



NHS values, compassion and quality indicators for relationship based person-centred healthcare

Comment on “Morality and markets in the NHS”

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Abstract

The paper by Gilbert *et al.* should be on the table of every politician and National Health Service (NHS) manager in the run up to the general election, when the NHS is at the hustings. They have raised profound moral dilemmas of the internal and external market in their present form, such as the practicalities of distributive justice and the enhancement of autonomy – to which are added the preservation of personhood, the values of listening, the maintenance of altruism and the origins of compassion. It is asserted that the quality of healthcare is dependent on the quality of the caring relationship between healthcare staff members, and between staff and patients. The nature of Compassionate Resilience is outlined with respect to Health Visitor training – and the contribution of faith communities to public health is also considered. The four Quality Indicators of an enabling environment first proposed by Cox and Gray are summarised, and the need for increased conceptual clarity of these key values recognised.

Keywords: National Health Service (NHS), Internal and External Market, Values, Person Centred Healthcare, Humanistic Indicators, Commissioning, Mid-Staffordshire NHS Foundation Trust

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Citation: Cox J. NHS values, compassion and quality indicators for relationship based person-centred healthcare: Comment on “Morality and markets in the NHS”. *Int J Health Policy Manag* 2015; 4: 407–408. doi: 10.15171/ijhpm.2015.70

Article History:

Received: 28 February 2015

Accepted: 13 March 2015

ePublished: 17 March 2015

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Introduction

Reading Gilbert *et al.*'s topical, closely argued and heart-warming communication ‘*Morality and markets in the NHS*’ (1), written from a public health and management perspective, is a breath of fresh air. Coal face National Health Service (NHS) clinicians were not after all alone in questioning whether the internal and external market was fit for purpose (2), and not alone in searching for a change of cultural climate in healthcare delivery.

Gilbert *et al.*'s analysis that low morale and demotivation of some NHS health professionals was in part linked to the economics of the competitive internal and external market as well as to top-down managerialism, corresponded with our own observations (3). Their proposition that a colony of ants might be better able to combine collaboration with competition, and that altruism with reciprocity could be a human virtue, suggested to this author that viewing a TV programme such as ‘*Call the Midwife*’ (with its blend of sacred and secular professionalism) or the wild-life programme ‘*Spring Watch*’ could be a useful component of continuing professional development.

The NHS is indeed, as Gilbert *et al.* have pointed out, at risk of drifting into a moral vacuum at the interface between commissioners and providers – and between patients and health professionals in the consulting room. The culture of financial top-down target driven management, which erodes relationship-based caring, has indeed percolated down to the intimacies of the patient-practitioner relationship in the way Gilbert and colleagues have described. Robert Francis in his

shocking report from Mid-Staffordshire called for a change of culture which would place the patient first.

Two solutions to this impasse, which are each ‘practical politics’ even within existing budgets, were proposed. The first proposal was that from the top to the bottom of the NHS, a consensus is sought about *an explicit values approach* to healthcare, which included distributive justice, autonomy – as well as, this author would add, the roots of compassion and primacy of personhood. These values, if internalised, would indeed change the culture of healthcare in the direction Francis recommended. The second proposal was for *a systems-based collaborative approach* to healthcare delivery. This multi-professional approach is axiomatic for good practice in mental healthcare and particularly for the continuity of care of patients with complex needs. Such an approach recognises that supporting staff, including general managers, so that they in turn are able to care for others, is important. That patients and carers are also fully involved in policy-making is a central component of this approach. This style of health delivery, which turned around a failing university hospital in the Netherlands (4), is based on patient empowerment and listening skills at all levels, which included the appointment of a Chief Listening Officer.

