Nursing theory and the delivery of compassionate care


Abstract
Compassionate care is a priority in current healthcare policy. However, its definition is amorphous, leading to difficulties standardising it in practice. This article discusses how nursing theory is central to the delivery of compassionate care. It emphasises the need to develop a theoretical framework that reflects the eclectic and pragmatic nature of nursing practice, and the importance of using patient feedback as an indicator of the quality of care and as a basis for adapting theoretical hypotheses.

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THE NURSING PROFESSION has a social mandate to contribute to the good of society and provide compassionate, evidence-based health care to a diverse population (McCurry et al 2010). Fry et al (2013) described caring as a central characteristic of nursing, defined as ‘the mental, emotional and physical efforts of the nurse to respond to and support individuals’. However, the term ‘compassionate care’ is ambiguous. This poses significant challenges for nurses, particularly in relation to promoting and assessing compassionate care in practice (Price 2013). There is no universally defined concept of compassion (Doane and Varcoe 2005, Maben et al 2009, Dewar 2013, Fisher and Freshwater 2014). Therefore, for the purpose of this article, compassion is defined as the necessity to recognise and support human vulnerability (Dewar 2013) rather than as relieving human suffering (Chochinov 2007).

Nursing role in compassionate care
The role of the nurse in providing compassionate care came under scrutiny following the initial report of the Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 to March 2009 (Francis 2010). The final report, Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis 2013), generated a UK-wide debate about the apparent crisis in the delivery of compassionate care in the NHS. Reports of abuse and neglect experienced by patients at the hands of healthcare staff employed to care for them prompted the British public and media to speculate that there were systematic failings in the NHS (Campbell 2013, Coward 2013), and to question whether some nurses had become bereft of compassion (Francis 2013).

Nurses are faced with a range of potential barriers in the provision of compassionate care, partly as a result of the dynamic and increasingly complex healthcare context in which they work (Burnell and Agan 2013, Dewar 2013, McEwen and Wills 2014). Patients are living longer, often with complex comorbidities, and are treated in the community and the acute healthcare sector. This has led to an extension of the professional roles and responsibilities that nurses are expected to perform competently and compassionately, irrespective of financial constraints and staff shortages (Kemp and Baker 2013). This, in turn, has resulted in a widening of the theory-practice gap and has compromised efforts to promote nursing as a competency-based profession (Levett 2010).

This article discusses how developing theory is central to nursing and the delivery of compassionate care. It demonstrates how generating nursing theory consolidates nursing as
a profession and enables nurses to ensure newly created roles are founded on a critically appraised evidence base (Fowler and McGarry 2010).

**Professional status of nursing**

Asserting the professional status of nursing has proved to be a significant challenge for nurses (McCrae 2012). Nottingham (2007) described nursing as an ‘insecure profession’ that has failed to constitute and control a market of expertise, often relying on borrowed knowledge from medicine and other social sciences. An inability to assert their professional status may hinder nurses’ capacity to advocate for patients and deliver compassionate care (McKenna et al 2006, McEwen and Wills 2014). The legitimacy of a profession is based on its ability to generate and apply theory (McCrae 2012, Porter et al 2014). Despite widespread efforts to improve nursing’s academic credentials, the discipline may be viewed as lacking specialist expertise, and without a clearly defined theoretical framework nursing is vulnerable to external control (McCrae 2012).

Compared with medical professionals, nurses appear to be reluctant to rely on professional rationales for their actions, preferring to use managerial justifications and implementing a ‘top down’ approach to care (Adamson 2013). Nottingham (2007) argued that professionalism is based on an ability to establish a jurisdiction and that nurses should identify their area of work and project themselves as uniquely positioned to undertake it. If nurses are unable to value their distinct contribution to health care and assert their professional status, they are at risk of governance by proxy (Kemp and Baker 2013).

