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Compassionate communication: Keeping patients at the heart of practice in an advancing radiographic workforce

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Title

Compassionate communication: keeping patients at the heart of practice in an advancing radiographic workforce

Abstract

Introduction

Compassion is a poorly understood concept in diagnostic and therapeutic radiography, but an increase in its focus was recommended in the Francis Report (2013). Much of the healthcare literature including policy and protocol has focussed on benchmarking and individualising compassion. Two separately conducted doctoral research projects, one therapeutic and one diagnostic, aimed to conceptualise compassion in order to understand its meaning and behavioural expression.

Methods

A constructivist approach was taken with appropriate ethical approval. Patients and carers, student radiographers and radiographers took part in interviews and focus groups and tweets were harvested from a Twitter journal club discussion between radiographers of the second author's published literature review. Data were transcribed and analysed thematically.

Findings

Key aspects of communication are fundamental to giving compassionate patient-centred care. These include verbal and non-verbal cues, actively listening and engaging and establishing rapport with the patient. Specific skills associated with these are also identified in these studies.

Conclusion

Keeping the patient as a person at the centre of radiographic practice in the rapidly evolving technical and cultural environment in which it exists requires timely and appropriate behavioural expressions of compassion from radiographers deploying a range of highly specific communication and interpersonal skills.

Introduction

Compassion was highlighted in the Francis Report detailing failures of care at one NHS Trust in 2010 which had led to, in some cases, "*appalling suffering*"[1]. The report contained recommendations for an increased focus on compassionate patient care and although radiography was amongst several health professions which escaped the attention of the report's authors, the role of the radiographer includes a responsibility to undertake increasingly technical and task-focussed procedures whilst caring with compassion for their patient[2]. Responses to the Francis Report did not take up the question of what compassion meant and how its recommendations might be meaningfully implemented; furthermore, there is a limited understanding of those behaviours and attitudes perceived as compassionate by patients in both the UK and the wider radiographic and healthcare communities.

Driven by the changing clinical landscape, ever-increasing demands on the NHS and promoted by the Society and College of Radiographers there has been a significant widening of the scope of professional practice, clinical skills and responsibilities across the radiographic workforce. A recent review established how this growth in consultant, advanced and specialised roles has created a positive impact for patients, staff and the healthcare systems[3]. However, health care professionals within these roles face increasing workload pressures and stressful working environments, both of which act as barriers to compassionate care[4].

Unknown to each other at the outset, two radiographers, one therapeutic and one diagnostic, undertook doctoral research projects to qualitatively explore the concept of compassion; its meaning and expression, with the aim of producing an understanding of compassion in diagnostic and therapeutic radiography. In this paper the authors present findings aimed at informing radiographers of those behaviours and practices which communicate compassion, thereby enabling them to practice individualised patient-centred care in what is a particularly technologically focussed context.

Literature Review

The aim of the literature review was to ascertain current understanding of the concept of compassion and its evidence base in healthcare. To this end, the first named author performed a Concept Analysis[5], a popular method of exploring the healthcare literature first identified by Walker and Avant[6] and the second undertook a scoping review of the radiography and wider literatures[7]. Whilst neither author performed a systematic review, use was made of PRISMA[8] & CASP[9] to refine the searches.

Across the literature base, dictionary definitions of compassion include ideas around compelling feelings towards another's suffering, feelings of discomfort through a process of identifying with them, and a positive desire to act in order to relieve suffering[10]. Definitions including that provided by the NHS[11] include terms such as pity, empathy and sympathy, care, altruism and kindness, each of which have their own definitions and assumptions as to their shared meaning. They also tend to be used interchangeably creating further ambiguity. The defining attributes of compassion from the concept analysis included recognition; connection; altruistic desire; humanistic response and action, and the antecedents and consequences illustrate the nuanced nature of these attributes in terms of the cognitive (e.g. recognition, attention) and emotional (e.g. distress, contentment) processes underpinning these attributes. From a review of wider healthcare publications there also was a proposition that the relationship between patient and practitioner is a core constituent of compassion[5,12-14].

