Tasks and Technology Versus Compassion and Caring in Nursing

Are they Mutually Exclusive?

Recently, I had the privilege of hearing a presentation by Wilfred McSherry, PhD, RGN, FRCN, professor in Dignity of Care for Older People. This is a shared appointment between Faculty of Health Sciences, Staffordshire University, and Shrewsbury and Telford Hospital NHS Trust (United Kingdom). He is also a part-time professor at Haraldsplass Deaconess University College in Bergen, Norway. He spoke on “Dignity and Spirituality: Do They Have a Place within Contemporary Nursing?” He began his presentation by reading from an article about a patient in ventricular fibrillation. A code was called, and about 20 people responded quickly pounding the patient’s chest, staring an IV, and administering medications. Several times the patient asked if he was going to die and no one spoke to him or answered his question. They just told him to breathe. Everyone was busy doing all the tasks they needed to do, but even with all their efforts, the patient died. The code team felt they had done everything they could for the patient. The author’s reaction was that there were 20 people in the room, but the patient died alone. This was an emergency situation where saving his life was the primary focus, but of the 20, not one focused on the patient. This happens more than we would like to think, even in nonemergent situations. We focus so much on the tasks and the technology that we forget the patient in the process. Is it possible for nurses to focus on both? Can we pay attention to the tasks and technology and still be caring and compassionate? Does one outweigh the other? Is one more important than the other?

Some writers have suggested that patients have become invisible and that caring and compassion have been overshadowed by the science of nursing. A detached or “hard” nurse has been defined as one focused on the patient’s condition and not the patient. They appear scientific, proficient, technical, competent, detached, and cold. The engaged or “soft” nurse, on the other hand, is concerned with the person and appears warm, emotionally present, valuing, accepting, giving of time, and recognizing the patient as a person. I have heard it said that we get treatment in the hospital and care in the hospice.

DEFINITION OF NURSING

Nursing’s Social Policy Statement: The Essence of the Profession (American Nurses Association, 2010, p. 3) provides the following contemporary definition of nursing: “Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations.” The International Council of Nurses (2014) states, “Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles” (http://www.icn.ch/who-we-are/icn-definition-of-nursing/).

In both these definitions, the word “care” is mentioned once in relation to care of certain groups, but they nowhere refer to “caring” (except possibly in the statement regarding the alleviation of suffering). Is there a difference?

DEFINITION OF CARE AND CARING AND COMPASSION

According to McSherry, care is both a noun and a verb related to paying attention or providing treatment. Caring is also both a noun and a verb related to looking after someone else. Others have defined the terms in a variety of ways, but the definitions are more confusing than helpful. Some
believe that caring is synonymous with nursing, and others believe that caring is a part of nursing, but only a part. Then there are caring theories espoused by Jean Watson, Madeline Leininger, and others. “Watson...believes that caring cannot simply be reduced to behavioural tasks and that, to care adequately, nursing entails a commitment to caring as a moral ideal directed towards the preservation of humanity” (McSherry, McSherry, & Watson, 2012, p. 8).

Leininger describes professional nursing care as “cognitively learned humanistic and scientific modes of helping or enabling an individual” (McSherry et al., 2012, p. 9). She feels that caring is the essence of nursing. Obviously, there is confusion about care and caring, but it is certainly easy to recognize when they are absent.

Compassion has been defined as synonymous with caring, and some authors believe it is a fundamental element of nursing care: a precious asset, a strength of the profession. The dictionary definition of compassion is that of sympathy for someone who is suffering and the desire to alleviate that suffering. One of the difficulties is that each person has their own definition of caring and compassion, which has personal meaning to them based on how they view the world.

According to McSherry et al. (2012, p. 14):
- “there is confusion about the concept of ‘caring’”;
- “We think that we care, but we do not know what ‘care’ is”; and
- “We think that we can recognize care and caring, but we do not actually know how to do so.”

CONCEPTS OF SCIENCE: TASKS AND TECHNOLOGY
It has been said that nursing is made up of knowledge and caring. However, some say that nursing has become more medically focused, and reliant on medicines and machines rather than on care and caring. The focus seems to be on the evidence and research, and we have disconnected from who the patient really is.