This poses a serious challenge in the provision of compassionate care, since ward managers are often driven in the current healthcare culture by productivity targets that promote efficiency, as opposed to patient-led goals (Dewar 2013, Francis 2013). A further risk of patient care outcomes imposed by a bureaucracy is that they create incentives that serve administrative rather than clinical objectives, as indicated in the Francis inquiry (Curtis et al 2012, Francis 2013). Service provision that emphasises the importance of targets has the potential to reinforce ritualistic, transactional and biomedical models of nursing (Adamson 2013). Even where nurse managers achieve their efficiency targets, this approach to care may result in the compartmentalisation of psychological and somatic care, causing patients to become dissatisfied and disempowered (Adamson 2013). This could be counterproductive as several nursing theorists have equated health with independence, suggesting that nursing professionals should act as agents of change (Peplau 1991, McCrae 2012). Im and Chang (2012) argued that development of theories is, therefore, central to the process of asserting nursing as a profession, by formulating knowledge that guides, describes and predicts practice (McKenna and Slevin 2009).

**Developing nursing theory through a philosophical approach**

The author discovered varying definitions of the word ‘theory’. For the purpose of this article, theory will be defined as rigorous and systematic structuring of ideas that conveys a view of a phenomenon (Streubert and Carpenter 2011). Several theorists have attempted to develop a definitive theory of nursing (Nightingale 1859, Pierce 1957, Leininger 1985, Schön 1987, Watson 1996, Roach 2002). However, this is unachievable because of an inability to translate practical knowledge into theoretical propositions (Dunne 1993). It is further complicated by the ongoing debate about whether nursing is an art or a science (Reimer and Moore 2010). Kikuchi (2004) suggested that the essence of human nature is unique to each individual and is therefore not accessible to scientific study. Moreover, if nursing is practised exclusively as an applied science, this may exacerbate impersonal, ritualistic care (Kikuchi 2004, Curtis et al 2012, McCrae 2012). Therefore, for care to be compassionate and person centred, nursing theory can only progress considering the practical philosophy of art.

Pesut and Johnson (2008) emphasised the benefits of a philosophical approach as a less prescriptive method of theory development. An artistic philosophical approach draws on beliefs and values, judging and perceiving what is significant about an experience of patient care (Pesut and Johnson 2008). This differs from scientific theory generation, which seeks to address specific physiological and psychological conditions in nursing and aims to standardise treatment of those conditions (McKenna and Slevin 2009).

Compassionate care is guided by our innate humanistic ethos and is developed by experience. Therefore, efforts to develop a definitive scientific nursing theory enhance the credibility of nursing (Roach 2002, Clarke 2006). A philosophical approach to theory development could enable inclusion of the broader philosophical issues inherent in personhood, an essential requirement of person-centred care (Curtis et al 2012).
This would be beneficial in the provision of the means and ends of the art of nursing practice, but only in philosophical terms (Murphy et al 2010). Nurses might require additional types of knowledge, such as scientific theory, to provide holistic and person-centred care. However, McCormack and McCance (2010) argued that the art of nursing should not be undervalued and that it is an essential component of professional competency and an integral factor in the development of clinical judgement.

Importance of tacit knowing
Disciplines such as nursing require professional judgement, for example the practical knowledge obtained by the expert nurse, which cannot be articulated in propositions (Wainwright 2003). Benner (1984) outlined the five stages nurses go through as they acquire mastery and develop professional judgement – from the novice who relies on objective facts to the expert who bases decisions on honed experience and tacit knowledge. One example in clinical practice might be the nurse’s practical knowledge when taking a patient’s pulse. From this particular intervention, the expert nurse is able to gain important information about the patient’s heartbeat (Charalambous et al 2009). Wainwright (2003) suggested that the levels of discernment obtained from this skill cannot be defined by propositions, since the nurse’s sense of touch and experience are able to detect more subtle differences than can be quantified.

Chinn and Kramer (2011) suggested that there is a demarcation between practical nursing knowledge, such as inserting a urinary catheter, and exploratory examination, such as taking a pulse. Although the experienced nurse might be able to determine irregularities of the heart through a sense of touch, for example, ‘thin and thready’ or ‘fast bounding’, the nurse is using theoretical knowledge as a basis for a nursing diagnosis and care delivery.

McCurry et al (2010) and Price (2013) stated that nursing care may be reduced to elements, despite complex needs, and that for each of these elements there will be a theoretical solution. This emphasises the necessity of developing a nursing theory that is practical and propositional in nature (Kikuchi 2004, McKenna and Slevin 2009). Carper (1978) identified four elements of nursing episteme (system of understanding): empirics, aesthetics, ethics and personal knowing, that demonstrate the benefits of integrating intellectual theory with clinical practice and portray nursing as an art and science (McCrae 2012).

