Chapter

13 Building Compassionate Health Systems

Compassion in Health Systems

The value of compassion in healthcare is both proven and undeniable. The various components of compassion offer benefits that are at once physical and psychological (Shea et al., 2014a). Most healthcare professionals are profoundly aware of this, often based on our own experiences of receiving compassion from others, our recollections of witnessing compassionate care in our workplaces, and our deeply human awareness of the intrinsic healing that compassion commonly brings.

Despite this, we sometimes struggle to translate our compassionate intentions into care that is always truly compassionate. There are many reasons for this, operating at several levels. So far, Part II of this book has focused chiefly on individual-level factors relating to compassion, and how to optimise these by 'Cultivating Mindfulness and Awareness' (Chapter 10), 'Deepening Compassion' (Chapter 11), and 'Developing Resilience' (Chapter 12). These are important undertakings for many reasons: strengthening our own awareness and resilience, increasing compassion in the care we provide, and delivering better outcomes for all stakeholders in the health system.

Our efforts as individuals and teams, however, always occur in specific contexts. For clinical professionals, that context is often a healthcare organisation such as an acute hospital, public health system, or other healthcare provider. While many of these organisations have compassion as a stated value, systemic factors sometimes impede the attainment of compassion. This is especially true in larger organisations which have become bureaucratic, depersonalised, and – at times – apparently lacking in compassion. This is not necessarily a reflection on the managers of such healthcare organisations, but rather a consequence of the mass systematisation of healthcare services. Sometimes, organisational efficiency appears to come at the cost of humane, compassionate care. This need not be the case.

Against this background, this final chapter in our book looks at systemic factors in healthcare systems and how these can promote qualities such as mindfulness, awareness, resilience, and compassion. The chapter starts by looking at the components of compassionate leadership in healthcare organisations, moves on to the topic of resilience in health systems (especially in the context of sustaining compassion), and then outlines specific approaches that healthcare professionals can take to increase compassion across the services in which we work. Finally, relevant conclusions are presented at the end of the chapter.

https://doi.org/10.1017/9781009390217.014 Published online by Cambridge University Press

Compassionate Leadership in Healthcare Organisations

What does compassionate leadership in healthcare look like? It is easy to suggest that we should be more compassionate as we provide care and as we shape health services at the managerial level, but is there a way to systematise compassion at the level of organisations? Or is the very idea of 'operationalising' a value like compassion contrary to its essential nature? Is compassion too personal and too relational to form part of standard operating procedures or to be made into a mandatory feature of care and management?

When considering compassionate leadership and designing compassionate health systems, it is useful to think not about systematising compassion as such, but rather about how we create circumstances in which compassion is not inhibited but is rewarded and promoted. Can we design workplaces and work processes that facilitate compassion, that acknowledge compassionate care, that reward it, and that actively encourage compassion to flourish?

This is indeed possible, and a growing evidence base provides more detail on what it involves. In 2024, Östergård and colleagues published 'a mixed-methods systematic review' of 'health-care leaders' and professionals' experiences and perceptions of compassionate leadership' (Östergård et al., 2024). The purpose of their study was 'to identify and synthesise the best evidence on health-care leaders' and professionals' experiences and perceptions of compassionate leadership':

> Ten studies were included in the review (five qualitative and five quantitative). The thematic analysis identified seven analytical themes as follows: treating professionals as individuals with an empathetic and understanding approach; building a culture for open and safe communication; being there for professionals; giving all-encompassing support; showing the way as a leader and as a strong professional; building circumstances for efficient work and better well-being; and growing into a compassionate leader. (Östergård et al., 2024; p. 49)

The authors concluded that 'compassionate leadership can possibly address human resource-related challenges, such as health-care professionals' burnout, turnover and the lack of patient safety. It should be taken into consideration by health-care leaders, their education and health-care organisations when developing their effectiveness' (p. 49).

It is interesting that the themes identified in the research emphasise 'treating professionals as individuals', 'open and safe communication', and 'being there for professionals'. These are not expensive solutions. They are not technology-based or highly complex. They do not require high levels of investment, apart from time and commitment to make compassion a reality through thoughtful interpersonal interactions. These are very human values which accurately reflect the deeply relational nature of compassion. They also tap into compassion's potential to unlock potential in other people – and in ourselves – through good communication and collegiality.

