Nurse Education Today 34 (2014) 480–486

Contents lists available at ScienceDirect

Nurse Education Today

journal homepage: www.elsevier.com/nedt

The role of professional education in developing compassionate practitioners: A mixed methods study exploring the perceptions xof health professionals and pre-registration students

Lucy Bray [a,b,*], Mary R. O'Brien [a], Jennifer Kirton [a], Kate Zubairu [c], Angela Christiansen [c]

[a] Evidence-Based Practice Research Centre, Edge Hill University, UK
[b] Children's Nursing Research Unit, Alder Hey Children's NHS Foundation Trust, UK
[c] Faculty of Health and Social Care, Edge Hill University, UK

ARTICLE INFO

Article history:
Accepted 12 June 2013

Keywords:
Compassion
Compassionate care
Education
Nursing
Health care
Student

SUMMARY

Compassionate practice is a public expectation and a core health professional value. However, in the face of growing public and professional unease about a perceived absence of compassion in health care it is essential that the role of education in developing compassionate practitioners is fully understood. The aim of this study was to explore qualified health professionals' and pre-registration students' understanding of compassion and the role of health professional education in promoting compassionate care. A sequential explanatory mixed methods study collected data using surveys and qualitative semi-structured interviews from qualified health professionals (n = 155) and pre-registration students (n = 197). Participants were from a range of health and social care disciplines and registered at a UK university. The findings indicate a high level of consensus in relation to participants' understanding of compassion in health care. Acting with warmth and empathy, providing individualised patient care and acting in a way you would like others to act towards you, were seen as the most common features of compassionate care. However, ambiguities and contradictions were evident when considering the role of health professional education in promoting compassionate practice. This study adds to the debate and current understanding of the role of education in fostering compassionate health care practice.

Introduction

Recent debates have brought the notion of compassion in health care to the fore and have emphasised the importance of developing compassionate practitioners (Department of Health (DH), 2010; Francis, 2010). The reiteration of compassion as a core professional value has arisen in response to growing public and professional concern that, at a most fundamental level, the ability of practitioners to practise compassionately is either lost, eroded or compromised (Maben and Griffiths, 2008). This concern has particularly, although not exclusively, focussed on nursing where compassion is considered a core professional value, intrinsically bound up with notions of what it is to be a nurse. Internationally, predominantly nursing-orientated professional and regulatory bodies (Nursing and Midwifery Council (NMC), 2010; Canadian Nurse Association, 2008; American Nurse Association, 2011) identify compassion as a core professional attribute. In the UK, the National Health Service (NHS) Constitution (DH, 2012a), which is of relevance to all health professionals, identifies compassion as a fundamental value and suggests that at times of basic human need; it is care and compassion that matter most. Given the current debates and concerns it is important to investigate the notion of compassion in health care and identify the potential of health professional education to promote compassionate practice. Although it is recognised that compassion is an essential value within other disciplines and professions, this paper will focus on nursing and nurse education.

Background

The General Medical Council and Nursing Midwifery Council (2012) jointly state that health professionals need to demonstrate compassion and kindness, as well as knowledge and skill. Indeed the NMC (2010, p. 13) identifies "safe, compassionate, person-centred, evidence-based nursing that respects and maintains dignity and human rights" as an essential skill and professional value that students must acquire before professional registration. The renewed focus on care and compassion has developed against a landscape of growing concern, triggered by recent high profile cases of poor care, that health care is failing to respond to the needs of people with care and compassion (Patient Association,

* Corresponding author at: Evidence-Based Practice Research Centre, Edge Hill University, UK. Tel.: +44 1695 657231.
E-mail addresses: brayl@Edgehill.ac.uk (L. Bray), obrienm@Edgehill.ac.uk (M.R. O'Brien), kirtonj@edgehill.ac.uk (J. Kirton), kate.zhubairu@Edgehill.ac.uk (K. Zubairu), christia@edgehill.ac.uk (A. Christiansen).

0260-6917/$ – see front matter © 2013 Elsevier Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.nedt.2013.06.017

2009; Healthcare Commission, 2010; The Parliamentary and Health Care Ombudsman, 2011).

Whist it is agreed internationally that compassionate care is important for health care professionals, elements within the concept remain contested (Curtis et al., 2012). The term "compassion" is derived from Latin and in its original form means "with suffering" (Maben et al., 2009). The notion of suffering is evident in the many definitions of compassion, where a person takes into account the suffering of others and attempts to alleviate it as if it was their own (Schultz et al., 2007) and identifies and deliberately participates in the suffering of others (Von Dietze and Orb, 2000). Compassion is described as a profound feeling, triggered by witnessing the pain and distress of others, which can be demonstrated by acting in a way that you would like others to act towards you (Chamber and Ryder, 2009).