Responses from political and professional bodies emphasised amongst other factors, the shared responsibility for compassionate care within the NHS[15-17]. However, there was a focus on quantifiable measures and means of incentivising compassion[18] with little in the way of questions as to the meaning and manifestation of compassion in practical patient care[19,20].

Our shared objectives were to talk to patients, radiographers and students, and in one study carers about what compassion means to them based on their experiences, opinions and beliefs and to identify how compassion might be displayed in radiography.

Methods

Since the aims were not to measure, quantify or enumerate individuals' experiences of compassion, a qualitative approach was taken by both authors, with a constructivist methodology in which knowledge and truth are not discovered but created through mental processes of meaning-making and understanding[21]. The schematic summary in figure 1 details this.

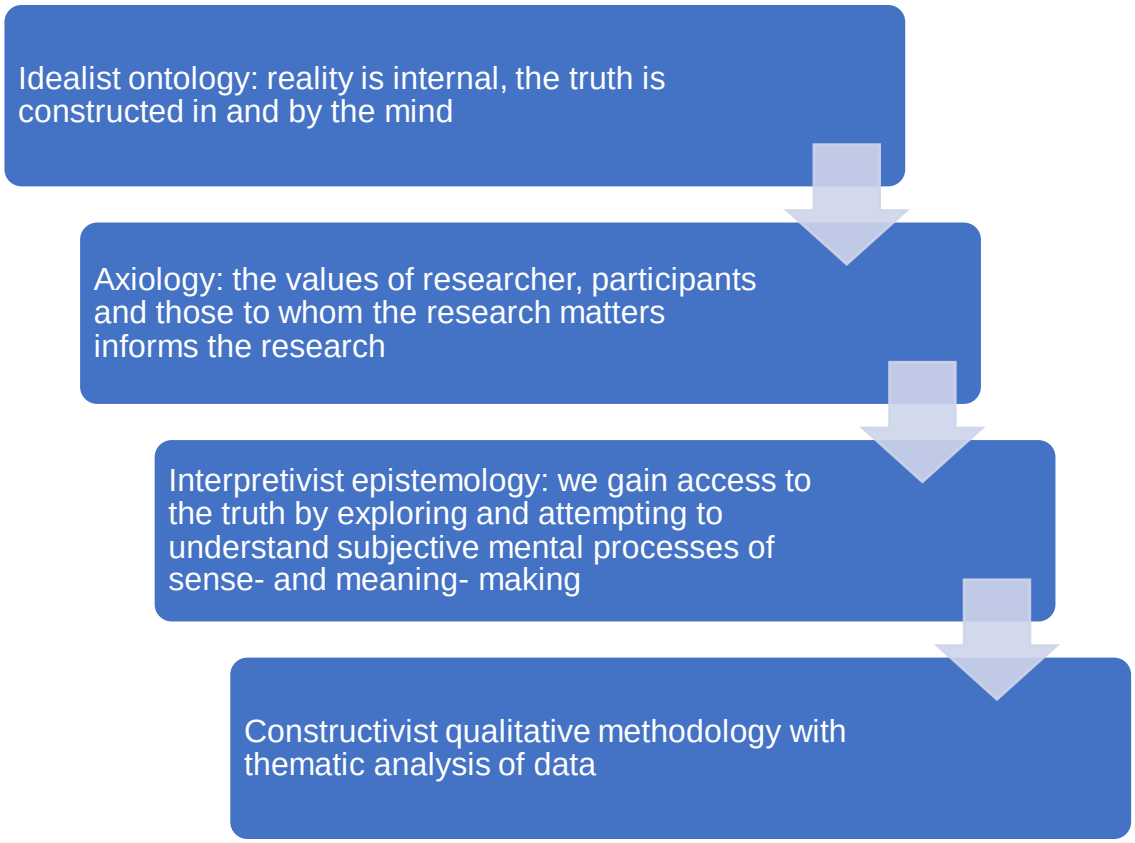

Figure 1: Schematic summary of the constructivist research paradigm used by both authors