Listening is central to this process, both listening to staff and listening to patients (Frampton and Goodrich, 2014). Listening fosters collaboration, mutual respect, and better care. Listening creates an environment in which everyone's ideas and perspectives are valued. It promotes trust and encourages open dialogue, which are both essential for innovation, problem-solving, and collaboration. When individuals feel heard, they are more invested in the tasks at hand, leading to a more inclusive and creative team atmosphere and greater compassion in care.

https://doi.org/10.1017/9781009390217.014 Published online by Cambridge University Press

In addition, listening strengthens relationships by showing interest and understanding, even when diverse views are expressed. Listening helps to identify potential conflicts early, address them before they escalate, and cement the vital working relationships which form the basis of compassionate care. Ultimately, listening is not just a passive activity but a critical component of successful teamwork that helps teams to cohere, focus on the outcomes that matter, and keep core human values, such as compassion, at the heart of healthcare.

Resilience in Health Systems

Many of the difficulties with compassion in healthcare relate not to generating compassion in the first instance, but to sustaining it in the face of challenges and complexities. Most of us seek to be compassionate, but we are worn down by bureaucracy, workloads, and the emotional intensity of the illnesses we encounter at work. Many of us start the day with plenty of compassion, but by lunchtime we are struggling to survive. What can we do, as individual clinicians and as organisational managers, to sustain compassion in these challenging circumstances?

This question brings us back to resilience, which we explored in Chapter 7 of this book ('Resilience and Compassion') and Chapter 12 ('Developing Resilience'). Those chapters looked at the value and limits of resilience at the level of individual healthcare workers. But is there a research base to help us promote resilience not only at the individual level, but at the level of organisations and work cultures, too? Individual resilience is clearly relevant to our organisations, but what about the settings in which individual resilience operates and is, too often, tested beyond its limits? What does the research say about resilience in the organisational context?

In 2022, Lyng and colleagues explored 'capacities for resilience in healthcare' through 'a qualitative study across different healthcare contexts' (Lyng et al., 2022). Their aim was 'to contribute to this discussion by synthesizing knowledge and experiences from studies in different healthcare contexts and levels to provide holistic understanding of capacities for resilience in healthcare':

> Ten different capacities for resilience in healthcare emerged from the dataset, presented here according to those with the most identified instances to those with the least: Structure, Learning, Alignment, Coordination, Leadership, Risk awareness, Involvement, Competence, Facilitators and Communication. All resilience capacities are interdependent, so effort should not be directed at achieving success according to improving just a single capacity but rather at being equally aware of the importance and interrelatedness of all the resilience in healthcare capacities. (Lyng et al., 2022; p. 1)

The authors emphasised 'that all resilience capacities are associated with contextualization, or collaboration, or both' (p. 1). These two factors are clearly essential for building resilient healthcare organisations in which compassion can be sustained over time; that is, 'contextualization' and 'collaboration':

> Our study indicates that efforts to understand or translate resilience capacities into practice need to provide appropriate levels of collaboration and contextualization for intervention activities and for everyday practice. What is clear from our framework is that these translation efforts should involve tailored intervention activities, and material based on this new knowledge about the key role of the collaboration-contextualization dimensions for each

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> resilience capacity. The framework and the inductively arrived resilience capacities constitute a sound basis that will support future resilience learning tools and interventions. (Lyng et al., 2022; p. 12)

These two values, 'contextualization' and 'collaboration' are highly consistent with the third 'c' that concerns us throughout this book: compassion. By promoting resilience, 'contextualization' and 'collaboration' can help to sustain compassion when it is tested by circumstances, by fatigue, and by the sheer complexity of providing clinical care day after day, month after month, year after year.

Critically, such resilience depends not only on resilience at the level of individual healthcare workers, but also on organisational context, which can be improved by working on the 'ten different capacities for resilience in healthcare' identified by Lyng and colleagues: 'Structure, Learning, Alignment, Coordination, Leadership, Risk awareness, Involvement, Competence, Facilitators and Communication' (Lyng et al., 2022; p. 1).

In the next section of this chapter, specific actions are outlined to try to optimise the organisational context for greater compassion in healthcare systems.

Building Compassionate Contexts and Cultures in Healthcare Organisations

So far in this chapter, we have looked at the components of compassionate leadership in healthcare organisations and examined resilience in healthcare systems, especially in the context of sustaining compassionate care. This can be especially complex in the face of the sustained challenges presented by illness, its treatment, and people's varied expectations and experiences of care.

Against this background, what can we *do* to build compassionate contexts and compassionate cultures in healthcare organisations? Here are seven steps that can help healthcare professionals to increase compassion across the healthcare systems in which we work:

(a) The first step is to lead by example. The importance of this cannot be overstated. We encourage compassionate behaviour in other people by behaving compassionately ourselves. This applies to our work when directly providing care, our interactions with colleagues and other team members on the corridor, and our decisions in any management roles we occupy. If we seek to demonstrate respect, kindness, and compassion in all our interactions, no matter how minor, this has a ripple effect around us and beyond us. Compassion is not a zero-sum game. Demonstrating compassion does not use up a finite supply of compassion. Compassion breeds compassion. Compassion spreads organically across teams, departments, and organisations. We lead best when we lead by example. If we seek to create compassionate cultures within our organisations, this means leading through compassion.

