I am Beyond Caring

By Marcus Evans

The Francis Report outlined:

- the way staff systemically became detached, cruel, and disengaged from their responsibilities
- the lack of compassion from nursing staff for their patients.

The response has been calls for compassionate treatment, courses in compassion and even compassion therapy.

What has gone so wrong that a high court judge has to write a report emphasising the need for compassion in nursing? Is this not a given?

In his letter to the secretary of state lord Francis says;

‘Building on the report of the first inquiry, the story it tells is first and foremost of appalling suffering of many patients. This was primarily caused by a serious failure on the part of a provider Trust Board. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust’s attention’

(Francis 2013).

Proper healthcare goes beyond the physical needs of the patient.

It has to help patients and their relatives manage the anxieties associated with illness, dependency, death and psychological disturbance.

To provide good care staff need to feel supported and valued by a management structure that understands the nature of their work.

They also need clinical and managerial structures that help them contain the inherent anxieties in their work .

The therapeutic setting

Implicit in the role of the nurse's relationship with the patient is the capacity to empathise and contain the patient's suffering.

This is a process of taking in the patient's states of mind and projections through observations and contact with the patient's emotional and physical state (Fabricius 1991).

Using his/her own internal experience of suffering and anxieties about illness and damage, the nurse forms an identification with the patient and understanding of the patient's anxiety and pain through a compassionate and thoughtful attitude .

To develop and maintain a balanced approach nursing staff need:

- settings and structures that help them digest the anxieties and pain involved in their work
- support through clinical discussion, reflective practice, and good management

These help the nurse separate from the effect of the patient and restore an objective clinical approach.
Staff who have become hardened are helped to reflect more on the emotional impact of clinical contact .

Leadership and Institutional support

Good leadership is an essential ingredient in any well-run team.

The leader is responsible for establishing an environment in which high quality clinical care can take place.

Leadership provides teams with:

- clear lines of accountability
- realistic goals
- effective communication
- high standards in relation to recruitment of staff
- appropriate training
- adequate staffing levels
- good relationships with ancillary support

The capacity to provide good care is affected by factors outside the ward including the quality of managerial support and containment provided by senior clinical managers external to the ward or team.

Teams need senior clinical managers who are engaged in helping to resolve conflicts and dilemmas involved in difficult clinical issues.

Senior clinical managers need to help front line clinical managers to review staff performance and issues concerning recruitment and development .

The fragmentation of authority for clinical areas

Clinical nurse managers are left with the responsibility and anxieties about the quality of care available in the clinical setting, but without the authority needed to execute these responsibilities.

The effect of survival anxiety on the health care system

The internal market, introduced early in the 1990s, created a fragmented healthcare system with different parts of the system encouraged to compete for patient contract, rather than work together in the interests of the patient.

Unhealthy aspects of competition affect relationships between colleagues and services when destructive rivalry infects thinking.

The effects of cuts

- economic pressure forces a downgrading of clinical staff and of the skill mix in teams
- nurses frequently have to reapply for their jobs and accept lower salaries
- experienced staff take voluntary redundancy or retirement
- senior managers are often unable to really listen to concerns about lack or resources for patient care.

These changes have left healthcare assistants on the front line of clinical care with qualified nurses increasingly responsible for management.

The target culture

Over the past 20 years there has been a substantial shift in the clinician/patient relationship away from the authority of the clinician being accepted as a guarantee of good quality care.
NHS regulatory authorities, commissioners and patients look for ‘objective measurable outcomes’.
This information can only be helpful when fed into the managerial system in a way which adds to the overall picture allowing managers to think about its meaning and decide on appropriate action.

Although objective measures can be helpful, they provide no more guarantee of good treatment than the clinician's opinion. Our preoccupation with measuring everything can become a defensive distraction from the task of caring for the patient

(Proctor, Wallbank, Dhaliwall, 2013).

The effect of survival anxiety on the healthcare system resulting from the internal market, financial cuts and targets, is that senior management are so insecure they are unable to provide the containment that clinical managers need.

The resulting lack of empathy from senior managers for clinical staff is one of the factors that leads to the nurses' lack of empathy for patients.

The Training of Nurses

Project 2000 moved responsibility for nurse training from the hospital-attached schools to universities.

Accompanying this physical move was a shift from ‘hands-on’ learning apprenticeship model to academic classroom learning.

Emphasis in student nurse selection shifted from vocational aptitude to academic ability.

Financial pressure on universities has left tutors overseeing too many students and unable to give enough time or make regular hospital visits to support students or their clinical placements in a meaningful way (DH 2006).

A weak relationship between tutor and student can leave students drifting or failing to make best use of the training.

Fewer placement visits leave clinical staff managing placements without the opportunity to discuss students' progress.

As a consequence of the failings in this system, many nurse directors and managers have recognised that recently qualified staff are often unable to complete basic nursing procedures
(Department of Health 2006).

Many universities have had contracts (with financial targets attached) to fill a certain number of student nurse places which inevitably affects the quality of recruitment.

Clinical leadership roles are vital containers of anxiety.

Anxieties about survival and fear of persecution erode the confidence and authority of the clinical nurse manager.

Clinical nurse managers are left with their anxieties about managing the gap between senior managerial expectations and their capacity to deliver appropriate clinical standards.

Clinical services need experienced staff familiar with the realities of clinical practice, able to know when corners are being cut, standards compromised and damaging risks taken.

Teams need senior clinical managers who assist them in their job with regular, supportive contact not directives and surveillance.

Senior managers need authority and confidence to communicate difficulties, back up the hierarchy and communicate issues down the chain of command.

They must be prepared to stand up to senior colleagues to protect standards of care in front lines services.

Have we reached a tipping point in this system?

Can we still rely on individuals’ valency towards care and responsibility?

The persecution inherent in the system is creating an environment antithetical to thoughtful care.

Only exceptional clinical managers can juggle the demands of ‘target culture’ while keeping the patient care at the heart of their thinking.

This is not a sustainable position.

We need experienced leaders able to manage the anxieties in the work and support front line staff.

These clinical leaders, in turn, need support from senior managers, reducing fragmentation and splitting.