Defining compassion and compassionate behaviours in radiotherapy

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I hereby declare that:

1. I have been enrolled for another award of the University, or other academic or professional organisation, whilst undertaking my research degree. I was an enrolled student for the following award:

   Name of award: Postgraduate award in mixed methods for health research
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2. None of the material contained in the thesis has been used in any other submission for an academic award.

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Abstract

Inadequate care and compassionate practice have been blamed for failings within the NHS. UK healthcare legislation can be criticised for its failure to provide meaning or clarity of practical compassionate care. Consequently, hindering the ability of NHS Trusts, service delivery managers and employees to interpret and implement policy recommendations regarding compassionate practice at a local level. To support the implementation of compassionate legislation, the study sought to understand the perspectives of those in receipt and those delivering compassionate practice. The research aimed to co-construct a context specific definition of compassion and identify commonly recognised compassionate behaviours.

Co-production underpinned the qualitative methodological inquiry and design of the research. Eleven focus groups were conducted, five with therapeutic radiographers, three with cancer patients and carers and three with student therapeutic radiographers. On completion of thematic analysis from those groups, three co-production workshops were conducted, integrating the data to ensure the co-produced findings were equally representative of the perspectives of the three participant groups.

The co-produced definition conveys how compassion can be recognised by the intention to help, achieved through recognition of individuality and a tailored approach to meet the person's individual need. An understanding of compassionate display is illustrated through the construction of a conceptual framework. The findings indicate four components are essential for compassion demonstration and perception of compassionate display: 1) attitude, 2) behaviours, 3) understanding individuality and the appreciation of needs and 4) practices. Collectively these four components enable the therapeutic radiographer to behave in a manner which facilitates a connection with the patient whilst denoting their intent to be compassionate. Consequently, expression of intent enables the patient to perceive the practices as compassionate.

This co-produced definition, underpinned by a conceptual understanding of compassionate display, will facilitate the translation of policy into practice. Recommendations are made which aim to equip the profession with therapeutic radiographers that hold intent to be compassionate, are motivated and have both the confidence and opportunity to be compassionate in a supported culture which shares the vision for person-centred compassionate care. Consequently, this should improve the quality of compassionate care received by patients.

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Contents

Glossary of terms

The following terms have been used for the purpose of this thesis.

Concept analysis: The review of literature and associated resources which address a complex concept to provide clarity. This process enables it to be distinguished from other similar concepts and identifies all aspects of the concept. These outcomes provide practical understanding of the concept and how it is conceptualised within a specific context.

Co-production in research: Recognition of the value of multiple perspectives and the incorporation of those perspectives into the joint production of new knowledge between different groups in society and the researcher.

Co-production workshops: Practical sessions where the different societal groups work together alongside the researcher to share their perspectives and complete tasks, resulting in the generation of new knowledge which is representative of the different groups.

Carer: A family member, friend or partner of an individual diagnosed with cancer.

North Trent Patient and Public Involvement Group: An established patient and public involvement group who worked alongside the researcher (see patient and public involvement). The group consisted of individuals diagnosed with cancer or are a carer for an individual diagnosed with cancer.

Patient: An individual diagnosed with cancer who has been under the care of the National Health Service (NHS)

Patient and public involvement: The engagement of the patient and public in the design, development and dissemination of research. Its purpose is to create research and findings that are meaningful to those being researched and to improve the quality of the research design.

Partners in Learning: A collective group of individuals diagnosed with cancer or a carer for an individual diagnosed with cancer who worked in collaboration with the host higher education institution. They were involved in the academic design and delivery of the radiotherapy and oncology programme to provide ‘lived’ experience of cancer and treatment.

Student Therapeutic Radiographer: An individual enrolled on a higher education institution programme training to become a Health and Care Professions Council (HCPC) registered Therapeutic Radiographer.

Therapeutic Radiographer: A HCPC registered allied health profession trained to effectively and safely treat and care for people with cancer, offering support while using highly advanced technology to target and destroy cancer cells with radiation.

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Chapter 1: Introduction

Overview

This chapter will provide the underpinning rationale for the research, outlining the current deficit in compassionate practice and the consequences of this shortfall. The chapter will progress to identify causation, addressing the limited understanding of compassion within the radiography profession and the implications of this. The chapter will then propose that in order to enhance the delivery of compassionate care it is a necessity that a co-constructed shared definition of compassion is developed. The chapter will conclude with consideration of the author's position within the research.

The deficit in compassionate care

The importance placed on compassionate care within the United Kingdom (UK) healthcare legislation has amplified since the start of the decade following an increase in patient complaints corroborated by Care Quality Commission reports of substandard care. In recent years, several high-profile incidents have been reported on cases of malpractice, poor care and neglect. An inadequacy in care and compassionate practice has been blamed for reducing quality of life and resulted in patient deaths [1-4].

Although compassion was traditionally perceived to be congruent with the core values of the UK's National Health Service (NHS) Constitution [5], Lord Francis's report which summarised the public inquiry into the malpractices at Mid Staffordshire NHS Foundation Trust propelled the concept of compassionate care back into the forefront of discussion. His report portrayed a bleak picture of an NHS Trust that was systematically failing both its patients and its staff by adopting an ostrich culture, burying its head whilst patients were neglected and at risk of experiencing 'appalling suffering' [2]. Lord Francis made 290 recommendations encompassing several themes. Not simply a list of what went wrong but like any inquiry, lessons to be learned and actioned to help prevent their recurrence [6]. The most pertinent recommendation was that the NHS as a collective needed to put the patient first, ensuring they are the number one priority, and receive services from caring, compassionate and committed staff [2].

