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Teamwork: Developing clinical leadership

Hospitals today have been shown to fail to provide basic levels of humane care. A series of high profile healthcare scandals have shown that patients can be left hungry, thirsty and in pain by staff, many of who believe they are doing a good job. What does compassionate teamwork look like? And what happens when members of healthcare teams, the majority of whom entered the profession with a strong set of ideals, come to the conclusion that human caring is a "hopelessly naïve notion".



What do patients want from the team responsible for their healthcare? The priority, almost certainly, is safe and effective treatment. But there's evidence that patients also want the team responsible for their care - however many people that might involve - to treat them with the respect and the right to dignity and privacy that they expect from individual practitioners.

Here is one woman's experience of compassionate care provided by 'the people at the hospital'.

 *"I found the people at the hospital hugely helpful, the kindest people when you consider their job on a cancer ward. They were the nicest people, and the thing that impressed me most was that they sort of looked at you as you went home and said 'if you have anything at all that troubles you, always remember you do not have to put up with it' and that stuck really in my mind. I felt that was the best bit of advice I'd been given. And were always prepared to answer the phone 24/24 if you had cancer related side effects or symptoms that you didn't understand or you couldn't cope with, they were very, really very helpful."*

The use of unscientific words - 'kindest', 'nicest', 'sort of looked at you', 'really very helpful' - may suggest that this experience is too personal to be capable of analysis as a factor in healthcare. Yet there is a view, increasingly supported by evidence, that quality of care is an integral part of treatment. As such, it cannot be something that may or may not be offered according to the personality or the mood of the individual practitioner.

Compassion in healthcare was officially recognised in 2007 when it was listed as one of five core values for healthcare practitioners in the NHS Constitution. In fact, its importance has been recognised for more than a decade. UK healthcare practitioners were urged to treat patients with respect by the Bristol Royal Infirmary Inquiry which was set up to investigate the causes of the excessively high mortality rate in paediatric surgery in the early 1990s.

The experience of being a patient, the Inquiry noted in its report published in 2000, is characterised above all by:

"a sense of powerlessness and loss of control over personal decisions" - exaggerating the existing "imbalance of power between professional and patient".

A key factor in restoring balance to this relationship, the report said, involves:

"treating patients as thinking, feeling, interacting beings for whom contact with the NHS will be different in each and every case" ... "as people who live complex lives rather than as clinical problems with a collection of symptoms".

Significantly, the report put the onus for demonstrating respect to patients on the team rather than the individual - with a call for a change to the culture of healthcare rather than an appeal to an individual's ethical sensibility. It said:

"If a sense of powerlessness is a common experience, and engenders feelings of frustration or worse, ways must be found to empower the patient, and, in the case of unwell children, their parents. The aim should be to foster an environment in which both patients and professionals feel that they are playing a mutually supportive role in the patient's care."

This patient takes the same view. Here he describes an interaction with an insensitive clinician.



"At the pre-operative outpatient stage after the TRUS biopsy (the trans rectal ultrasound biopsy) whilst waiting in a crowded corridor full of other patients and their relatives a clinician whom I'd not encountered at any stage during the procedure itself and who had her coat on ready to leave stuck her head into the crowded corridor to shout in my general direction that I should expect to see blood in my semen for a period of time after this biopsy."

Like the Bristol inquiry, this man is convinced that it's not good enough to blame either lack of resources or individual insensitivity.



"Now that was a highly avoidable example. It would have taken literally just seconds longer for me to be taken to a room somewhere or even just behind a curtain somewhere for this information to be imparted to me with a little greater discretion. So I firmly believe that that has nothing to do with resources. It has to do with personal choice, personal practice. It has to do with training. It has to do with culture. Perhaps it has also has to do with managerial performance management practice because these things go on because we work in a system that allows them to go on."

In recognising the need for systemic change, the Bristol Inquiry was influential, helping to form the thinking behind the NHS Constitution. This document, launched in 2007, includes the pledge that as healthcare professionals:

"We respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for those we serve and work alongside. We do not wait to be asked, because we care."

