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### Review: Compassionate communication in acute healthcare

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## Commentary

### Compassionate Communication in Acute Healthcare: Establishing the Face and Content Validity of a Questionnaire

Pam Smith

Compassionate care has been high on the NHS agenda since 2008. Alan Johnson the then Secretary of State for Health, made the controversial proposal that nurses' compassion should be rated on their smiles (Carvel 2008, Smith 2008). The authors of the current paper acknowledge the influence of Johnson and others on the development of indicators and tools to measure compassionate care (DH 2008, Johnson 2008, Griffiths et al. 2008, Maben et al. 2012). They also mention the impact of the Francis' Inquiry report of the failings in care at the Mid-Staffordshire NHS Foundation Trust (Francis 2013). The report sent shock waves through the NHS with nurses in particular being held culpable for the failures. The Inquiry became 'a defining moment in the history of the NHS' revealing how 'the pressure to meet targets and financial imperatives' could adversely affect quality care (Smith 2013).

The authors also refer to a key policy document on nursing's role in compassionate practice identified as the six Cs: compassion, care, commitment, courage, competence, communication and introduced in 2012 by England's Chief Nurse (CN) (DH 2012). These six Cs have since been embedded in a new framework *Leading Change, Adding Value* to emphasise 'best quality experience for our patients and people'; 'best health and wellbeing outcomes for our populations'; 'and best value for every pound spent' (DH 2016). Part 5 of the document is dedicated to 'Tools to support the framework' and lists a range of resources on compassionate care but surprisingly no specific measurement tools are mentioned.

The current study addresses this gap by engaging with quantitative methods and questionnaire development to capture nurses' compassionate communication. The authors describe the process of amending an existing questionnaire to measure nurses' non-verbal methods of compassionate communication in acute care settings and explain how they established face and content validity using lay and research experts. The authors' detailed discussion of the statistical results is limited by presenting small numbers as percentages rather than qualitative narratives. They also suggest the questionnaire's potential to standardise the measurement of compassionate communication nationally. This seems reasonable in the light of the CN's recent policy proposals but with the proviso that further testing of a revised questionnaire will be required given regional and specialist variation.

The authors are very aware of the challenges of operationalising such an elusive concept as compassion (Dewar 2011) and agree with Pearson (2006) 'that small actions suggesting compassion often go unnoticed'. These insights were reminiscent of my own research findings on the emotional labour of nursing (Smith 1992, 2012). Emotional labour involves smiles, touch and caring conversations to make people feel safe and cared for (Hochschild 1983). It can be used as a qualitative device to describe complex and nuanced situations and capture the 'little things' to connect caring processes with compassionate outcomes.

Reviewing this paper stimulated me to reflect on the importance of theoretical and methodological triangulation by combining quantitative and qualitative research to generate numbers and narratives to make care count in a cost driven NHS.

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