Standardising care using empirical research
Carper’s (1978) seminal principles are a naturalistic conceptual framework encompassing empirics, aesthetics, ethics and personal knowing in nursing. Carper (1978) emphasised that empirics are crucial to the development of nursing practice and that a heuristic approach to care threatens patient safety. For care to be compassionate, it must also be competent (Nursing and Midwifery Council (NMC) 2015). By generating a body of scientific nursing theory, nurses are provided with objective and research-based knowledge that meets criteria required to assert professional status (Polit and Beck 2011).

The quantifiability of empirical data enables objective measurement that can be replicated by other nursing staff, allowing for the standardisation of care, which is central to current health and social care policy (Department of Health and NHS Commissioning Board 2012, Gerrish and Lacey 2015, NMC 2015). An example of this in the practice environment might be the use of the National Early Warning Score system (Hill 2012) to help nurses to recognise the antecedents of cardiac and respiratory arrest and to respond appropriately.

Empirical research is an important element in developing nursing practice and asserting nursing as a profession, but there has yet to be a standardised scale developed for measuring compassionate care in nursing (Burnell and Agan 2013). Attempts to explain compassionate care through an empirical approach can impede person-centred care (Polanyi 1966, McKenna and Slevin 2009). Therefore, the nurse should also consider the importance of other elements of the nursing episteme, such as ethics, in their provision of care.

Incorporating an ethical approach to care delivery
Virtue ethics is defined as the application of moral excellence (Avery 2013). This ethical philosophy is the basis of healthcare practice in the NHS. It encompasses the ideals of compassion, empathy and courage, and is central to person-centred care (McCormack and McCance 2010). Efforts to professionalise nursing and make it a competence-based profession do not imply that practitioners should neglect to apply virtue ethics to their practice (Dewar and Nolan 2013). Professionalism does not conflict with virtue ethics; competency is associated with excellence and excellence in care is a virtue (Avery 2013). A nurse may possess all the necessary virtues such as compassion and empathy, but may be at risk of harming the patient if they do not have the
knowledge to support their practice (Chochinov 2007). Care delivery that fails to incorporate nursing knowledge limits clinical decision making and the nurse’s capacity for ethically responsive practice (Doane and Varcoe 2005).

Maben et al (2009) advised implementing a simultaneity paradigm to ensure a holistic approach to care. This approach to the task of caring combines empirics and technical skills with empathy and compassion, ensuring the patient’s inherent value is recognised (Avery 2013). However, incorporating nursing arts such as compassion, empathy and the therapeutic use of touch in practice has become increasingly challenging in the current healthcare context (Risjord 2010). This is partly as a result of the reduction in the time spent providing ‘hands-on’ nursing care and the emphasis on evidence-based practice (Risjord 2010).

**Bridging the theory-practice gap**

Theory and practice have been viewed as separate entities, resulting in the perception that academic knowledge is an ideal with limited extension to practice (Risjord 2010). This theory-practice gap has been accentuated by the demands of the evolving healthcare context and the evidence-based practice movement (Habermas 1986, Rolfe 2006). Doane and Varcoe (2005) suggested that the term ‘evidence-based practice’ assumes that evaluated theory is defined as a product of ‘good’ research. A theory that is unconditionally based on empirically derived evidence may be refuted at any time by further investigation, and so practice that is based on empirically derived evidence may result in sub-optimal patient outcomes (Duffy 2005, Im and Chang 2012).

Efforts to assert nursing as a competency-based profession have established technical rationality as the dominant discourse (Habermas 1986, Rolfe 2006). Technical rationality refers to prioritising theory over tacit and aesthetic knowledge (Fisher and Freshwater 2014). The existence of the theory-practice gap may also be attributed to the fact that nursing knowledge is often an amalgamation of knowledge from other fields, including the social sciences. This may result in the inappropriate application of findings generated from inappropriate methodologies (Rolfe 2006).

There are important limitations to delivering compassionate care in nursing when using a social science approach to research and theory development at a macro level (Walker and Avant 2011). As nursing practice is based on a series of unique experiences and situations, the practitioner should be cautious when applying a specific theory at an individualist level (Price 2013). Nurses should be aware that empirical research that is based on data collected from a large group is designed to generalise average behaviour and should not be used in isolation as the basis of person-centred compassionate care delivery (Hanberg and Brown 2006). Liaschenko and Fisher (1999) and Hatlevik (2012) asserted that there is no inherent gap between practice and theory and that nurses regularly apply theoretical principles in practice but often do not realise that this is what they are doing.