Both authors drew on their literature reviews to inform the design of the methods chosen. Using a mixture of interviews, focus groups and an online discussion group, both spoke with patients, radiographers, student radiographers and, in the case of the first author, carers. The first author proceeded to co-construct a definition and conceptual framework of compassion using co-production workshops. The second author assembled data from interviews with patients, focus groups with students and a Twitter discussion between radiographers. Table 1 shows the number and type of

participants in each study. For both projects Health Research Authority and host Higher Education Institution research ethics were granted in addition to local research and development/innovation approvals. Ethical concerns included privacy and confidentiality of the participants and data; these were protected using secure storage with password protection. Power and influence in focus groups were addressed through careful moderation and the psychological wellbeing of participants in recalling upsetting memories was monitored by checking with participants with the offer of specialist help if needed. Data were analysed using thematic methods[22,23].

Study	Patients +/- carers	Student radiographers	Radiographers
Author 1	16	24	27
Author 2	34	30	85

Table 1: Summary of each author's participants

Findings

Our findings highlighted the centrality of communication in a compassionate encounter between radiographer and patient. The findings were thematically mapped and are presented under four sub-themes supported with evidence from the data; figure 2 shows a co-created schematic summary. Participants' anonymity was preserved using acronyms (Table 2).

Study	**Acronym**	**Short for**	**Example**
Author 1	PaC	Patients and carers + site of focus group	PaC Site A
	TR	Therapeutic radiographer + site of focus group	TR Site C
	STR	Student therapeutic radiographer + year of academic programme	STR Year 2

Author 2	RadTweet	Radiographer Twitter data	
	P	Patient + patient number	P05
	FG	Diagnostic student focus group + year of academic programme	FG1