Tackling the compassion deficit has been placed at the centre of government initiatives [7-8] alongside improving patient experience, another important facet of UK Government policy [8-14] as compassionate behaviours are considered synonymous with patient-centred care [7, 15-16]. The policies and directives placed the responsibility on both higher education institutions and NHS Trusts to instil and develop core caring and compassionate skills in the future and current healthcare workforce. Collectively, proposed changes included moving the focus of professional practice towards a system that places compassion and the values of dignity and respect at the heart of a new code of conduct [12,17] rather than a target-based system [2,16,18]. To realise this ambition, higher education institutions needed to align their pedagogy with the government values of patient-centred care, considered as the golden thread that should run through all pre-registration education and continuing professional development [19]. Furthermore, it was judged essential for Trusts to recruit the "right staff" to provide compassionate care [17, 20] and create an impetus for higher education institutions to attract and enrol the "right students" to their patient-centred pedagogical programmes.

However, the proposed changes were fundamentally flawed as the supporting policies and directives failed to provide explicit information to assist achievement. No definition of compassion within a healthcare specific context was provided or indication of how compassion should be displayed, nor did they testify how to develop compassionate skills or behaviours in future and current health professionals [2-3, 7, 11, 14, 20-23] or clinical practice.

The 'Six C's' advocated by the Department of Health's compassion in practice became a fundamental part of healthcare structure and is now the cornerstone of values-based recruitment [9]. Compassion, alongside care, competence, communication, courage and commitment are the six core values which registered health professionals and supporting staff must possess and display in their daily practice. The policy explains that the six values "*gives an easily understood and consistent way to explain our values as professionals*" [9]. No detail or clarification of the concept of compassion is however provided, instead it indistinctly describes compassion as "*how care is given through relationships based on empathy, respect and dignity*" [9]. Instead of a definitive meaning providing easily understood clarification, this definition merely aids confusion, simply providing a 'buzz-word' list of values without explanation. Neither the pre nor post Francis policy has changed this trend, with either ambiguous definitions

[7, 24] or no definition at all [12]. Many simply refer to the definition provided by the Department of Health with no additional explanation or common understanding [22].

Whilst supporting the compassion in practice directive, many have criticised the Department of Health's policy, believing that compassion should be viewed as the value that underpins all the others, not as a distinct and separate entity [25]. Wider criticisms of the policy have also ensued with many arguing that communication is not a value, but an essential clinical skill [26-28], casting doubt over the eligibility of the document.

The radiography profession's response to the Francis report

The necessity to develop and subsequently utilise caring and compassionate behaviour within the healthcare workforce is central to radiographers' professional practice [29]. Radiography's own professional body recognised the implications of the Francis report for its members and their professional practice. Although acknowledging radiographers were not specifically under scrutiny as a result of recent failings, the collaborative network in which they practice and the duty of care they have to patients meant standards needed to be examined to ensure patients continue to be protected and receive the care they are entitled to as their human right. In response to recommendations, which placed importance on 'putting the patients first' the Society and College of Radiographers (SCoR) revised their code of professional conduct. The updated code placed the safe and compassionate care of its patients at its heart, delivered as standard practice by professionals who are fully accountable for the quality of that compassionate care [29]. The SCoR's code expresses how the "*best care means that patients can be assured that your practice in undertaking examinations and/or treatments is compassionate*" and "*best compassionate care also means that patients' safety is paramount, including measures to control infection, radiation safety and general health and safety*" [29].

Although the professional body advocates compassionate care as an integral component of a radiographer's professional practice, the code implies that compassion is simply part of effective treatment delivery and patient safety. It could be considered that these two components are within the general scope of practice [30], but not specifically compassionate care. The assumption perhaps is that radiographers know what compassionate care is, and therefore the code fails to consider what compassionate care is, what it encompasses and how it should be delivered.

The current challenge to compassionate practice

The limited definition and explanation of compassion and its meaning has led some to consider whether the complex construct of compassion is fully understood [31-32] and if not, how can it be successfully promoted in practice [25, 33-35].

Importantly, despite reactive policy there continues to be a surfeit of failings, which are all too often considered to be inevitable [36-37]. The NHS has been criticised for promoting a culture amongst its staff which is more focused on carrying out the system's business rather than the patients in its care [2, 38]. This continuance raises questions regarding the ability of NHS trusts, service delivery managers and individual employees to understand and implement policy recommendations regarding compassionate practice at a local level. Thus, subsequently hindering their ability to design and develop infrastructures which supports the implementation of policy.

Defining compassion

The concept of 'compassion' is subjective and traditionally argued to be shaped and influenced by the environment and the objects in which they are situated [39]. Dictionary definitions are in abundance, but these frequently include terms such as pity, empathy and sympathy, each of which has their own unique definitions. Often, each of these terms is assumed to share the same meaning or value and they are frequently used interchangeably, creating further ambiguity around the true meaning of compassion [40].

A recent concept analysis has identified there is no one agreed definition of compassion, and those currently in use have been assigned a meaning based on previous literature and dictionary definitions rather than being developed within an appropriate healthcare context [41].