One example of this in the practice environment might be when a nurse gives a patient advice on how to use a new piece of equipment to promote self-management of their condition, such as an intermittent catheter. When the nurse gives information to the patient, they customise the information they provide while observing and assessing the patient’s level of understanding, engagement, distress and enthusiasm (Rolfe 2006). In doing so, the nurse may not be aware that they are drawing on the work of communication theorists such as Leininger (1985) and Peplau (1991), or that they are adapting these theories to customise patient care. This example indicates how theory should not be applied as a rigid set of rules and may only be used as a guide to practice. When the nurse alters their communication strategy to maximise the patient’s level of receptivity and comfort, they are demonstrating their ability as a critical, questioning and synthesising practitioner. Not only should theory inform practice, but practice should also inform theory. This concept is known as nursing praxis (Chinn and Kramer 2011).

**Role of nursing praxis in implementing compassionate care**

Compassionate care is a fundamental component of nursing praxis that involves the nurse theorising about unique clinical experiences, adapting theories and testing revised hypotheses (McKenna and Slevin 2009). Praxis does not pertain to the role of the nurse, but represents an insightful exploration into the reality of what it is to practice nursing in the evolving clinical environment (Fry et al 2013). The practice of compassionate caring in nursing praxis involves negotiating the relationship between the physical and emotional wellbeing of patients and recognising the patient’s potential vulnerability as a starting point for compassionate behaviours (Dewar et al 2014). One example of how this can be achieved in practice is through the giving and receiving of patient feedback (Burnell and Agan 2013).

Feedback can be an important tool to enhance practice and identify how compassionate care...
was achieved (Adamson 2013). Nurses are able to gain insight into patient values and how they perceive compassionate care, by engaging in caring conversations with patients and colleagues (Fisher and Freshwater 2014). It is also essential to reflect in the moment with colleagues about care, since this provides an opportunity to share experience and work together to adapt theory when care is difficult and complex (Fry et al 2013).

There may be a misconception that the time constraints imposed by a busy care environment limit the opportunities to engage in caring conversations (Maben et al 2009). However, such conversations are central to the delivery of care and are achievable in contemporary healthcare provision (Dewar et al 2014). Without effective communication between patients and nursing professionals, there is a risk that a sub-optimal workplace culture can develop, that is not conducive to person-centred care (Price 2013). A prolonged lack of meaningful engagement between nurses and patients may result in this becoming the ‘norm’ in the clinical environment, resulting in patient dissatisfaction and a perceived lack of compassionate care (McCurry et al 2010, Francis 2013). Wilkinson (2007) defined this phenomenon as acculturation. In a qualitative study by Timmins et al (2014), patients did not limit their description of ‘care’ to the nurses’ ability to execute a technical skill, but included ‘soft skills’ such as their therapeutic use of touch and active listening skills.

Burnell and Agan (2013) suggested that a theoretical understanding of a specific clinical intervention is insufficient to provide compassionate care. Without effective communication and patient feedback as an indication of the quality of care, nurses are at risk of providing care that is based purely on professional interpretation and assumptions; thus contributing to a technical rationality discourse (Curtis et al 2012). Theories are important to orientation. However, nurses should not restrict themselves to a singular paradigm to advocate practice since it limits critical thinking and methodological perspectives (McEwen and Wills 2014). Therefore, the role of the researcher should not be separate from the role of the nurse because to practice is to research (Rolfe 2006).

Conclusion

Theory is central to developing nursing knowledge and to asserting nursing as a professional occupation. The dynamic nature of current health care requires nursing professionals to constantly add to their body of knowledge, applying critical thinking to ensure that the best evidence is selected to support interventions. There is no universal definition of the term compassionate care and no single theory encompasses all aspects. It is important that nurses use a combination of knowledge, such as Carper’s (1978) principles of knowing and patient feedback, to implement a holistic approach to practice. Nurses should use caring conversations together with empirical knowledge to ascertain what patients determine as compassion and use feedback as an indicator of quality of care to adapt theoretical hypotheses.

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