Table 2: Acronyms used in anonymisation of participants

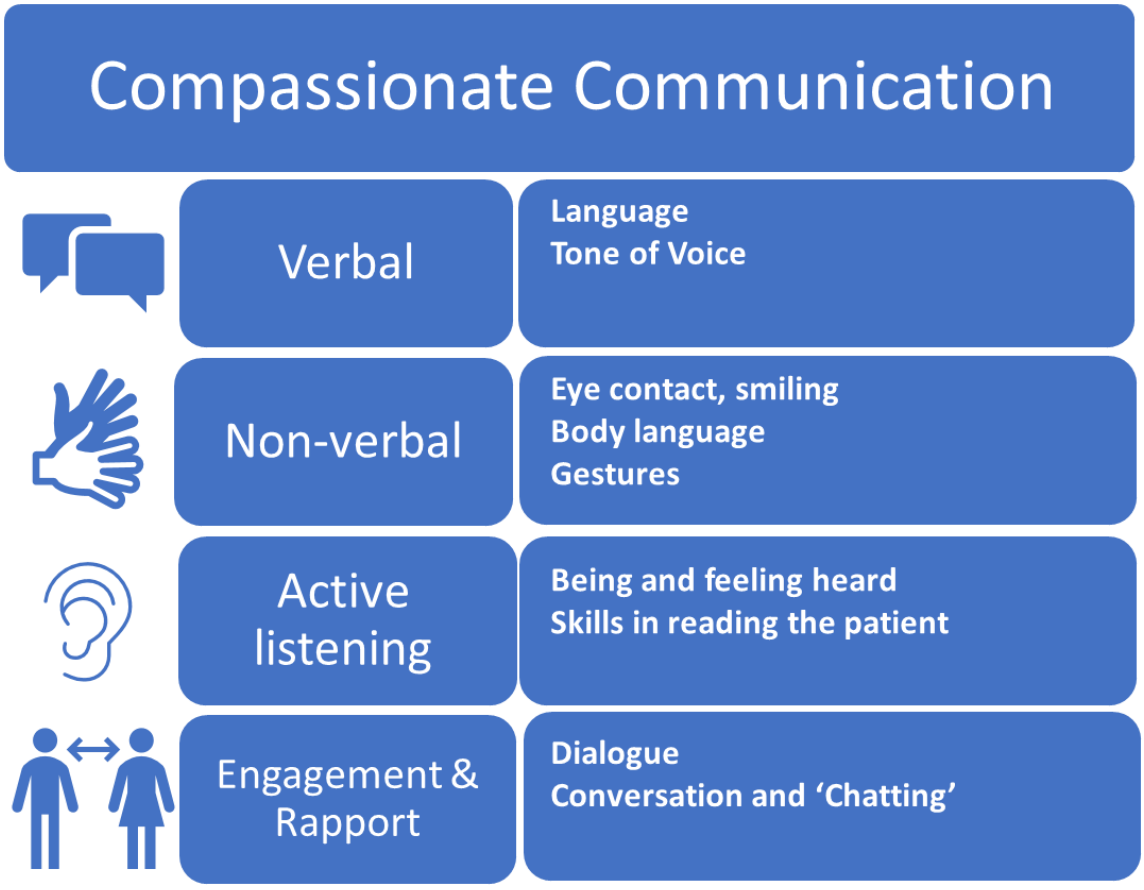

Figure 2: Co-created schematic summary of compassionate communication

The four sub-themes are presented next.

1. **Verbal cues**

Verbal communication cues comprise not only what is said, but the way in which words and language are used by the radiographer and received by the patient. They

include rate, pitch, volume and speaking style. Analysis of our data revealed interesting insights into some of the linguistic and paralinguistic cues noticed in the radiographer-patient interaction.

Language

The language used with patients, in particular the use of medical terminology, is well recognised as a barrier to good communication and potentially to the communication of compassion, as seen in the following quote:

> *"The lady that ran the chemotherapy unit had no compassion either because when I talked to her about this neutropenic sepsis … I had to go look it up"* PaC Site A

This was mirrored with a concern amongst radiographers about the dehumanising effects of referring to patients in terms of their body part, imaging examination or clinical status:

> *"…the language we use is critical. The patient, not "the wrist", Mr Jones, not "the trolley"."* RadTweet

> *"..and she said, well that one's ambulance, that one's a car, and what's that. And that was me."* PaC Site C

The language used also affected the meanings and interpretations placed by patients on what they heard, in terms of whether or not they perceived compassion in the encounter:

> *"But it's like asking (the) patient and not telling them, would you like to get on the bed, get on the bed. That's the difference between compassion and not isn't it."* TR Site C1

This is important, as although communication is used by radiographers to inform patients and help them understand what is happening at the time of treatment or imaging, it is also used by patients in the less apparent processes of meaning-

making after the event. This impacts their perceptions of their experience as a whole, colouring their recall for better, or for worse.

Tone of voice

The ways in which radiographers speak to patients was also seen in the data. Tone *per se* does not display compassion, however as seen with the language used it impacted on the sense and meaning made by patients of their experiences and subsequent perceptions of whether compassion featured during the interaction:

> *"If you are very exhausted the tone in which you say* [something] *can actually be interpreted as either negative or defensive or aggressive, depending on how the other person is feeling on that day, so it's all these little nuances that really* [affect] *certain interpretations".* TR Site B1

A comforting tone was more likely to be associated with a compassionate encounter, and was used by the radiographer to gain a patient's co-operation in a way that did not appear directional or overbearing:

> *"They had* [a] *comforting voice as well, they weren't like really stern."* P23

Verbal cues form only a minority part of the overall encounter, with non-verbal ones having an even more meaningful impact on patients. The next section details those found to be most relevant to a compassionate patient-centred interaction.

2. Non-verbal

Non-verbal communication cues include facial expressions, body language and gestures. The lasting impact left by these can be negative or positive but was felt by, and more importantly, stayed with patients long after their examination or treatment.

Eye contact, smiling

Eye contact and smiling were the most commonly reported facial cues seen in the data:

> *"They ask you a question which is almost routine, and you give the answer and they're not looking at you and you think, well crikey."* PaC Site B

"I wish I could remember more exactly but I remember eye contact, definitely. "…to be honest, when you're a person going in to have an X-ray, it's just that immediate eye contact, isn't it? It's the making you feel at ease by whatever means." P06

It's probably the most enduring memory of both my wife and I: of people smiling." P30

Sometimes though, eye contact alone is sufficient to establish a connection between radiographer and patient as the following example demonstrates:

"I didn't know what to say back to that so all I did was look him in the eyes and just nod. I tried not to make the facial reaction to what he was saying to me even though in my head I was thinking well okay." TR Site B1

As well as facial cues, body language and gestures represent a visual display to the patient of the radiographer's attitudes, thoughts or feelings and are important in communicating compassion; examples are given in the next section.