Compassion in healthcare

Compassion and compassionate care have become a prominent and debated topic within healthcare with an abundance of publications, opinion papers and counter arguments flooding the academic arena in addition to the tabloid and media coverage. Most published literature concentrates heavily on the nursing and medical professions [32, 42-48], often failing to reflect the contribution that radiographers have on the patient's pathway and care.

Compassion in Radiography

Although the volume is not comparable with nursing, over recent years there has been an increase of research into the concept of compassion within radiography. Three distinct research themes have emerged: compassion fatigue, compassion pedagogy and understanding compassionate care.

Compassion fatigue and burnout

The first theme, compassion-fatigue and burn-out in the current and future radiographic workforce. These studies addressed the concept within a clinical context; with empirical works that investigated the current levels of fatigue and strategies for management within therapeutic radiographers (TR) [49-52]. Consequently, they did not define or attempt to understand compassionate practice beyond the scope of compassion fatigue.

Compassion pedagogy

The second theme investigated the development of pedagogical approaches to address compassion in response to the failings highlighted in the Francis report. Hendry's critical review of compassion aimed to outline the importance of including compassionate practice in radiography curriculum, based on its necessity in clinical practice [53]. Although situating the discussion in the profession of radiography, Hendry acknowledged that the critical review focused on the nursing profession. Despite many aspects of the study transferable to radiographers and wider health professionals, it must be acknowledged how TRs undertake a distinct and specialised role that requires care of the patient throughout their radiotherapy pathway [49]. As the continuity of care required by cancer patients undergoing radiotherapy may differ from the care occurring in other settings across other healthcare professional roles the need for compassionate care may differ. Thus, some of Hendry's conclusions drawn regarding what compassion should look like in both clinical practice and education may not be transferable to TRs. In addition, Hendry bases the critical review on the definition provided by the Department of Health's compassion in practice policy which as established, is limited.

Hodgson et al., report on a collaborative educational project between higher education institutions and cancer patients and carers [54]. Although the project focused on compassionate pedagogy, meaning and understanding of compassion was not explored, subsequently providing limited contribution to knowledge of the concept.

The literature review by Bleiker et al., aimed to explore the radiographic context in which compassion was currently found in policy, protocol and academic and research literature [31]. Its findings are important to this research as they demonstrated that despite the term being commonplace, its use implies a shared understanding when actually there is no clarity or definition to the term. Subsequently, strengthening the necessity for research to define and aid understanding of compassion within radiography in order to promote compassionate practice within the profession.

Compassionate care

The third theme evaluates research that explores how compassionate care is understood [55-57]. Bolderston et al., investigated what TRs (n=27) understood by the terms care and compassion [55]. Focus groups identified that these concepts were seen primarily as a part of supportive relationship with the patient, but they were unable to agree if the technical aspects and procedures were considered a part of caring. The research failed to validate if these were the behaviours which patients themselves perceived as compassionate or behaviours, they wished to see in professionals caring for them in the radiotherapy department.

In their research, Halkett & Kristjanson explored the patient perspective on the role of TRs by conducting semi-structured interviews with breast cancer patients (n=34) [57]. Patients felt TRs played a central role in enabling them to achieve a sense of emotional comfort. Patients also acknowledged that although TRs performed a technical role, they also needed to remain aware of their role in providing patient care and take appropriate steps to ensure that they can assist patients in feeling comfortable during their treatment. The findings identified the importance that patients place on the caring and not just the technical element of the role of a TR. The research did not however aim to directly explore patient understanding of compassion and compassionate practice; subsequently it did not explain or define what compassionate practice is within a clinical context.

The non-judgmental acceptance of diversity is considered by Bleiker, et al., to be a facet of compassionate care [56]. Aiming to explore this facet of compassion from the patient's perspective they undertook semi-structured interviews with patients (n=34) undergoing diagnostic imaging. Their research established how diversity is not limited to the common classifications of age, race, etc., but also includes emotional states, beliefs and characteristics. Although this research investigated the patient perspective within radiography, it did not explore how patients would define compassion or how it should be displayed, only considering diversity as a facet of compassion. Importantly, the researchers did not establish from which evidence base the concept of diversity as a facet of compassion had been established. Assumptions were instead made based on professional policy, thus failing to validate if diversity is in fact a facet of compassion.

Implications for the research

Although the scope of the findings is limited, the lack of additional research in this area means any conclusions drawn must be based upon what has been conducted. Predominantly, Bolderston et al.,[55] and Halkett & Kiristjanson [57] identified there is a lack of clarity around the meaning of compassion in the TRs professional role both from the TRs and patient's perspective. There is also confusion regarding whether the fundamental process of delivering radiation is part of compassionate practice. Furthermore, neither studies nor Bleiker et al., [56] sought to directly explore the meaning of compassion and how compassion is displayed within the context of radiography. Subsequently there is no empirically established understanding of compassion within the profession.

This raises some fundamental questions, if compassion in radiography (radiotherapy in particular) is not specifically defined, how can it be understood and implemented by:

- NHS Trusts in the design of their organisation and services
- The management of departments and services
- TRs engaging and incorporating compassion in their practice

The need for a shared understanding of the concept

Bleiker et al's., [31] research identified how shared meaning and understanding of the concept has been assumed, this is supported further by Bolderston et al., [55] who's work only explores TRs perceptions and Halkett & Kristjanson [57] only exploring patients' perceptions.