It also led to increased awareness of the importance of clinical governance, introduced in 1998 as a means of redressing the balance and making high quality care the priority in an NHS seen to be adversely skewed towards financial issues and activity targets. Putting "patients' satisfaction with the service provided" alongside the "technical quality of professional performance", clinical governance, currently managed by the Care Quality Commission, was hailed by the BMJ in 1998 as "a big idea that has shown that it can inspire and enthuse".

The NHS Constitution has had some influence: hospital wards may now have posters on the wall asking for feedback to a question such as: "Dignity and Respect: How Are We Doing?" Yet a series of inquiries into NHS scandals suggest that for some hospitals at least the answer might well be

unprintable.

Mid-Staffordshire NHS Foundation Trust, supposedly a beacon of excellence that should have been driving up standards in healthcare, became famous for filthy wards and uncaring staff who caused thousands to suffer "horrific experiences that will haunt them and their loved ones for the rest of their lives".

Now the subject of a public inquiry, a previous independent inquiry's report, published in February 2010, gave evidence of dangerous clinical practice throughout the hospital's emergency services, leading to the deaths of up to 1,200 people over a three-year period. Just as chilling were the queues of witnesses describing how their loved ones had been left in pain, or without food or drink, or needing the toilet and left sitting in soiled bedding, for several hours at a time.

"This was an appalling failure at every level of the hospital to ensure patients received the care and compassion they deserved," - Health Secretary Andy Burnham, February 2010.

The Healthcare Commission's 2007 enquiry into a similar failure at Maidstone and Tunbridge Wells NHS Trust also revealed a situation of "patients not being fed, call bells not answered, patients told to empty their bowels or bladder in the bed and general disregard for privacy and dignity".

The Patients' Association report, Patients Not Numbers, People Not Statistics (November 2009) claimed that far from being isolated incidents, these high profile scandals were symptomatic of failures throughout the NHS, particularly in nursing care. Around a million NHS patients had been the victims of "neglectful, demeaning, painful and sometimes downright cruel 'treatment'", it claimed - with "tales of soiled beds, filthy toilets, lack of food and water and failure to respond to repeated cries for assistance" over six years from 2002 to 2008.

Anecdotal evidence suggests that this uncaring treatment may have been endemic for decades. In a memory from the early 1990s, this father describes how his daughter was all but left to starve while being treated in hospital for a broken neck.

"Flat on her back, her head was completely immobilised so that she could see only the ceiling. She was unable to see people who came into her room, she couldn't see out of the window, she couldn't see a television or read a book. To sensory deprivation was added starvation. There was no system to ensure that my daughter would receive adequate food – a critical component of her healing and recovery. For a day or two this might be a tolerable state of affairs; her sentence was three months. In the beginning, we imagined that this neglect was a simple oversight in a busy public hospital with the usual chronic shortage of staff. However, annoyance turned to disbelief and anger when it became apparent that the hospital system was incapable of responding to these simple human needs."

And there is evidence that far from being a nursing issue, this is a problem throughout the healthcare industry. The media regularly carries stories of patients alleging that their doctors have been uncaring or arrogant.

Oxfordshire GP, Dr Angela Jones wrote recently in the BMJ, that as a doctor: 'I know that this evidence is not just media scaremongering'. She went on:

"I regularly treat acutely unwell elderly patients in need of hospitalisation who beg me not to send them in. I know sensible people who have given up going to their general practice, disillusioned by doctors who seem to be more interested in their computer than in them. I share the despair of patients with complex mental healthcare needs, refused help from psychiatric services because they

have concomitant drug or alcohol issues or are labelled as 'untreatable', and the weary outrage of homeless people, discharged from hospital straight back onto the street while still recovering from a serious illness.

The sheer size of the problem makes it clear that this is a system failure rather than something that can be blamed on the actions of negligent individuals. Indeed the evidence suggests that practitioners become uncaring against their will."