Body Language

Shortness of time was a feature of the interaction commonly noticed by patients but a radiographer whose body language suggested that they appeared unhurried was one important way in which patients were left with feelings of a compassionate encounter. In the following quotes it can be seen that communicating a sense of rush or hurry, however unintentionally, led to negative perceptions:

"…the worst thing about it was when I was trying to get my shoes back on and I felt like I was having to rush and …and it was just, 'I can't do this any quicker, love; 'cos my feet don't do what they're supposed to do necessarily', so it was just a bit…I do feel like I was rushed." P07

"We were trying to get them through like, a bit not quicker but, you know, like, trying to make up some time. And the lady got on the bed and she said why are you trying to rush me when you were the ones behind?" TR Site B2

As well as facial cues and body language, gestures of kindness were noticed as non-verbal indicators of a compassionate interaction, with examples from the data given next.

Gestures

Like smiling and making eye contact, there was a suggestion that small gestures of kindness are the 'little things' which have been reported elsewhere in the literature which personalise and humanise the patient's experience:

> *"Sometimes you can offer them a tissue or something 'cos once they're crying you can't just stand there and go, 'okay'." // "Just doing up their straps on their gowns, you know, it's just little bits like that." // "Carry their basket."* FG1

Patients appreciated these gestures particularly when they were offered spontaneously. This requires a degree of attentiveness, observation and careful listening; not always easy when the focus for the radiographer is on the technicalities of the task. In addition to technical expertise therefore, active listening and skills in observing patients are key to a compassionate encounter.

3. Active listening

Being and feeling heard

The term active listening denotes something deeper than the simple human mechanics of hearing. Active listening by the radiographer leads to feelings in the patient of being heard, with compassion perceived when a radiographer takes actions other than those associated with the technical task based on what they hear or observe. Inadequate or ineffective listening was thought by all participants to be a barrier to compassionate practice; believed to hinder the radiographer in recognising and subsequently working towards a resolution to help the patient:

> *"It destroys any communication that there was if they don't listen, doesn't it"* PaC Site B1

"… [I told her] *my back's so bad, it's quite difficult to lie flat and in certain positions but she was very conscientious on all that and checked before she moved me."* P04

When actively listening, the radiographer can pick up on, or 'read' the verbal and non-verbal clues which may signify a conflict between what is being spoken and how the patient really feels:

"but this patient was laughing like everything she said to you she would laugh at the end … but I got to realise that she was not really laughing, it's like a way maybe to deal" [with the difficult emotions she was feeling at the time]. STR Year 1

Skills in reading the patient

Developing skills in reading and interpreting the verbal and non-verbal cues from patients displays a deeper understanding of the individual and contributes to a person-centred approach. Patients appreciated that although not easy, being able to recognise distress or discomfort is a component of compassion:

It could be somebody … may not show the anxiety in the way that, you know … you've got to be able to recognise the symptoms." P25

There was little data identifying what these skills are. The analysis suggests that radiographers appear to be able to 'sense' a patient's emotional state, by *"picking up"*, and *"reading body language"*:

"If you call from the waiting room and just depending on how they stand up for a start you can like…yeah…start like treating them differently…" FG3

"he was really showing that he needed someone to talk to" STR Year 1

It was however suggested these skills could develop with experience:

"your own arsenal [of responses to patients' verbal and non-verbal communication cues] *also gets improved by choices since you've experienced this kind of behaviour, this kind of approach. You also know how to choose, you know which one would be the right one to try, try one that doesn't work.*

Try the next one but as long as there are many options based on experience that will help you to a certain degree." TR Site B1

The exchanges in conversation which create connections between radiographer and patient form the final sub-theme in this section which demonstrates how rapport can be established in the short time available.