Mirroring this trend is research exploring the concept of compassion within nursing, medicine and allied health professions cancer context [45, 58-62]. Across the research only one perspective is explored, and to date, understanding of the concept has never been co-constructed. In research which has considered perspectives of both the health professional and patient have not focused upon compassion rather general care-giving skills [63]. No research has been conducted which has explored jointly TRs and patients' perceptions of compassion and compassionate display within radiotherapy or cancer care services.

By conducting research on the different perspectives independently, researchers have failed to consider the relationship between the different perspectives of compassion. This has created a silo effect that fails to grant either party understanding of the others' assigned meaning. Thus, meaning and understanding of compassion has been assumed, creating a dissonance between what is expected from patients and what TRs are actually delivering.

Equally, the perspectives of student therapeutic radiographers (STR) have not been explored or considered to aid understanding of the concept. STRs are in a unique position, situated in-between higher education institution and clinical departments. Their perspective on compassion is shaped through their own experiences, those ‘taught’ to them through pedagogy and those ‘demonstrated’ during their clinical training. Their inclusion in developing a definition and understanding is essential to provide a third perspective to connect meaning between academic and clinical perspectives.

Consequently, three problems are faced:

1. Compassion has never been defined in the context of radiotherapy.
2. Compassionate display has never been described within radiotherapy.
3. Construction of a definition and understanding of compassionate display has never been undertaken to include the perspectives of those in receipt (patients and carers), those delivering it (TR) and those who are being trained to deliver it (STR).

To promote and develop compassionate practice within the current and future therapeutic radiography workforce, a context specific definition of compassion and understanding of compassionate display needs to be developed. The definition and understanding must be co-created by the three participant groups who are situated within the radiotherapy environment to provide ‘real-life’ understanding of compassionate care. Thus, co-construction is a central tenet of this study.

Potential Impact

There are three aspects to the research outcomes of this study:

1. This study will present a co-created definition of compassion and conceptual framework that provides a 'real life' meaning of compassion, allowing NHS Trusts, service managers and TRs to interpret and implement health care legislation [9,13-14,17,20,64] into 'real world' practices.

2. The conceptual framework will provide the basis of a pedagogical approach, presenting higher education institutions with an opportunity to develop their curriculum to increase the likelihood of students completing programmes with skills that will ensure good quality compassionate patient care.

3. There is the potential to enhance the compassionate care delivered by current and future TRs. As consequence, this should improve the quality of compassionate care received, aid the cultivation of patient-centred care and reduce the failings experienced previously by patients undergoing care and treatment within the NHS.

My position in the research

Professionally I am a TR, qualifying in 2006, then moved into academia in 2012 and into research in 2016. During my days of clinical practice, I always had a strong interest in patient care and ensuring patients had the ‘best possible’ experience during this difficult time in their lives. I was always interested in the patient voice and how it should be used to shape the services and we offer to patients. This interest was strengthened further when completing my MSc dissertation, as I had the opportunity to undertake focus groups with breast cancer patients to hear their views on what they would want from an immobilisation bra. During the data analysis and write up stage I was quite moved by what the patients were saying and the way in which the behaviours of TRs, my colleagues, peers and friends have positively and unfortunately negatively influenced their radiotherapy experience. At this point I decided I wanted to incorporate research (somehow) into my professional role. I was lucky enough to secure a lecturer position later that year.

The move to academia although meant a loss in direct patient contact, provided me with a unique opportunity to shape the profession and influence the students on the programme. Although involved in the wider programme, patient care and management became my main areas of teaching. I also ensured that any other teaching incorporated patient care, for example when teaching the fundamentals of imaging and verification I emphasised the importance of explaining to patients what they were doing, how keeping them informed would help to reduce their anxiety and aid their immobilisation. A year after joining the university I became involved with the service user education programme, partners in learning which invited ‘experts by experience’ to work with the students in developing their patient care skills alongside their understanding of the impact a patients clinical experience including the treatment and interactions with TRs could have on their emotional, physical and psychological well-being.

In a desire to continue with my own academic development I decided undertake my PhD, to which I began looking into the idea in 2014. I was really interested in the ‘effects’ the partners in learning programme was having on the student’s professional skills and so decided to make this my area of interest. Compassion as a professional skill kept on being discussed during the sessions with students and in the literature. The period in which I was investigating my ideas was the year after the Francis report, so compassion was at the forefront of discussion and the need to develop and / or enhance the levels delivered by professionals within clinical practice was deemed of paramount importance. I therefore decided to try and investigate whether having the partners in learning sessions was increasing the compassionate skills of the students on the course.

The starting point was to establish what compassion was so that I could design a study that would measure any ‘change’ in compassion ‘levels’ by using the partners in learning programme as an intervention. This was when it became apparent that compassion could not easily be defined and that what had been defined was in a general context and not healthcare (or radiotherapy) specific. So, what I was trying to measure had not clearly been defined. This led me to readdress my PhD. Instead of looking at how compassion could be increased in TRs, stripping it right back to what compassion is and how it can / should be displayed by TRs.

Personally, I feel compassion is an essential component of a TRs role and one that is lacking in the practices of some TRs (only a few though I would add). I believe as a TR our purpose and goals are to be there for the patient, not just for the safe and technical delivery of radiotherapy but for the patient holistically, although everyone is human, we should not be failing our patients in any way.

The driving force behind my research has been my thought that if we don't know what compassionate display our patients want to receive how can we effectively deliver it, subsequently, is what we think we are delivering really compassion?

Chapter Summary

This chapter has identified how some of the current failings in patient care have been attributed to a lack of compassion by healthcare professionals. Although responsive government action has ensued, failure to provide understanding and clarity of the concept has meant Trusts, managers and health professionals do not understand and subsequently cannot effectively implement the policy into practice.

