deal with people in acute distress or anxiety is an issue that rarely receives the attention it merits. Under a 'stiff upper lip' ethic, a professional ethic of cool efficiency consigns the emotional complexities of dealing with another's suffering to the margins – something that any experienced professional should automatically know how to do.

In nursing literature, the importance of 'external emotional work' continues to be the topic of vigorous debates, gauging the relative importance of clinical and professional skills as against emotional attributes.[4-8] These debates touch a much broader audience than academics, as exemplified by the widely reported sermon in 2006 of the then Archbishop of Canterbury, Dr. Rowan Williams (http://rowanwilliams. archbishopofcanterbury.org/articles.php/1488/nursing-dignity-and-florence-nightingale-sermon-at-westminster-abbey).

You could say that the modern profession of nursing was born out of a passion for human dignity - not just the sense of a practical job to be done, but a serious conviction that what is due to people in situations where they are helpless and even dying is time, respect and patience, no less than practical skill.… Specifically in the health care professions, a growing number of people now say that the simply personal and relational skills of healing are squeezed out in training and seriously undervalued in favour of mechanistic skills. And for nurses especially, this is a huge and damaging shift away from that fundamental commitment to the service of human dignity with which we began.

An author who was way ahead of her time in discussing the emotional demands of nursing work was Isabel Menzies. Based on research in a London teaching hospital, her study "*A case study in functioning of social systems as a defence against anxiety*"[9] can rightly claim to be a classic. Nurses, argued Menzies, operate in an emotional maelstrom of demands and expectations made by patients and their relatives. These include both positive and negative emotions, 'rational' and 'irrational' ones, ranging from gratitude, respect and admiration to envy, resentment, contempt and rage. In addition, nurses experienced profound and conflicting feelings of their own towards their patients, including closeness and personal caring, but also impatience, frustration and anger. These emotions are compounded by an awareness that mistakes can be very costly, that their patients may die or that they may be powerless to control their fear, panic and anger.

"The work situation arouses very strong and mixed feelings in the nurse: pity, compassion and love; guilt and anxiety; hatred and resentment of patients who arouse these strong feelings; envy of the care given to the patient" (p. 46).[10]

Faced with such an emotional cauldron, many nurses are prone to feel primitive anxieties whose origins, in Kleinian theory, can be traced in the experiences that we all have as children. According to Klein,[11] every infant experiences a tremendous rage when they first discover that their mother is not there to care for them. They respond to this absence by 'splitting' the mother into two separate objects, the 'good mother' and the 'bad mother' and the maternal breast into two separate breasts, the idealized 'good breast' that is the source of life and the 'bad breast' that threatens life.

Such anxieties are liable to resurface later in life when we experience life or death situations that precipitate splitting – precisely what often happens in clinical encounters when the clinician is liable to split the patient into a 'good patient' (obedient, pliable, and grateful) and a 'bad patient' (demanding, self-centered, and ungrateful) and the patient is liable to split the clinician into a 'good nurse (or doctor)' (life-giving, caring, and wise) and a 'bad nurse' (withdrawing, cold, and indifferent). Nurses cast in the role of the 'bad nurse' or believing themselves to be cast in this role are then liable to experience intense (and at times unbearable) anxieties from which they seek to defend themselves by looking at patients as bed-blockers (people who stay too long in hospital because there is nowhere else for them to go), parasites or worse.

Menzies decisive contribution, and what makes her work very relevant to contemporary discussions on compassion, was to establish how an organization's own bureaucratic features, its rules and procedures, rotas, task-lists, checks and box-ticking, paperwork, hierarchies, and so on, all of these impersonal devices act as supports for the defensive techniques. By allowing for 'ritual task performance,' by depersonalizing relations with the patients, by using organizational hierarchies, nurses contain their anxiety. Thus a patient becomes 'the kidney in bed 14' or 'the tracheotomy in ward B.' In this way, nurses limit the anxiety they would experience if each patient were to be dealt as a full human being in need. And remember – Menzies was writing this in the 1950s and 1960s, a time that is now presented as a golden age of the NHS for its caring qualities. This is a point repeated many years later by Bauman[12] in his adiaphorization thesis – the pronounced ability of bureaucratic organizations to emasculate individuals' moral impulse and to neutralize their sense of moral responsibility, thus eliminating their capacity

for compassion.

Now comes Menzies's decisive contribution and the one that puts her ahead of others theorizing how bureaucratic organization neutralize their employees' moral impulse. Organizational defences against anxiety not only dehumanize the patient but are ultimately ineffective in protecting the clinician.

> "The system made little provision for confronting anxiety and working it through, the only way in which a real increase in the capacity to cope with it and personal maturation would take place. As a social defence system, it was ineffectual in containing anxiety" (p. 363).[13]

The system's inadequacy is evidenced by its failure to train and retain nurses, low morale, high levels of stress and burn-out, and absence of work satisfaction. By contrast, institutional health is testified not only by performance and output indicators, but also by morale indicators, and individual feelings of fulfilment from performing an invaluable service. Along with other psychoanalytically trained theorists, Menzies believed that skilful organizational consultants can restore an organization to health, by implementing a number of principles:

> These principles match quite closely the criteria for a healthy personality as derived from psychoanalysis. They include avoiding dealing with anxiety by the use of regressed defenses; more uses of adaptations and sublimation; the ability to confront and work through problems; opportunities for people to deploy their capacities to their fullest, no more or less than they are able to do; opportunity to operate realistic control over their life in the institution while being able to take due account of the needs and contributions of others; independence without undue supervision; and visible relation between efforts and rewards, not only financial (p. 373).[13]

As we have noted, in highlighting the importance of working with the turbulent emotions unleashed by clinical encounters, Menzies was well ahead of her time. On the basis of research in four London teaching hospitals, Lökman and colleagues[14] have demonstrated that the emotional dynamics and depersonalization of patients that afflict nurses also afflict doctors. Other theorists, like Obholzer and Roberts,[15,16] Fotaki[17] and Gabriel[18,19] have built on Menzies' legacy demonstrating why not just nurses but entire health systems become charged with unrealistic expectations for miracles, health and even immortality, which generate immense anxieties for their own staff. Unless we develop ways of containing these anxieties without denying them or viewing them as indicators of weakness and failure, health workers will continue to be confronted with impossible and damaging demands.

Seeking to promote compassion by sermonizing, scapegoating and box-ticking will only have the opposite result – it will enhance feelings of guilt, anxiety, and resentment, resulting in superficial displays of compassion accompanied by defensive and regressive positions which ultimately do no good to the patients, to clinicians or to the system. This is not to deny the importance of compassion emerging for an organizational ethos of caring, as advocated by Fotaki in her editorial. Such genuine compassion can only result from the containment of anxieties, the moderation of the expectation of miracles, the acknowledgement of vulnerability and suffering and, above

all, a continuing endeavour to bring painful emotions to the surface rather than seek to obliterate and deny them. These seem to me to be the preconditions for a healthcare system that is able to learn from mistakes without a blame culture and able to sustain a humane and caring service.

Ethical issues

Competing interests

Author's contribution
YG is the single author of the manuscript.

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