Bible study ***3***

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The art of compassion

[1 Corinthians 13]

Sometimes it helps us to understand the meaning of a well-known passage if we read it in a new translation. I was struck by Dr Samir Dawlatly's version of this very well-known passage published a few years ago in the magazine of the Christian Medical Fellowship. (Dawlatly, 2014) It started off a train of thought which led to this bible study.

'If I speak in the language of physicians or of surgeons, but do not have compassion, I am only a resounding gong or a clanging cymbal. If I have the ability to diagnose and can fathom all symptoms and all pathology and if I have a knowledge of evidence-based medicine that can answer almost any clinical dilemma, but do not have compassion, I am nothing. If I work for a pittance and I give all my time to my patients that I may boast to others of my selflessness, but do not have compassion, I gain nothing.
Compassion is patient, compassion is kind. It does not envy the ability of colleagues, it does not boast of correct diagnoses, it is not proud. It does not belittle patients, it is not self-seeking nor does it just tick boxes, it is not easily angered by lateness, it keeps no record of multiple DNAs. Compassion does not delight in the correct diagnosis but rejoices with the doctor-patient relationship. It always protects the patients' interests, always trusts in the humanity of interaction, always hopes for the best, often expecting the worse, always perseveres beyond the ten-minute appointment.
Compassion should never fail. But where there are primary prevention medicines, they will one day cease; where there are explanations, they will be unnecessary; where there is evidence-based medicine, it will be superseded. For we know in part and we hope we are aware of what is unknown; but once the syringe driver is set up, the importance of our knowledge shrivels away.
When I was a student, I consulted like a student, I thought like a student, I reasoned like a student. When I became a doctor, I put the ways of childish student life behind me. For now, we mostly diagnose illness based on what we can measure; in the future we should aim to view our patients as whole people. What can be measured is only part; I should aim to know them fully, even as I know myself.
And now these three remain: knowledge, consultation skills and compassion. But the greatest of these is compassion.'

What do we understand by compassion? Raymond Chadwick, writing in the British Medical Journal in 2015 (Chadwick, 2015) quoted an earlier account of compassion, defining it as *'sensitivity to the distress of the others with a commitment to try to do something about it.'*

I don't know about you, but my medical training focussed almost exclusively on the science of medicine – at the cellular and at the whole organ level; the biochemical pathways, the anatomy of the different parts of the body, the way disease affected the physiological functioning of the different systems of the body. I learned in my psychiatry attachment about psychiatric illness and its manifestations and treatment but only started to discover the interplay between mind, body and spirit as I read some of the books of Paul Tournier alongside books by Carl Jung.

I am now a consultant cardiologist and see patients in clinic and look after inpatients in hospital with heart failure and other general medical conditions. I have limited time with each patient and must try and work out what is wrong with each one to be able to offer them the right treatment. How can I do this better and more compassionately?

A trap I fall into repeatedly, both personally and professionally, is thinking I have the solution to people's problems and difficulties and just need to tell them what to do to deal with the problem or illness. The truth is, I may have it completely wrong or only have part of the solution to the patient's illness. I will almost certainly not understand why the person in front of me has presented with their particular set of symptoms and will have very little idea of how their previous experience of health and illness has influenced their clinical presentation and their psychological reaction to their illness or how it will be impacting their relationships with family and friends. Equally, my experience with other patients with similar disease will influence the way I discuss the diagnosis and the advice I give the patient. As Paul Tournier wrote in 'The Meaning of Persons': *'All that we have lived through and felt in the past is inscribed in us and helps to make us what we are today'.* (Tournier, The Meaning of Persons, 1957) Part of the art of compassion is knowing that we have only part of the story or as Paul puts it 'we see through a glass, darkly' (1 Corinthians 13; 12) and there may be good reasons for the person's behaviour and reaction to illness that we know nothing about, some of them influenced by the way I am interacting with them.

Scientific knowledge and training can make us fall into the trap of arrogantly thinking we *know, we have the answers.* Again quoting Paul Tournier, this time in 'The Person Reborn': *'What we should like would be to have only successes... the truth is that we do not help others when we think we have arrived, but only when we fight and seek, as they do.'* (Tournier, The Person Reborn, 1967)

Tournier quotes one of his patients in 'The meaning of persons,' who wrote to him: *'Those who impose upon us their ready-made solutions, those who impose upon us their science or their theology, are incapable of healing us'.* It is all too easy as doctors to tell our patients what to do: lose weight, exercise more, take your pills regularly, stop eating salt… Are we treating our patients with compassion when we talk to them in this way?

There is a chapter in John Pritchard's book 'Living Faithfully' on being attentive. (Pritchard, 2013) He writes: '*As a society we seem to find it extremely difficult simply to be present. We find it hard to focus on the present moment and the person or situation there before us'.*

He goes on to ask how we can reflect about this. *'It all starts with self-awareness. How aware am I of how I come across in human relationships? Do people find me interested, genuine, focused, caring or detached, self-absorbed, careless with their feelings? Do I tend to give answers before I've heard the problem? If we reflect on the way Jesus encountered people in need, it's clear he attended acutely to what people were both saying and not saying. When he met a woman who had come to a village well at midday (to avoid having to meet the other women of the community) he entered a deep conversation with her and soon realised that she was coming from a distressing series of relationships that had left her confused and demeaned. He helped her through to healing and hope for her future (John 4; 1-42).'* Pritchard gives other examples and concludes : '*Always, it seems, Jesus managed to so attune himself to the other person that he got under the surface of the presenting situation to the real issue beyond. Could we seek to emulate that?'*

That phrase 'got under the surface of the presenting situation to the real issue beyond' leapt off the page at me. In English we talk about 'taking a history of the presenting complaint' before we examine the patient, so I read it as 'get under the surface of the presenting complaint to the real issue beyond.'