Further barriers to implementation are that there is no one agreed definition, no definition which has been developed within a healthcare context or developed collectively with individuals who have a lived experience of compassion.

Therapeutic radiography specific research has only explored perspectives of those with lived experience independently, never collectively, thus failing to co-create a definition within a radiotherapy or cancer healthcare context.

Subsequently the research wishes to address this gap in knowledge and by the process of co-production to co-construct a shared definition of compassion and explore understanding of compassionate display by those who are both in receipt and responsible for its delivery.

Thesis overview

This thesis presents to the reader a study undertaken to co-construct a shared understanding and definition of compassion. The next chapter presents a concept analysis, this provides the thesis with the current understanding of compassion within the literature base with a specific focus on how compassion is displayed. Chapter three provides the methodological approach and philosophical position of the research. Chapter four details the research process, the methods utilised for data generation, capture, analysis, integration and synthetisation in the three phases of the research. Chapter five outlines the findings of the research, the generated co-constructed radiotherapy definition of compassion and conceptual framework. The discussion chapter presents the underpinning theory behind the findings, exploring how the understanding generated by the conceptual framework can enhance the delivery of compassionate care by TRs. Chapter seven concludes the thesis, culminating with recommendations for practice and the key take home messages.

Chapter 2: Literature review and concept analysis

Introduction

This chapter details the concept analysis which examined the current literature base, situating the thesis with the understanding of compassion and compassionate practice within healthcare. The rationale for the use of a concept analysis rather than a traditional literature review is addressed. The chapter concludes with a summary of the concept analyses contribution to the research’s methodological approaches and method.

Literature review

To ascertain the current understanding and evidence base specific to the concept of compassion the research was designed to incorporate a review to examine published materials and literature [65]. As the previous chapter established, there is no singular consensually agreed definition of compassion within use, those which are in use are not healthcare, nor radiotherapy or cancer care specific. The literature review sought to establish what was already known and understood about compassion and the mechanism of its display by professionals working within the context of healthcare.

An initial scoping search identified several fundamental papers whose key words were used to develop search terms in conjunction with database specific indexed control vocabulary, including The Medical Subject Headings terms (MeSH) (Table 2.1).

Table 2.1: Search terms for literature review.

Concept: Compassion	**compassion*, "compassion* care*"**
	AND
Context: Healthcare professionals within a healthcare environment	healthcare, "health profession*", medic*, "clinical medic*", "Medical care*", "nurse* practice", "allied health profession*", "multidisciplinary team", hospital*, "professional carer*", "health service*" "healthcare organisation", "health person*".
	AND
Display: Healthcare practice	"Professional behav*" "practitioner-patient relation*", "nurse-patient relation*", "patient car*", "person-centred car*", "professional-patient relation*", "relational practice", "staff-client relation*", "relationship-centred car*", "professional issues", "patient-centred car*" Behav*, behavio#r, attribute*, trait*, relation*, attitude*.

The following databases and journals were searched as part of the review; Medline, Cumulative Index to Nursing and Allied Health Literature (CINAHL) complete, Scopus, PubMed, PsycINFO, Science Direct, Cochrane, Database of Abstracts of Reviews of Effects (DARE), Journal of Radiotherapy in Practice, Patient Education & Counselling, Journal of Medical Imaging and Radiation Oncology and the Journal of Medical Internet Research.

A building block approach provided the foundation to the search; facets were connected or eliminated by using BOOLEAN operators [66]. Truncations were used to widen the search for example: compassion* retrieved compassion and compassionate. Similarly, wildcards allowed for variances in spelling of common words, for example behavio#r or behavio?r.

Inclusion criteria were established to encompass resources which:

- Were written in English
- Published between 1995 and 2015
- Reviewed compassion and its concepts within healthcare
- Discussed and/or examined compassionate behaviour in healthcare

Exclusion criteria were established to encompass resources which:

- Reviewed compassion outside of healthcare practice
- Addressed self-compassion
- Investigated/reported approaches to reduce compassion fatigue
- Solely addressed the management of patients receiving End of Life/Palliative Medicine
- Related to professional practice issues outside of compassion for example, medical errors which are not due to poor compassionate care
- Addressed other behaviours for example medical skill levels which are not attributable to compassion.

The review was not designed to exclusively consider evidence-based material as the concept of compassion is fluid and open to individual interpretation. The literature review therefore wanted to capture the wider discussion around compassion and as such included non-research-based material including discussion papers, commentaries, letters to editors, book chapters etc. Google and Google Scholar were used as method of searching grey literature and as a supplementary tool in conjunction with reference searching from seminal papers respectively.

Practical challenges

The database searches generated an extensive number of returns. Despite the application of the inclusion and exclusion criteria some of the database searched retrieved over one million articles each. The process of reviewing the articles, including the assessment of supporting references identified further articles which met the inclusion criteria. The volume of articles was deemed too high and a review of the search terms was undertaken. The decision was made to remove the terms which searched for literature addressing the display of compassion (C) as the literature which addressed the practices of healthcare professionals was being captured when searching for literature on the context (B) (Table 2.2).

Table 2.2: Modified search terms for literature review.