4. Engagement and Rapport

Engagement and rapport were seen in terms of the quality of the dialogue which took place during the radiographic encounter. This was perceived in a variety of ways by patients, sometimes as formal and directional, and at others as informal and chatty.

Dialogue

When rapport was absent, there was little dialogue and the radiographer appeared to issue instructions aimed at achieving a principal aim of image acquisition or treatment:

"No and they didn't have, they weren't … no sort of rapport going, it was more 'I need you to do this'." FG1

"Well, the first thing he said to me was, 'have you got bones in your brassiere? And go in there and remove your clothes and take your brassiere off.' …it was more or less orders what I had to do for the different positions. … I felt, when I walked [into the x-ray room]*, you know that…what is it when you get with a doctor, that you feel you've got a good rapport with them. I felt there wasn't any connection."* P20

Rapport when present involved the radiographer appearing to acknowledge and humanise the person as well as attending to the technical and mechanical elements of the examination and inviting the patient into the conversation, thereby helping to welcome the patient into the clinical environment:

"I think it [talking to the patient] *has an impact and I think that did have an impact, that I remember and so I went and talked to her when I came back to placement the second time."* STR Year 2

"A sort of rapport while you're there. … Sharing …in like I've said, 'sorry about the bed, sorry about the table, they're not the friendliest of places and if at any time you feel uncomfortable, please let me know. … And asking you if there was any particular positions you were gonna find uncomfortable so that they could understand." P20

Conversation and 'Chatting'

'Chatting' and 'chit-chat' were noted as important in developing rapport and demonstrating an appreciation of patient individuality. This signifies to the patient how their radiographer understands they are an individual, not purely defined by their diagnosis or examination. Recognising when 'chit-chat', is inappropriate and unwanted by a patient respects their individuality:

"But there are some patients who really don't want to talk about the weather, that they don't want chit chat." TR Site A

"(It is) not like delivering one service, one same service for everyone." STR Year 3

Apparently informal chatting involves giving information to, and receiving it from, the patient and is integral to compassion as it relieves the psychological suffering associated with unfamiliarity with the procedure and its outcome. Moreover, the data suggest that the choice of subject matter should perhaps be confined to the patient's current situation rather than wider, less relevant topics as the following quote illustrates:

"So then even if we're just trying to chat away to them about what did you have for tea last night and they're thinking well, I'm laid here, I've got my trousers lowered and I've got some young lady sticking their head in my pelvis or looking at my tattoos and you're asking me about my tea." TR Site B1

These findings indicate that the four components of communication identified are both indicators of compassionate behaviour and a mechanism for obtaining knowledge and understanding of the patient. These enable the radiographer to give

compassionate, patient-centred care to each individual whilst performing a highly technical and task-based procedure.

Discussion

The findings bore remarkable similarities regarding the key elements involved in caring with compassion for patients in therapeutic and diagnostic radiography. This was despite differences in the nature of the procedures patients were undergoing and in the geographical areas from which participants were drawn. Whilst similar qualitative methodologies were used in both studies, the data were analysed entirely independently with no possibility that each author's interpretation and theme development could have been influenced by the other, which lends support to the quality of the research and strength of its findings.

The findings have demonstrated that communication connects patient and radiographer and is therefore vital to the development of a positive relationship[24-27]. It is also an essential element in fostering relations built on trust and empathy[28-32].

When radiographers make time to engage with their patient in the ways identified in this research, compassion is more likely to be perceived in the interaction, particularly when welcoming the patient into the x-ray or treatment room. A study of radiographer-patient communication by Pollard *et al* revealed the importance of explanations and information, with feelings of comfort, calm and confidence reported[29]. In this study, patients' descriptions of their feelings when the introduction included a brief dialogue mirrored Pollard *et al*'s and included the low-intensity words *"comfortable"* and *"pleasant"*. Although these might be dismissed as inconsequential, we suggest that they reveal compassion as a mechanism for preventing escalation of feelings or worry and anxiety.