"Most newly qualified nurses, have a coherent and strong set of espoused ideals around delivering high quality, patient-centred, holistic and evidence-based care. However within two years in practice the majority of these nurses experienced frustration and some level of burnout as a consequence of their ideals and values being thwarted." - Maben et al (2007).

The same point is made by the US surgeon and healthcare guru, Atul Gawande.

"At times, in medicine, you feel you are inside a colossal and impossibly complex machine whose gears will turn for you only according to their own arbitrary rhythm. The notion that human caring, the effort to do better for people, might make a difference can seem hopelessly naïve.

But does it really matter whether doctors and nurses are kind to patients. It is demonstrably bad for patients to be left unwashed, unfed and having their need to go to the loo ignored. Yet apart from hurt feelings and perhaps a bumper crop of complaints (two out of three complaints about hospital care relate, not to clinical treatment, but to person-related issues), are there good clinical reasons for healthcare practitioners to be show compassion? Here are some examples in which a lack of compassion is clearly bad for your health.

For a start, there is substantial evidence that patients talk more about their symptoms and concerns, yielding more accurate understanding and diagnoses when the caregiver shows empathy (Epstein et al 2005), and that patients' anxiety and fear delay healing (Gilbert and Proctor 2005). Here are some ways in which it can happen."

This man was left aghast by the brusque way in which a doctor told him he had terminal cancer (happily, wrongly as it turned out).

"So this guy came in and he said "I'm ever so sorry er the cancer looks as if it's er spread," and he says "I think you've got a spread. It can be debris, it can be lesions, it can be scar tissue but I don't think so."

And he just went out, left us in the air, just like that.

I couldn't hear any more. I was just like gob-smacked and just in a very bad state. And as far as we were concerned there was another surgeon, part of his team that was sitting on a chair next to me and he was sitting there with his mouth wide open because I could see that he couldn't understand how a guy could relate like this.

And my partner was with me, she was, had her mouth open as well. Well someone must have, I think this guy who was sitting next to my partner walked out the room and sent him back, I think he must've sent him back.

He came back and he wasn't much better when he came back and he says "If you need a second opinion I don't mind," and he said "but I'm around the whole of Christmas and if you want to see me you can." And he said that "I think that you ought to go off and enjoy yourself as much as you can. (laughs)"

This woman facing a mastectomy describing how the uncaring approach of her anaesthetist has left her with a long-lasting fear of surgery.



"My experience in the, when I actually went down to theatre, that wasn't a very nice experience either. When I went for the anaesthetic, the anaesthetist didn't treat me very, well he, I felt as if I was a piece of meat to be honest. He said 'which one is it' and 'we've got to put a cross, put a mark on it' which I realise they have to do to make sure they've got the right one. But unfortunately I was left with that, a nurse should have been with me right the way through, but I was left with two men. I was made, as I say, just to feel like a piece of meat and that, since, has given me a terrible fear of having to go through any operation since that experience."

In the following case, a woman in intensive care describes what it feels like to have no power and no dignity.



"You lose, that's it, it's a loss of control. That's it encapsulated. You have no control over yourself any longer. You are effectively in a torture situation. You are tied to a bed. And I remember saying a lot of times, 'I hate this bed.' And I can't tell you how much I did hate that bed. They kind of misunderstood it. It wasn't the physical bed as such always. It was the fact that I was riveted to it. I was not able to get away from it, up off it. I was attached to equipment, which attached me to the bed physically. I was spread-eagled on that bed. I didn't have a covering apart from a sheet, a terrible blue and white thing in a J-cloth kind of fabric, which was attached on either bits of the bed. And they would lift up bits of it, and you were naked underneath that with tubes coming out of you. The indignity of that, the indignity of it.

The material itself, you know, you couldn't even be covered with something, a sheet stretched out. It was this J-cloth, throwaway material. That's how little worth you were. That you'd wash that up and you'd throw it in your bin in the kitchen. That was keeping my dignity so-called. That was, it was a disrespect. So I'd lost control out of my bodily functions. I couldn't speak, I couldn't communicate, I couldn't write. I was alone. Only what was in here [inside the mind]."