Concept: Compassion	**compassion*, "compassion* car*"**
	AND
Context: Healthcare professionals within a healthcare environment	healthcare, "health profession*", medic*, "clinical medic*", "Medical car*", "nurs* practice", "allied health profession*", "multidisciplinary team", hospital*, "professional carer*", "health service*" "healthcare organi#ation"

Despite modifications to the terms, the numbers retrieved from the database searches without searching the supplementary grey literature was still more than one million. This volume of literature was deemed to be too high and unmanageable. The investigation into alternative approaches to review the literature established the employment of a concept analysis to be the most suitable method [67].

Concept analysis

Rationale

The concept analysis was originally completed in response to the practical challenges created by the volume of literature on compassion. Whilst conducting research into the rationale for its use, the compatibility and suitability of this form of review became evident.

As established in chapter one, the concept of compassion is vague, thus limiting the ability to both understand it and to establish the differences between it and associated concepts. This thesis focuses on compassion in radiotherapy ~~cancer care~~, a physical environment; it therefore requires understanding of the practical components of compassion. Due to the volume of published works covering too wide a spectrum of subjects on the topic, a traditional literature review is not considered to be an appropriate method to achieve conceptual understanding [65]. Even with the strict search strategy, the literature review did not enable compassion to be distinguished from other concepts and limited its ability to clarify the meaning of compassion and its suitability to generate understanding of the components of compassionate display.

The concept analysis required the inclusion and review of sources wider than journal articles to provide understanding of the defining attributes of the concept, allowing for the synthesis of existing views [67]. This enabled compassion to be distinguished from other similar and associated concepts thus resolving gaps or inconsistencies in knowledge [68]. For these reasons, concept analyses are commonly undertaken within the nursing profession, as the theoretical knowledge base they provide allow for links to clinical practice to be established [68].

To aid development of the method, a further aim of the concept analysis was to integrate the findings with the concurrent pilot focus group in the design of the study.

Concept analysis method

The model by Walker and Avant's was used as the framework for the concept analysis [67]. Their eight-step process (Table 2.3) was modified and simplified from the original model by Wilson [69]. This provided a more pragmatic and procedural format than other models which often place more emphasis on the philosophical and conceptual approaches [70,71]. By using this structured eight-step framework both a connotative (theoretical) and denotative (operational) definition that reflects the theoretical base meaning of compassion was developed [68]. Thus, identifying those practical components associated with compassion and its physical display. This process achieved clarity on the abstract and ill-defined concept of compassion [72], helping to gain construct validity [67].

Table 2.3: Eight steps of Walker and Avant's concept analysis [67].

Step	**Method**
One: Select a concept	Compassion is the focus of the PhD and selected in accordance.
Two: Determine the purpose of the analysis	Compassion is the focus of the PhD and selected in accordance.
Three: Identify all uses of the concept	Resources incorporated into the concept analysis were reviewed.
Four: Determine the defining attributes	Resources incorporated into the concept analysis were reviewed.
Five: Identify a model case	A model case was created by using a clinical example within a healthcare context. Behaviours, actions and responses associated with compassion identified in the literature were incorporated into the case to provide a practical example of compassion, where all five attributes of compassion were being displayed.
Six: Identify borderline*, related cases and contrary cases	Additional cases were created by using clinical examples within a healthcare context. Behaviours, actions and responses associated with compassion and non-compassion identified in the literature were incorporated into the case to provide practical examples. Behaviours and responses were omitted which represented three of the five defining attributes in the related case and all five within the contrary case.
Seven: Identify antecedents and consequences	Resources incorporated into the concept analysis were reviewed.
Eight: Define empirical referents	Resources incorporated into the concept analysis were reviewed.

Data collection was undertaken, utilising several resource types (Table 2.4). The databases were searched from October 2015 to June 2016 using the comprehensive search strategy and inclusion/exclusion criteria designed for the literature review. This strategy was applied to ensure only papers relevant to healthcare and with a focus on compassion were included. The Twitter search used #compassion to capture current discussion over an eleven-day period, providing a broader meaning to the term outside the published healthcare context by collating accounts and posts from individuals, newspapers, charities and organisations (Appendix 1).

Table 2.4: Resources categories used in concept analysis

Resource category	Details
Dictionaries	Online English-language Nursing, medical, and psychology
Social Media	Twitter
Databases and Journals	Medline, CINAHL complete, Scopus, PubMed, PsycINFO, Science Direct, Cochrane and DARE Journal of Radiotherapy in Practice, Patient Education & Counselling, Journal of Medical Imaging and Radiation Oncology and the Journal of Medical Internet Research.
Internet	Google and Google Scholar Websites including the Department of Health (DoH-GOV), INVOLVE, The Kings Fund
Books	Book chapters on human values and characteristics
Doctoral thesis	http://ethos.bl.uk, Database of over 40,000 theses

Results from each literature source were collected and examined independently (Figure 2.1). Principal points were documented, collated and compared across the categories allowing for the development of key themes and generation of a thematic map. A Wordle was produced documenting key words and phrases used in conjunction with the concept of compassion (Figure 2.2). This contributed to the development of behaviours and attributes associated with compassion, forming the basis of its antecedents. Saturation was reached once the literature sources generated no new themes.