Interpersonal relationships and the market

The provision of healthcare thus depends on the quality of the interpersonal relationships between staff members and on the quality of their relationship with patients. Medicine starts with listening to the patient's history. The nature of these

quality relationships is hard to define but it includes reciprocal listening, confiding, trust and an attitude of wanting to care and to be compassionate. These components of professional relationships can contribute to the culture of care – and of putting the patient first. Marketisation, especially when there is excessive competition between providers, secrecy, intolerance of whistle-blowing and preoccupation with financial targets, can distort or obliterate the motivation to be altruistic and to be ‘of service’. For some health professionals, as noted by Gilbert *et al.* marketisation of healthcare is not consistent with the first principles and values of the NHS, and the consequent cognitive dissonance can be demotivating – and lead to burn-out and drop-out. For some health workers the provision of healthcare remains primarily a personal vocation.

Health Visiting, developing Compassionate Resilience and Quality Indicators

In recognition of these difficulties, the Institute of Health Visiting (iHV) is promoting ‘Compassionate Resilience’ to support health visitors in their new public health role (5). The iHV lists the characteristics of ‘compassionate resilient’ health visitors as being able to express and regulate their emotions, form close secure relationships and experience hope. These health visitors can also demonstrate the attributes of compassion, including sensitivity to suffering, and can ‘contain’ emotional distress and have an empathic non-judgmental approach.

Implementing the systems-based and values – explicit approaches, proposed by Gilbert and colleagues to counteract negative impacts of market forces on healthcare, will be facilitated by self-awareness training, such as the Compassionate Resilience course for Health Visitors. These approaches would also be strengthened by adopting humanistic Quality Indicators such as those proposed by Cox and Gray (6). The Indicators were derived from clinical experience, as well as from familiarity with large and small group processes. They included the provision of personal support for all staff by experienced mentors, the utilisation of educational methods in interpersonal sensitivity (e.g. Schwartz rounds and Balint groups), training of all staff in listening skills and in the nature of compassionate empathy, as well as the provision of role models for person/people – orientated health and social care.

The possible contribution of faith communities to public health

There is, however, one question that Gilbert *et al.* have only partially considered in their paper. What are the cultural, religious and humanistic roots of caring? The answer to this question is certainly complex and would include in depth consideration of psychological/developmental processes, as well as the contribution from ethics, philosophy, theology and biology. Furthermore, some readers may regard this question as too personal or beyond the boundary of health policy discourse. The general lack of process research in Europe exploring this boundary between the secular and the sacred, and between faith communities and public health, is another difficulty. To establish the contribution of faith communities to public health through for example social support, ritual,

prayer, spiritual direction is, however, a research project that would in this author’s opinion be very worthwhile. It is possible that a ‘free good’ is being overlooked, and that any positive contribution of church, mosque, temple and synagogue to well-being and healthcare provision is not understood or not recognised.

It is hoped that Gilbert *et al.* and others of like mind, will use their authority as health policy leaders to mobilise opinion about these existential, humanistic and moral issues in this pre-election period – and also sustain an overdue debate afterwards.

Conclusions and a question

Could this Journal take a lead by opening up a discussion about these neglected areas of human motivation – and in particular begin a dialogue between the sacred and the profane on the one hand, and the provision of healthcare in a universal tax funded NHS on the other?

Repeal of the clause in the 2012 Health and Social Care Act, which opened up competition to the private sector, was considered by Gilbert *et al.* and may be a step in the right direction. But watering the roots of compassion by politicians, patients, managers, faith communities and grass roots activists is more likely to yield the green shoots of hope in a very parched land. These shoots could then grow in a new cultural climate and so help to rescue the NHS from the condition it is in at the present time. This ethical and moral cultural change might also persuade the electorate that health and social care, and person-centred medicine, requires personal and financial investment which could be beneficial in the short and long term. These changes could restore the idealism of the NHS – and are likely to be cost effective.

Ethical issues

Not applicable.

Competing interests

The author declares that he has no competing interests. JC is a retired consultant psychiatrist and an unsalaried lay member of a Methodist Church in Cheltenham.

Author’s contribution

JC is the single author of the manuscript.

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