But what causes her to feel truly isolated is the way she herself is ignored by specialist nurses whose job is to keep her alive.



"They're highly trained, everything that they do, all of your things are monitored and fed into a computer, and they have to respond to the computer and so on. And they're actually becoming dehumanised. And I can understand how that occurs and not everybody can be total perfection.

But to some extent, what they need to do is to supplement that. Some of the people who nurse in Intensive, it must take a particular type of person and personality because things need to be more precise, more technical. And you can't be all things to all people. So your physical needs are very well taken care of. Of that, you know, I haven't got any anxiety as far as the Intensive Care Unit at my hospital is concerned."

Indeed, it is this very complexity that, perhaps, creates a situation where compassion can seem a luxury. Medicine, according to surgeon and safety champion, Atul Gawande, is increasingly "a test of our ability to manage extreme complexity". The most recent edition of the World Health Organisation's international classification of diseases, he points out, lists more than 13,000 diseases, syndromes and injuries - with clinicians having at their disposal more than 6,000 drugs and 4,000 medical and surgical procedures.

What's more, he points out, the components of routine hospital care are hugely complicated. Israeli scientists monitored patients in intensive care and found that on average, they required 178 individual actions per day, ranging from administering a drug to suctioning the lungs. Adding to the complexity

are many changes in modern healthcare practice: the increase in the number of seriously ill people in hospital as the length of stays has reduced dramatically; the complexities of daily handovers between shifts; the opportunities for errors and omissions in care between primary and secondary care.

All these factors have led to a growing awareness of the safety risks caused by the human factor in modern medicine. Alongside the safety issue, however, modern healthcare also risks becoming uncaring. The view that 'it's their problem, not mine' is surely alive and well in an environment in which ill people are left to starve or lie in their faeces in a well-funded, adequately staffed modern hospital.

There's no question of turning the clock back. Medicine will continue to become more complex, clinicians will need to specialize perhaps even further, handovers will have to be accomplished - and patients' discharge cannot be delayed simply to foster compassion in their carers.

But the first step in humanising the healthcare team, according to Jocelyn Cornwell of the Kings Fund writing in the BMJ, is to decide exactly who belongs to the modern multi-disciplinary healthcare team.

"What is it? Who does, and does not, belong to it? What do the team members think and talk about together? Do they share the same values? Do they have a common perspective? Have they articulated what they want to achieve for their patients? If their intention is to provide completely personal care, have they worked out the arrangements and processes that could make it a reality? And who is in charge of making it happen?"

Already, surgery, with its fast-moving, high-risk clinical activities, has confronted this issue and come up with small but highly significant changes in the way the team is defined. The operating team may appear to be clearly defined. Yet until recently, there was no requirement for team members to regard themselves as having a common aim and shared responsibility for doing their best - rather than simply doing their own individual job.

In February 2009, the WHO Safer Surgery Checklist was made mandatory and became routine in many NHS operating theatres requiring team members to introduce themselves and describe their roles before every operation. In a world in which surgery is increasingly complex and membership of operating teams change daily or even more frequently, this brief intervention has been shown to have brought in a new era of safer surgery, according to a BMJ editorial.

"Without proper introductions, team members may work together all day without knowing each other's names. It is much harder to speak up, ask a question, or voice a concern in the absence of a modest degree of familiarity. Despite initial scepticism from doctors, briefings are popular with nursing and other theatre staff. Briefings improve team communication and reduce errors and unexpected delays." (http://www.bmj.com/cgi/content/full/338/jan21_1/b220 - REF9)

Anecdotal evidence shows only too clearly the importance of junior members of staff feeling able to speak up when they see there is a problem occurring - even when that problem appears to be the responsibility of senior members of the team. Martin Bromley's wife died following a minor operation to clear her sinus problems when her airways collapsed early on in the operation - and the surgeons tragically miscalculated the seriousness of the emergency. Yet, as this extract from a newspaper story about the tragedy explains two nurses also carry responsibility for her death.