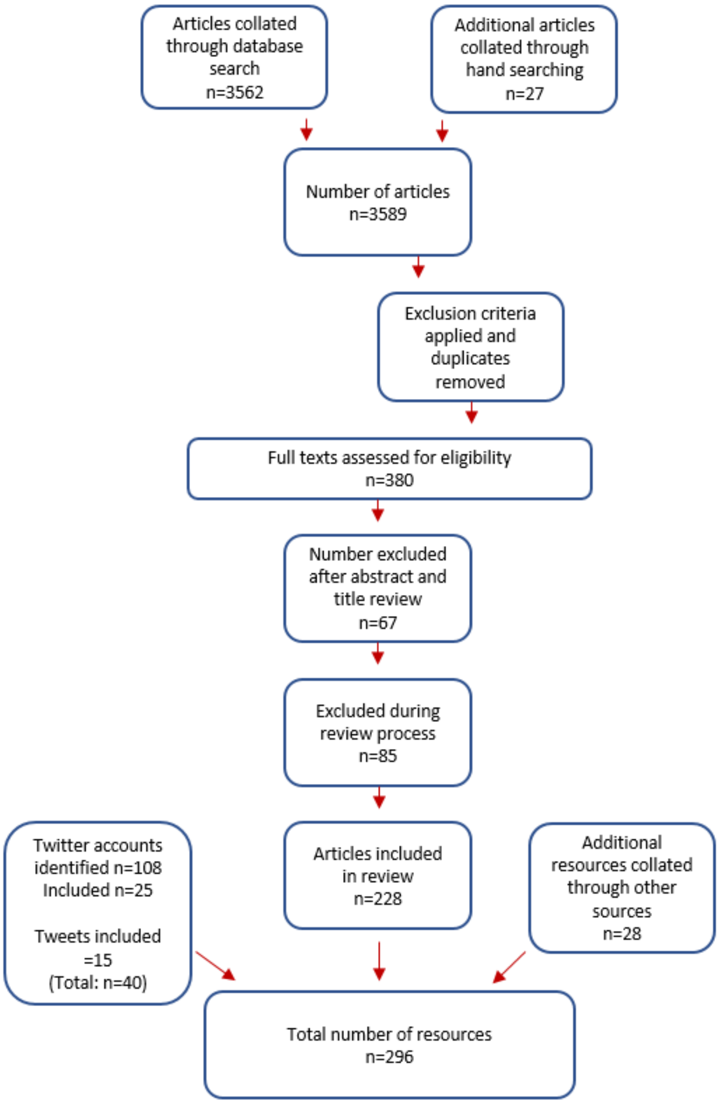


Figure 2.1: Stages of the concept analysis review process.

Figure 2.2: Wordle of phrases and words associated with compassion derived from the resources. larger font denotes more common terms found in literature

Findings

Step 1: Concept

Identification of an area of interest:

The concept of compassion in healthcare was selected. The concept was not limited to radiotherapy or cancer care specifically, as the analysis wished to gain a broader understanding of compassion in healthcare generally.

Step 2: Purpose of the analysis

An outline of why the analysis is being undertaken:

To understand what compassion is and how it is displayed within a healthcare context by health professionals.

Step 3: Uses of the concept

Identification of all uses of the term both within and external to the chosen context, allowing for validation of defining attributes:

Eleven terms on the concept of compassion were identified within the literature. Six of them were included to form this concept analysis and were considered to reflect accepted use of the concept within healthcare: compassion, compassionate, compassionate care, compassion satisfaction, compassionate practice and compassionate caring.

The other five terms were excluded from this concept analysis. Compassion-fatigue and self-compassion (inner-compassion) are heavily discussed in relation to compassion and compassionate care, but their focus is on the self rather than towards another. The terms compassionate-love, compassionate-leave, and compassionate-use, although possessing a focus on another rather than the self, represent the love of a partner or spouse, a policy of authorised leave from work or the prescription of non-licensed drugs respectively.

Step 4: Defining attributes:

Defining attributes are characteristics of the concept identified repeatedly through the literature. These enable the classification of the occurrence of a specific concept as differentiated from similar concepts:

The literature examined identified compassion in healthcare as comprising of five defining attributes:

1. Recognition: Cognitive recognition of another's adverse circumstances, physical, psychological or emotional wellbeing.
2. Connection: Personal connection with another based on automatic, authentic and genuine thought.
3. Altruistic desire: Altruistic desire to aid another.
4. Humanistic response: Humanistic, person-to-person, understanding of what it is to be human
5. Action: Undertaking of an act or responsive behaviour

Although these occur sequentially and each attribute needs to occur, the individual who is to display compassion may need to move between the attributes depending on the situation (Figure 2.3).