Has the art of nursing been lost in the science? One author expressed that caregivers performed nursing tasks without any apparent interest in the person under their care. The nurse did not ask questions, make eye contact, or offer any kind words. They were simply handing the machines at the bedside. They were, in effect, not “emotionally present” (Douglas, 2010). Another author felt that the focus was on volume and flow, where patients feel like they are in a foreign land not understanding the language. Furthermore, the nurses (and doctors) did not take time to translate in a way the patient and family could understand (Brown, 2014). Another author expressed concern that the training of nurses has become too academic and does not prepare the students for the realities of the job. In the process, nurses are losing their sense of compassion. The author felt that nurses needed to be at a certain intellectual level today, but it should not come at the cost of treating patients with compassion and dignity (Adams, 2012). Another author believes that nurses are now being described as an “assistant” to the doctor, a care technician (Jones, 2005). Corbin feels that caring is not a lost art, but is at odds with today’s working conditions. Patients require more highly technical care than previously, and in addition, the nurse’s time is spent on paperwork, meetings, and managerial tasks (Corbin, 2008). According to Coward (2013), “It’s not that nurses are not caring, but that our hospital system is struggling. ‘Nursing in hospitals now isn’t about caring for people. It’s about reaching targets. It’s awful how we’ve lost our way.’” I was in a meeting recently when one of the nurse participants said that caring is where the heart of nursing wants to be but can’t be because of organizational requirements. I could go on with other examples, but I think that covers the major points. Technology and systems appear to be getting in the way of caring and compassion.

THE QUESTION
So the question I am posing is—can a nurse be technically competent and deliver high-tech evidence-based care in a caring and compassionate manner? Another question may be “why does society expect nurses to be caring?” Certainly, our patients are not as familiar with what is required for a nurse to be competent in this mentally challenging career as they are with compassion and caring. In the introduction to his article on compassion in nursing, Davison says “Compassionate care is a key product of healthcare providers and is expected by the public. It is also a vital aspect of good nursing care. However, using computers and doing administrative tasks are part of modern nurses’ daily routine, and it is claimed that these have distracted them from being compassionate” (Black, 2008, from Davison & Williams, 2009). Is it that we are so focused on the technology that compassion is taking a back seat? Are we so busy doing tasks and documentation and management and meeting metrics that we no longer have time to care? Do we have different definitions of compassion and caring and believe we, ourselves, reflect the definition but it is expressed in a way that others don’t recognize? Can we measure compassion and caring? Are there specific behaviors that we can observe? What factors influence care and compassion? What level of compassion should we expect? Can those be accomplished at the same time we are giving competent care? According to Pence (1983), scientific competence and compassion are not mutually exclusive, but so much depends on how we define our terms. He believes that we need to change our systems that do not reward compassion. This is certainly something we need to discuss and think about. I personally believe that high tech does not have to result in low compassion and caring. As nursing continues to adopt more and more advanced clinical skills and becomes more and more complex, we need to remember that our patients are people with need for respect, compassion, and understanding.
Nursing Professional Development specialists can work with new graduates to help them become more compassionate and caring as they are struggling to fit into the nursing workforce. We can define behaviors that show compassion and caring and then measure nurse’s ability in those areas. A good mentor can support a new staff member in both competence and compassion. We can reward staff who show caring and compassion along with competence and nurture both. Moreover, we can provide the feedback given by patients regarding their care.

A telling poem was written by an elderly patient in a geriatric ward of a hospital in England pleading for the nurses to really see who the patients are, to care for them as an individual person with a history and a present. The poem (McCormack, 1966) ended with the following lines:

“So open your eyes nurses, Open and see...Not a ‘Crabbit Old Woman,’ Look closer...see ‘Me.’”

I challenge you to answer the questions posed for yourself and to help our staff give both compassionate care and excellent technical care. Nursing at its very best is both caring and competent.

References


National Accreditation Standards for Nurse Residency Programs, Part 1 Correction

The article mentioned above contains inaccurate information regarding the Commission on Collegiate Nursing Education (CCNE) accreditation for nurse residency programs. The statement, “The standards are not generalizable outside of those organizations that use the UHC/AACN program, and the only organizations that achieve certification are those that are running the UHC/AACN program. This has left the vast majority of NRPs without a way to demonstrate their value and quality by becoming accredited,” is not correct. To clarify, CCNE accredits entry-to-practice nurse residency programs in diverse healthcare organizations across the United States, and programs seeking CCNE accreditation are not required to use any particular curriculum model.

CCNE values the diverse institutional perspectives of residency programs seeking accreditation and works collaboratively with applicants to foster innovation in these programs.

Additionally, the article refers to UHC as the “United Health Consortium,” when in fact UHC is the University HealthSystem Consortium.

We regret these errors.

More information can be found at www.ccneaccreditation.org regarding CCNE’s accreditation of nurse residency programs, including revisions to the accreditation standards (begun in 2014 and finalized in summer 2015) and the CCNE Board of Commissioner’s expansion of the scope of accreditation to include nurse residency programs 1) serving all entry-to-practice nurses and 2) in all healthcare settings.

Reference

www.ccneaccreditation.org

DOI: 10.1097/NND.0000000000000236