What made the situation worse was that two of four nurses admitted that they "knew exactly what needed to happen": one brought tracheotomy equipment into the theatre but was not acknowledged; another booked an intensive care bed but was led to understand that she was overreacting and so cancelled it. "Both of these nurses knew how to save Elaine's life. But they didn't know how to broach the subject with their bosses," says Mr Bromley.

And it's not just surgery. Professor Gawande has pointed out that the safety issue addressed by the Safer Surgery Checklist is a potential hazard beyond the operating theatre.

"There are hundreds, perhaps thousands of things doctors do that are as dangerous and prone to error as surgery; the treatment of heart attacks, strokes, drug overdoses, pneumonias, kidney failures, seizures. And consider the many other situations that are only seemingly simpler and less dire - the evaluation of a patient with a headache, a funny chest pain, a lung nodule, a breast lump. All involve risk, uncertainty and complexity."

Jocelyn Cornwell's questions about the modern healthcare team are clearly relevant to the failure of some of the team members to take responsibility for a patient's safety. They are also relevant to the manner in which those involved in the care of patients fail to take responsibility for showing kindness and consideration.

This man in his 50s was highly critical of the uncaring treatment he received from some members of staff when a lung nodule was being investigated for a suspected terminal cancer. He believes that part of the problem was that many, if not most, of the health professionals that he saw did not regard themselves as members of the multi-disciplinary team that was responsible for his care. The reason, he concludes, is that there is more than one healthcare team.



"One is for me there was a multi disciplinary team of cardiothoracic surgeons oncologists pathologists and respiratory guys. Now they think they work very well and I've absolutely no doubt they do work very well. But that's not a team that I see. I never see the respiratory guy, or the pathology guy and I've only see the thoracic chap twice. I see the oncologist a lot. So that's a team that does work very well but it isn't the team that the patient experiences. I visualise a vertical team who I saw. For example the cancer specialist nurse, the SHO, the anaesthetist, the junior anaesthetist, the nurses on the ward, the radiographers that do my chest X-ray before I left. So there's a vertical team which really starts, really starts with the guy in the car park when you approach the car park, who tells you where the ward is, where your bed is and who's going to be dealing with you and so on through those investigations."

It may seem preposterous to include the car park attendant in the clinical team responsible for a patient's healthcare - except if the team is defined from a genuinely patient-centred viewpoint.

This hospital porter, for instance, has no doubt at all that he has a therapeutic role to play.

"Sometimes I think the patients feel more comfortable talking to us than they do to the nurses or the doctors - sometimes an old bloke will say to me: 'I haven't understood a word that doctor's just told me cos he's talking too technical', so you go back to the doctor and ask." (Extract from Seeing the Person in the Patient, Kings Fund 2008).

This woman expresses a common concern about the make-up of the healthcare team when she describes her failure to find 'the doctor in charge'.

"When I asked to speak to the doctor in charge they looked at me as if I was completely blown out and said, 'well you can talk to any of them'. I'm saying - 'who's the person that has the lead responsibility?' and they said they could not say that because it was a different person each day... I never got to the bottom of the accountability in the trust. She had a name at the top of the bed but that person did not deliver the care." (Taken from Seeing the person in the Patient, Kings Fund 2008)

So who decides on the definition of the team?

Here, one patient with lung disease offers an explanation as to why both healthcare staff and patients are confused about the healthcare team:



"Well one of the problems is that I don't think it is defined. I think, it's a good question. I think it should be defined. I think the vertical team should be defined so that people are aware of look who is dealing with this bloke. From his arrival in hospital to his consultant interaction. What other professions are involved. SO I think the first answer is I don't think it is well defined but because it's not well defined people aren't sure whether they're in the team or not you know.

Did the junior nurses on the ward that I was on did they think they were part of the team looking after me. Did the radiographers think they were part of the team looking after me? I don't think they did. I don't think THEY did but I certainly thought they were because I'm going down to get X-rays from them and check X-rays and scans and stuff so they're very very much part of the team that I see so they're very much part of the team with which I interact. But I think if you ask them they would just say I was part of a throughput of patients who were coming for important investigations."