As a core value in health care, compassion has been described as responding with humanity and kindness to each persons' pain, distress, anxiety or need and identifying things, however small, which can give comfort and relieve suffering (DH, 2012b). Compassion involves respecting and valuing people as individuals and responding to them in ways that appreciate the human experience of health care (McLean, 2012). Compassion then becomes more than being kind, but is an emotional connection that involves seeing 'the person in the patient' (Goodrich and Cornwell, 2008). References to compassionate practice are particularly prominent in nursing literature and compassion and care are seen as central concepts for nursing, being described as "nursing's most precious asset" (Schantz, 2007, pg 48). Indeed, humanity and compassion are regarded as foundations for excellent nursing care (Maben and Griffiths, 2008).

There has been discussion regarding the role of health professional education in influencing the development of compassionate practice. The debate has centred on whether the move to graduate level registration (Herdman, 2004) and the delegation of bedside caring roles to health care assistants (Jones, 2003) have resulted in a devaluing of care and compassion. This paper reports on health professionals and pre-registration students' understanding of compassion with a focus on the perceived role of education in fostering compassionate practice.

Method

Design

A mixed-method design was adopted to gain insight into the topic. Survey methods aimed to gather structured data from participants; qualitative data allowed the exploration of subjective experiences, perceptions and personal beliefs (Moule and Goodman, 2009). The use of mixed-methods aimed to increase the scope and comprehensiveness of the study (Morse, 2003). The different methods were used sequentially, with the qualitative phase providing the opportunity to gain a deeper and broader understanding of the quantitative findings (Creswell and Plano-Clark, 2007). This approach has been termed an explanatory design, where the quantitative data is collected and qualitative methods are used to elaborate, expand and explore the quantitative data (Creswell and Plano-Clark, 2007). This study placed an equal emphasis on the findings from the quantitative and qualitative components.

Data Collection

Survey

A structured survey was used to gather self-reported data on the meaning of compassion to qualified health professionals and students, their perceptions of barriers and facilitators to providing compassionate care and opinions on whether compassion could be taught, learnt or assessed within practice and educational settings. The survey reflected issues from the literature and consisted of two questions where respondents rated statements according to their opinion; twelve closed Likert-scale questions and two open-ended response questions focussed on what promoted and prevented the delivery of compassionate care. The majority of data collected were closed responses supplemented by short written responses. The survey was pre-tested on five pre-registration students and three lecturers to help inform face and content validity (Gerrish and Lacey, 2010). This resulted in minor changes to several words to improve the understanding.

The survey was distributed to the participants by a member of the research team during teaching sessions within the university. Health professionals and students were provided with the opportunity during coffee and lunch breaks to complete and return the survey into a drop-box.

Interviews

Qualified health professionals and pre-registration students were asked to identify themselves on a separate slip if they wished to be further involved in the study. This was returned in a separate drop box to ensure the survey responses remained anonymous.

Individual interviews aimed to explore participants' perceptions, subjective experiences and opinions and intended to illuminate the quantitative survey data (Gerrish and Lacey, 2010). The interviews were semi-structured which allowed participants to discuss issues of importance to them whilst the use of a topic guide helped to direct the interactions. The interviews were conducted by two members of the research team (xx & xx) either face to face within the university (in a quiet location) or over the telephone depending on the participants' preference. All interviews were audio-recorded with the participant's consent.

Sampling and Recruitment

All participants were recruited through a university in the North West of England. Qualified health professionals were accessing the university either for short educational or degree courses and all the pre-registration students were registered with the university. It is recognised that the views of health professionals who are actively seeking further education may differ to those who do not access formal educational opportunities. The study used a stratified purposive sample (Kemper et al., 2003) to include different disciplines and professionals. All participants were provided with an information sheet which detailed the purpose of the study, their involvement and the treatment of their data. Pre-registration students from all nursing branches (adult, child, mental health, learning disability), paramedic practice, operation department practitioner (ODP) and midwifery together with qualified midwives, paramedics, ODPs and nurses were approached to participate by members of the research team.

Analysis

The quantitative data from the questionnaire were analysed using SPSS version 16.0 to produce descriptive statistics (percentages and frequencies). Inferential statistics were conducted (independent samples t test) to explore relationships between data. The short structured free text responses from the questionnaires were analysed using content analysis (Polit and Beck, 2010) to categorise the frequency of responses.

All interview data were transcribed verbatim, open coded and analysed using a thematic approach which involved data being organised according to emerging themes (Tappen, 2011). Analysis was independently carried out by three members of the research team (xx, xx, xx) who met and discussed the resultant codes and themes. Any discrepancies or differences in labelling and coding