(b) The second step is to actively support the wellbeing of colleagues and any staff we manage. Sometimes, the steps that managers can take here are simple, practical ones, but these can be the most impactful ways to demonstrate compassion. These measures might include offering flexible work arrangements, implementing more considerate rostering practices, increasing flexibility in scheduling, and ensuring fair dispute resolution. All these measures can help to reduce burnout and allow healthcare professionals to balance our work and personal lives more effectively. It is also useful to explicitly prioritise the emotional health of clinical staff through wellness supports,

https://doi.org/10.1017/9781009390217.014 Published online by Cambridge University Press

counselling services, and stress management resources when they are needed. Happy people have more capacity for awareness, resilience, and compassion. At individual level, these values are further supported by active listening, emotional intelligence, and treating other people as we wish to be treated ourselves. Supporting staff wellbeing means supporting compassion.

(c) The third step is to foster open communication within our organisations. This applies at both the individual level and the level of organisational culture and context. It is essential that we create spaces in which staff feel safe sharing concerns or discussing challenges without fear of judgement or repercussions. This atmosphere creates a solid basis for awareness, resilience, and compassionate care. Listening is the bedrock of open communication. Even if you have a great deal to say yourself, it is important to listen to the views of others and engage with their perspectives. Active listening fosters connection, engagement, and dialogue. If you want to be heard, listen. If you want to create a culture of compassion, communicate.

(d) The fourth step is to ensure that open communication includes patients and their families whenever this is possible. This means involving patients and their families in decision-making processes, valuing their perspectives, and making sure that their emotional needs are met in an open, authentic way. This generally involves spending time with people and simply being there for them. Compassion is not a high-tech intervention. Compassion is a very human intervention which is often best achieved through quiet presence and attentive awareness. This helps not only at the level of the individual but also at the level of organisational culture. Patient-centred care requires communication that is open, available, and informed by compassionate intent.

(e) The fifth step in creating compassionate healthcare organisations builds on the first four steps; that is to say, (a) leading by example to promote compassionate behaviour; (b) supporting the well-being of colleagues and any staff we manage; (c) fostering open communication across clinical and managerial teams; and (d) including patients and families in decision-making and valuing their perspectives. The fifth step is to promote teamwork and collaboration that are inclusive, adaptive, and resilient. This means building strong, supportive teams in which members rely on each other, support each other with kindness, and experience a sense of belonging and shared purpose. Such teams constitute a solid basis for awareness, resilience, and compassion. Generating this kind of teamwork is both an individual endeavour and a collaborative one. Teams flourish in organisational cultures that are open, largely blame-free, and centred on learning from experience. Thriving teams are better placed to provide compassionate care.

(f) The sixth step is to recognise and reward compassion. Many healthcare workers are quietly compassionate, offering extraordinary levels of kindness and support to patients and their families without seeking any recognition. The work is its own reward. While it is important to respect this, it is also useful to acknowledge and celebrate compassionate acts when appropriate in order to reinforce the importance of kindness in care. This might involve formal recognition programmes or organisational awards, but it might also mean a quiet word with an individual staff member. This can be a very powerful intervention by a colleague or manager: 'I noticed the time you spent with that patient the other day. I know it made all the difference to them. Thank you for all you do.'

(g) Finally, do not forget the centrality of self-compassion. Organisational compassion will falter if managers and staff are too self-judgemental, too self-critical, or too demeaning

https://doi.org/10.1017/9781009390217.014 Published online by Cambridge University Press

of their own efforts. Healthcare is challenging. Outcomes are not always what we would like them to be. Sometimes, sitting with pain and loss is inevitable. In these situations, organisational cultures support self-compassion through open communication, realistic expectation management, and robust teamwork that promotes awareness, resilience, and solidarity. We are human. We care best when we care together and when we care for each other.

Compassionate Leadership and Collectivity in Healthcare Organisations

This chapter set out to examine the themes of compassionate leadership in healthcare organisations, resilience in health systems, and approaches that healthcare professionals can take to increase compassion across the healthcare services in which we work. The latter were summarised into seven key steps that clinical staff can implement, not necessarily in sequence, but in parallel with each other, in order to promote compassionate cultures in healthcare systems.