Could it be that many of the affronts to the dignity of patients, much of the uncaring nature of modern healthcare, is caused by this single confusion? On the Healthtalkonline website, there are numerous examples of patients making the point that while a certain group of clinicians take full responsibility for their care, another group, just as essential to their wellbeing, fail this test utterly.

This 31-year-old is typical. She received excellent care from the clinicians closely involved with the emergency caesarean section that may have saved her baby's life. But the members of her vertical team, the nurses who provided the aftercare, made it quite clear that she was merely 'one of a throughput of patients'.



"Well, I mean everything was fine during the birth and that and the women down there were, were brilliant, but up, up in the ward, I just... the only way I can describe it - and I can remember saying it to mum and dad - was I felt like a burden on them. And I mean, having a section, I mean, it's major surgery, you're kind of limited, I mean, I was in bed with a catheter and a drip, got new born baby beside me, never held a new born baby in my life, wanting to breastfeed, and I just felt... I felt like I was a burden because I needed people to help me get the baby and I didn't feel like they were very forthcoming in helping. It was like there were no allowances for... you know, it's like, "It's your baby, get on with it". And it doesn't matter that you're hooked onto a drip, catheter, you know, you've had a great big wound in you and you're trying to reach over and... so I did feel really, like... I mean a lot of it could have been made worse... the fact that you've just had a baby and your emotions are all over the place. But I didn't feel like the aftercare was very good at all."

This man in his fifties describes how uncaring, even humiliating behaviour frequently occurs when the healthcare practitioner is sincerely trying to do his or her best. He gives the example of being asked by one nurse to wait for a surgical bed in a day case room while the surgical ward was being cleaned.



"And then after about half an hour was set upon by an elderly woman in a blue uniform who I think was a clerk from casualty who entered the day case unit and said what's your name. And I said I'm Kieran Sweeney. And she said are you a day case. And I said no I think I'm overnight with the

thoracic surgeon. Well your name's on the day case unit, you must be a day case. And I said well no, I think I'm overnight. Have you been in that bed? And I said no, no I'm just sitting beside that bed actually, I haven't been in it at all. Well I need that bed. We've got a surgical admission coming in. And I said well I'd be happy to move. And what struck me about that is her sincerity. She was being terribly sincere about the need to get a bed for surgical admission. That was her mission in life.

And with that mission, that drive to say I need that bed, she just forgot the niceties of normal human interaction. Do you know what I mean? I thought it was funny in a way. I felt humiliated to be talked to like that isn't fun, but I kind of rolled over and thought she's just blown it badly. And you could see her thinking I've got to get it I've got to get it. Trying to get this bed as hard as she could. And she did achieve the aforesaid aim of getting me away from the bed which I'd fortunately not laid a finger on. But do you see the point? It's that simultaneously you can have someone acting very sincerely and trying to achieve their aim in life, but at the same time humiliating another person.

And the serious point is in her urgency to achieve her own aims she completely forgot about how to interact with someone who was peripheral to her aim of getting a surgical bed. Who didn't understand the urgency. If she explained the urgency I'd have said of course I'll go anywhere. I'm just sitting around waiting for a biopsy I'm cool about that. SO there's a serious point there which I think underlies that. And again, it wouldn't take much time, nor do you need, you don't need a PhD to do this. If she'd just stood and thought as Robert Burns would say, To see ourselves as others see us. How would she see herself. You know if that was video recorded how would she have felt. I think she'd have felt very embarrassed talking to me like that. Not just me, talk to anyone like that. But also she just forgot about what it must feel like to be talked to like that. She just forgot that bit. And that's all it takes. What must it be like to be him here while I'm trying to get that bed. Answer uncertain and embarrassing and very tense. So let's try and make it more sensitive. Anyway she got the bed."

There are other factors involved when the healthcare team fails to show compassion. According to the Department of Health's 2009b review, there is a need to counteract "deep-rotted cultural issues that are endemic in the NHS such as a culture of long hours and high levels of bullying and harassment". It's a view that Claire Chambers and Elaine Ryder believe is a serious problem.