Straight after reading this passage I saw a woman in the clinic who had stable, mild valve disease – not a problem, just needing monitoring at infrequent intervals. As we were chatting, she started to tell me about the stress she was under at work, and the strain it was placing her under. She then kept apologising for bringing it up until I laughingly told her that I had just been reading that morning about being attentive to what the real issues are in a person's life. For me, in my clinical practice, that is a key part of the compassion that rejoices in the doctor-patient relationship.

David Loxtercamp, a GP in a rural community in the US wrote in 2015, *'The ability to convey warmth, interest and reassurance to our patients can change health outcomes. Feeling close to our patients is just one factor in the complex dynamic of the therapeutic relationship. In becoming close to our patients, doctors learn that people are much more than a list of problems or a set of data points. Suddenly we are watching old friends age and die ….what we lose by not loving our patients is the joy that comes from caring for them…..Such recognition can open the door to tender, unguarded listening and transformative forgiveness. What patients likewise lose is the opportunity to hear bad news from a doctor who cares not only for them but about them.'* (Loxtercamp, 2015)

For many years now, I have been seeing a couple in clinic. He had a big heart attack which left him with very poor left ventricular function. He's always been someone who liked to keep busy, to get out every day, have a few drinks with friends in the pub and tell scurrilous jokes. There was nothing medically I could offer him. My interventional colleagues did all the usual tests, there was no viable myocardium, no angioplasty or bypass graft option. At this point they would have discharged him back to his GP. But my patient had great difficulty in accepting that he was no longer the fit and healthy ex-member of the armed forces that he had been. He felt increasingly breathless, got episodes of severe chest pain and dizziness, sometimes appearing in the casualty department of the hospital where ECG's and blood tests were always normal. He wanted me to DO SOMETHING. All I could do was see him in clinic every 3-4 months, listen to him voice his frustration and listen to his wife who was exhausted by his need to get out of the house every day. Examination in clinic was always entirely normal – no signs of heart failure, normal rhythm on the ECG. Each visit would end with him telling me a dodgy joke or two (to his wife's acute embarrassment), and then with her staying behind to tell me how difficult she was finding things. I continued to see them as he got weaker, unable to get out of the house much now, losing weight and becoming visibly cachectic until just before his death, and I know, because they told me and his wife told their GP after his death, that just coming and spending 20-30 minutes in my clinic room every few

months, where all I could do was listen to their concerns, was very important to them. I wasn't able to cure him, or to relieve many of his symptoms. All I could do was listen with compassion, give them both a hug at the end of the consultation and agree to see them again in a few months.

'*Compassion is patient, compassion is kind… it rejoices with the doctor-patient relationship.'* (Dawlatly, 2014)

A junior doctor, Daniel Grant, wrote last June of his frustration at being unable to be the doctor he wants to be, able to work with, relate to and help the person in front of him. He wrote: *'I spend 95% of my time with the computer instead of the patients. I identify them by their bed number or by their illness, I check their results remotely, and, at best, I have a brief clinical chat with them and hold their hand. Medicine has moved away from personal care towards depersonalised guidelines, academic elitism, and bureaucratic complexities. Patients can feel dehumanised because we make them feel like machines on a conveyor belt, when they should be treated as individuals. If we're allowed to communicate properly and engage the creative aspects of our nature, then we can begin to change what it means to be a doctor.'* (Grant, 2017)

'A*lways protecting the patients' interests, always trusting in the humanity of the interaction, always hoping for the best, often expecting the worse, always persevering beyond the 10 minute appointment.'* (Dawlatly, 2014)

There is emerging evidence that treating patients with compassion can provide measurable benefits both to the patients and to the doctor treating them. In an article by Robin Youngson and Mitzi Blennerhaslett, entitled 'Humanising health care – we have to start by building a more compassionate society', I found this: *'When we are sick, injured or facing a life crisis, our greatest human need is loving kindness and compassion in response to our vulnerability and suffering… Too often, what patients actually receive is rushed, clinical and detached care. Physicians have many evidence-based guidelines for disease management but little evidence-based medicine for care of the whole person. Randomised controlled trials have provided good evidence that compassionate care also improves outcomes. Empathetic and supportive preoperative consultation improves wound healing and surgical outcomes, halves opiate requirements and reduces length of stay. Patients in emergency departments are 30% less likely to return if treated with compassion… meta-analysis suggests that having a caring doctor reduces five-year mortality in men more than stopping smoking. Compassionate caring also gives meaning, joy and satisfaction to health professionals, aligns with their ideals, and protects against burnout.'* (Robin Youngson, 2016)

'And now these three remain: knowledge, consultation skills and compassion. But the greatest of these is compassion.' (Dawlatly, 2014)

I close with a wonderful blessing I came across in a fictional account of the first female archbishop of Canterbury entitled simply 'Archbishop' written by Michele Guinness (Guinness, 2014) (An excellent book if you get the chance to read it). The archbishop's mentor who is very ill and dies not long after, prays this blessing over her as they have what will turn out to be their last meeting together. It expresses everything I hope for in my dealings with friends, family and patients.

'The blessing of honesty and integrity, of courage and dignity, fearlessness and perseverance, of purpose and hope, joy and laughter, love and peace, of the indwelling of the Holy Spirit in all his fullness rest upon you for the remainder of your earthly days, however few or many, whatever God calls you to do.'

Amen.

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