These steps are: (a) leading by example to promote compassionate behaviour for better care; (b) supporting the well-being of colleagues and any staff we manage; (c) fostering open communication across clinical and managerial teams; (d) including patients and families in decision-making and valuing their perspectives; (e) promoting teamwork and collaboration that are inclusive, adaptive, and resilient; (f) recognising and rewarding compassionate care, both formally and informally; and (g) making self-compassion a key organisational value: healthcare is challenging, we are all human, and self-compassion is the basis of compassion for others.

It is not always easy to keep these steps to the forefront of our minds as we operate within, and shape, our organisational contexts and cultures. There are many reasons why clinical care can be less than compassionate, ranging from local issues to broader social factors that shape the environment within which healthcare is delivered (Iles, 2014). Despite these challenges, compassionate care can be supported by drawing on existing skills, accumulated knowledge, and personal experiences of compassion (Adamson and Smith, 2014). In this book, we have argued that there is a strong evidence-base informing compassionate care (Part I of the book) and this evidence-base can be operationalised at the individual level by 'Cultivating Mindfulness and Awareness' (Chapter 10), 'Deepening Compassion' (Chapter 11), and 'Developing Resilience' (Chapter 12).

This final chapter in this book moved to the collective and organisational levels, focusing on teams, cultures, contexts, and health systems. These are important because compassionate leadership in health and social care needs to be inclusive and collective, and usually involves collaboration across boundaries (West, 2021). These values are also essential to the provision of health services at the individual level, so it makes sense that they inform compassionate leadership at the level of organisations too. This can be especially challenging in high-stress scenarios like healthcare, which invariably involve multiple actors, diverse emotions, and managing uncertainty. But these complications also make compassion even more important in these settings.

As a result of these factors, building leadership for compassionate care means explicitly acknowledging and taking account of the challenges and difficulties of a context that routinely involves anxiety-provoking situations (De Zulueta, 2016). This means providing

https://doi.org/10.1017/9781009390217.014 Published online by Cambridge University Press

the requisite training, supplying supports for wellbeing, maintaining optimal levels of trust and connection, and sharing workloads, skills, and knowledge across silos. It also requires an atmosphere that facilitates experimentation, reflection, and learning from errors, which is why this chapter has focused on organisational cultures and contexts.

Finally, as mentioned above and in Chapter 8 ('Self-Compassion'), self-compassion is always central. Without self-compassion, it is difficult to generate compassion for other people or to grow compassionate organisations. Self-compassion is essential for compassionate leadership in health and social care because our relationship with ourselves forms the foundation of our relationships with other people (West, 2021). Being compassionate towards ourselves enables and empowers us to be compassionate towards others. At the organisational level, self-compassion helps us to build compassionate health systems which deliver better outcomes for the benefit of all. That is true compassion.

Conclusions

Compassion is not a static value. It is essential that the concept of compassion, along with other similar values, is continually re-formulated in the context of the specific skills and duties associated with different roles in healthcare organisations (Pedersen and Roelsgaard Obling, 2019). Change is constant, one size does not fit all, and some of the requirements for compassionate care evolve over time.

In addition, it is important that we recognise our personal limits, especially in the context of large organisations that can appear to lack compassion at the level of the overall system. Sometimes, we cannot have an immediate systemic impact to increase compassion in our organisations, so we need to focus on achievable goals at our level, at least for now (Kislik, 2022). With this in mind, it is always important to acknowledge the accomplishments of colleagues through appropriate accountability and to support them through advocacy and awareness.

Östergård and colleagues, in their 'mixed-methods systematic review' of 'health-care leaders' and professionals' experiences and perceptions of compassionate leadership', conclude 'that compassionate leadership has a broad and diverse entirety, and it diverges from other leadership styles by emphasising compassion':

> Compassionate leadership is comprehensive, and it involves many aspects that need to be taken into consideration in health care. Compassionate leadership was experienced through many aspects, from empathy to enhanced work circumstances. A compassionate leader is there for others and works as an example. Compassionate leadership can also be exhausting, and leaders should know their own limitations. This could be addressed with self-help abilities, as they have a significant impact on becoming compassionate leaders. (Östergård et al., 2024; p. 62)

In the end, compassion matters deeply both at the level of individual care and at the level of healthcare organisations (Shea et al., 2014b). At all times, however, compassion remains a very human value, which means it has added resonance in the deeply human contexts of illness, treatment, and outcomes.

The central argument of this book is that we can enhance compassion in healthcare through conscious effort. To summarise very briefly: we care as best as possible when we are as aware as possible, as mindful as possible, as resilient as possible, as compassionate as possible, and as supported by our organisations as is possible.

https://doi.org/10.1017/9781009390217.014 Published online by Cambridge University Press

We can only do what is possible, but compassion extends the limits of the possible. And that, surely, is the essence of good medicine.

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https://doi.org/10.1017/9781009390217.014 Published online by Cambridge University Press