"Health care professionals can be bullied or intimidated into not challenging or reporting unacceptable practice that lacks dignity and compassion. They can feel at risk of being suspended for whistle blowing and fearful of being involved in industrial tribunals. A competitive environment means that nurses are in competition with each other rather than caring for each other. Unhealthy competition between nurses is not only detrimental to other nurses but negatively affects the care they give. Therefore team dynamics and a positive team environment are essential in being caring and supportive of others in the caring team, as well as the patients in our care. It is not enough that one nurse is aware and supportive of a patient in distress. It has to be a collective response." - from Compassion and Caring in Nursing, by Claire Chambers and Elaine Ryder, Radcliffe Publishing.

Another essential factor for the compassionate team is that its members feel they have the time to care. Eight out of ten nurses said that they had left work distressed because they had been unable to treat patients with the dignity they deserved, with washing and privacy cited as common issues of concern as well as staff shortages, according to a poll of 2000 nurses carried out by the Royal College of Nursing in 2008. One nurse said:

"Patients seem to be becoming numbers not people. I am having to fight against what the system wants in order to provide dignified care to my patients."

However, nurses have long expressed concern that they do not have enough time to care for patients properly (British Journal of Nursing, 2004), and that tasks, routines and documentation take priority over holistic care (Pearcey, 2007).

And it's not just nurses who are under pressure – as can be seen by this cancer patient describing a medical consultation that many patients will recognise.



"I've found that on the weeks that I was in hospital receiving the chemotherapy the one day a week the oncologist specialist would breeze into the room with his entourage of junior doctors with him, he would stand at the bottom of the bed, er look at your chart, look at the percentage of the different drugs that were being given to you and the chemotherapy treatment. Ask you very quickly how you were feeling, a very quick examination and then he would go out of the room and the door would shut. And you knew because you could hear, hear them speaking outside of the room about you. And I almost found myself falling off the hospital bed with a cocked ear to try and hear what they were talking about. It's, that sort of situation is very poor in my own mind and it shouldn't be happening but it's along the same lines as the old style of doctoring and hopefully at some stage in the future that will change"

Jocelyn Cornwell of the Kings Fund has investigated the reasons why, when most staff are "motivated by the desire to provide high-quality patient care", patients' experience of that care so disappointing? She concludes that one of the main reasons is that compassionate teams don't just happen on their own.

Providing personal care for patients is phenomenally hard work for teams as well as for individuals.... The intention to deliver personal care needs to be matched by investment: in practical support for care-givers to help them to keep in touch with their own humanity; in training in multidisciplinary team working; and in clinical leadership.

Every detail is shaped by the actions, attitudes and behaviours of individual members of staff, which are in turn shaped by their personal experiences and values (including professional values) and attitudes, and by their colleagues. They are also shaped, in ways that are more difficult to discern, by the practices, opportunity and limitations of the organisation in which they work as well as the wider health care system. When that doesn't happen, "everyone dealing with (patients) is left to invent for themselves how to talk and how to behave towards patients and relatives".

The "phenomenally hard work" of enabling the healthcare team to provide compassionate, personal care for patients is a new science. But work has started - although possibly not, as yet, in a hospital near you. The third section of this e-article looks at the different ways in which compassionate teamwork can be developed so that the NHS Constitution becomes a meaningful tool in the provision of healthcare.

* The case studies are taken from www.healthtalkonline.org as well as from other sources. Healthtalkonline.org is an award winning website that allows visitors to share in over 2,000 people's experience of health and illness. It provides information about conditions, treatment choices and support by allowing visitors to watch or listen to videos of the interviews or read about people's experiences. The information on Healthtalkonline is based on qualitative research into patient experiences, led by experts at the University of Oxford.

About the author

Jane Feinmann is an award-winning medical journalist writing for the consumer and medical press. She is the author of several books as well as being a freelance producer for Radio 4. She can be contacted at jane@janefeinmann.com.