The benefits to patients and procedure from a welcome that begins with the radiographer introducing themselves by name are well documented[33] but crucially are lost if the radiographer then begins positioning the patient for treatment or imaging without explaining the procedure and asking whether and how they might be able to co-operate. Compliance may mask a need for compassion unless the radiographer listens to their patient's verbal and observes their non-verbal

communication cues. Compliance is welcome when workload pressures are high and the focus is on the task in hand, and is consistent with radiographers' labelling of patients as 'easy' compared to 'difficult' (i.e. ones who require more time or greater expertise[34]). However, the impact on patients of a poor quality start to the procedure can be strong, with words like *"assaulted"* and *"intimidated"* seen in this research to describe their feelings when instructed to remove clothing or lie down without explanation. It can also be the case that more time is needed to image or treat so-called 'difficult' patients if limitations to their ability to co-operate have not been ascertained during the welcome phase, i.e. before commencing the procedure; leading to perceptions in radiographers that there is no time for compassion, when our data suggest that time spent on brief introductions, explanations and questions can save time instead.

The data suggest students develop skills in observing and interpreting patients' verbal and non-verbal cues on placement, but once qualified these important skills can become casualties of a heavy workload and throughput pressures. A departmental culture that rejects ideas of rushing patients through[36] might allow these skills to flourish.

The inevitable limitations apply to these studies in terms of participants being drawn from only one geographical region, however the studies were conducted in two distinct areas of the country, namely the north-west and south-west of England. That the findings bear a considerable number of similarities suggests that they may be transferrable to other regions, although cultural and gender differences were not explored.

Conclusion and Recommendations

Compassion in therapeutic and diagnostic radiography resides in a technically competent and kindly undertaken procedure in which technical, communication and interpersonal skills combine to engender feelings in patients of dignity, comfort, confidence and reassurance. The communication skills required include verbal and non-verbal cues, active listening and engagement with the patient. A meaningful dialogue between radiographer and patient involves more than simple instructions

about their examination or treatment, particularly at the welcome phase of the interaction. To demonstrate compassion the radiographer needs to be clear and explicit in their information giving, ask personalised questions of the patient and subsequently tailor their interactions or actions based upon the answers.

Responses based on the answers are perceived as expressions of compassion and patients are emotionally touched when this dialogue takes place in an atmosphere of calm rather than of rush or hurry. Compassion lies latent in the radiographic encounter, not solely in the individual radiographer and is manifest when a radiographer perceives physical or emotional suffering in their patient and responds with acts of kindness. The radiographer disregards the consequence that this takes more time than is needed for the clinical task and the pressures of time and workload imposed by the culture of department, organisation or ideology.

Compassion, although in part characterisable to the individual, is also a complex cultural and organisational phenomenon. One of the principal conclusions from both authors' research was that, despite organisational and cultural dogma, radiographers are not singularly responsible for caring for their patients with compassion. What they can do as individuals, however, is to allow their practice to reflect a rejection of the subtle cultural emphases on throughput and efficiency at the expense of the values that underpinned their choice of radiography as a profession.

As a result of their research, the authors suggest the following recommendations:

1. That radiographers be mindful of their non-verbal as well as verbal cues when communicating with patients and ensure that the two are congruent.

2. Ask questions of the patient in addition to explaining the procedure before commencing imaging or treatment. This will reassure patients and foster impressions in them of compassionate professionalism. It will further help establish how best to conduct the examination or treatment and secure the patient's co-operation.

3. Observe their patient, looking for signs of distress, pain or discomfort and adapt their radiographic and, as importantly, their communication techniques if needed.

4. Resist external pressures to speed patients through if more time is needed to give what care the patient needs in that moment.

The patient's voice is vital to research investigating how to give individualised patient-centred care in a highly mechanised and technically focussed environment. We feel therefore, that the final word should also be given to patients who ask only that as compassionate professionals we remember to treat them with humanity:

> *"I think there needs to be a human interaction. You're not just somebody at the bottom of the … you're there because there's something wrong with you. You're probably a little bit worried and unsure so there needs to be a recognition of the human being."* P30

> *"Well, I think to be understanding and caring, even if the diagnosis is aggressive, the understanding and tenderness is important."* PaC Site C

Conflict of Interest Statement

No conflicts of interest were identified

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