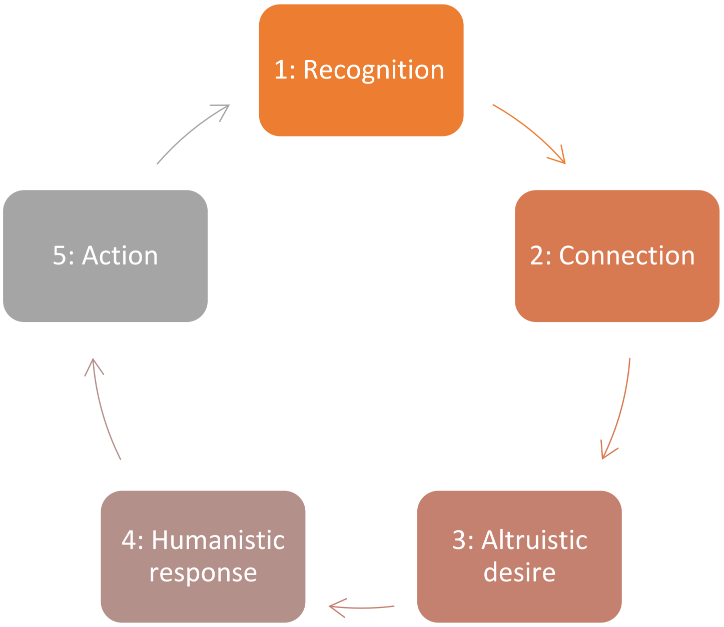


Figure 2.3: Defining attributes of compassion in healthcare

Step 5: Model case

A model case demonstrates all the defining attributes established from the literature. It provides insight into the internal structure of the concept, allowing clarification of its meaning and the context. The model case was based upon the experiences shared on Twitter by Dr Kate Granger. In her tweets she recalled both negative and positive experiences of care during the terminal stages of her cancer diagnosis. Some of the positive experiences were collated, reviewed and modified to provide a model case to display the five defining attributes of compassion during her care.

Kate was deteriorating; she had been diagnosed with advanced cancer and had been admitted to hospital, very ill with a serious infection. Kate was distressed and felt very poorly. The nurse who was looking after her could see (1) how vulnerable and frightened Kate was, so he gently placed his hand on her arm, knelt down beside her bed (2) and said to Kate we're going to look after you (3). Kate relayed her experiences to her friends and followers on twitter, tweeting about a number of similar events over *the course of her stay as an in-patient. She recalled her nurse ran her bath it was a hot, deep, bubbly bath, just the way she liked it (4, 5). On another evening she mentioned to the nurse that she had been struggling to sleep to which the nurse had replied don't sit awake in the night, just buzz me and I'll come and sit with you until you fall back to sleep (4,5).*

Stage 6: Additional cases:

Borderline case:

A borderline case contains most but not all the defining attributes of the concept:

Michael had been diagnosed with an extremely rare cancer 18 months ago and he was meeting with his consultant to discuss the results of his latest MRI scan. His consultant delivered the devastating news that it was no longer responding to conventional treatment and he was going to stop his current care plan. He knew no other treatments were available and the realisation had just hit him that it meant that his tumour could not be controlled any longer; his symptoms would worsen, and this cancer would soon be the cause of his death. Michael started to cry and began to beg his consultant to see if there is anything else, he could do. The consultant felt uncomfortable and stated that he was out of options; he would however refer him to the palliative care team and see him again in two weeks. The following week Michael received a phone call from the medical secretary asking him to come in for an appointment with his consultant the following morning. The consultant started his consultation by explaining that he had been doing some research and had been in contact with a medical colleague at another hospital who had recently referred a patient for a course of unlicensed drugs. He had been thinking about Michael (1) and felt that this was a possible option for him to try (3,4,5) but knew there were no guarantees of its effectiveness.

Related cases

Related cases are instances of the concept that are related to compassion but do not contain all its defining attributes:

Case 1

Clive a Therapeutic Radiographer for 20 years, was chatting with a 19-year-old patient called John who was about to start radical radiotherapy for testicular cancer. John was telling him that he'd already had the tumour and his left testicle removed and how he'd had to make the difficult decision as to whether to have his sperm frozen or not before he started radiotherapy. John told Clive that it has sparked him and his girlfriend to think about their futures together and decided to get married. He confessed he was worried and kept on stressing over whether the sperm banking process may not have worked and that he was worried how his fiancée would take the news if this was the case. Clive sat and listened to the young man's fears, ensuring that he knew he was there for him to talk to (2). Clive fully understood how John was feeling (1), not only had he treated many patients like John over his professional career, but when Clive himself was 22 he had received the same diagnosis so knew what John must have been going through.

Case 2

Claire a specialist urology nurse was asked to go and be present at Mr Jones post-surgery consultation, where the news of whether his surgery had been a success or not would be discussed with Mr Jones. Claire had just started shift and hadn't had time to review any of her case notes for the day but knew her role was to be there to support the consultant and the patient should they need anything. Claire walked in saw Mr Jones sat on his own in the room, she felt he looked really small and frightened (1), without saying anything to him or giving him the opportunity to speak, she walked over gave him a hug (3,5).

Contrary case

Contrary cases are examples where compassion is clearly not being displayed:

Frank was attending his weekly review with the specialist radiographer; he had a review every week as part of his radiotherapy treatment for prostate cancer. He'd been worried for some time about problems he was experiencing with his erection and had wanted to ask someone, but he had felt too embarrassed. His wife had told him that he must speak to someone at his next appointment as it was becoming a problem for them as a couple. Towards the end of his review the radiographer asked him if there was anything else she could help him with. Frank told her about the problems he and his wife were experiencing when they tried to have intercourse, to which she replied it's just an effect of his diagnosis and the radiotherapy treatment. Frank expressed that he knew this, but his original consultant had said there were some options and maybe some medication he could take. Reluctantly the radiographer nodded and replied this wasn't her area and so would go and ask a colleague for some advice. The radiographer exited the room into the main waiting area; leaving Frank sat alone with the door open. Whilst Frank was waiting he could hear laughter, listening in he heard his specialist radiographer saying, (laughing)…I know tell me about it and it his age it….(laughter), yeh good point I'll tell him to google it there be plenty of stuff on the internet for that kind of thing……well yeh, I suppose whatever floats your boat (laughter).

Step 7: Antecedents and Consequences

Antecedents

Antecedents are events or incidents that must occur prior to the occurrence of compassion. Figure 2.4 displays the antecedents established for each of the five attributes of compassion.

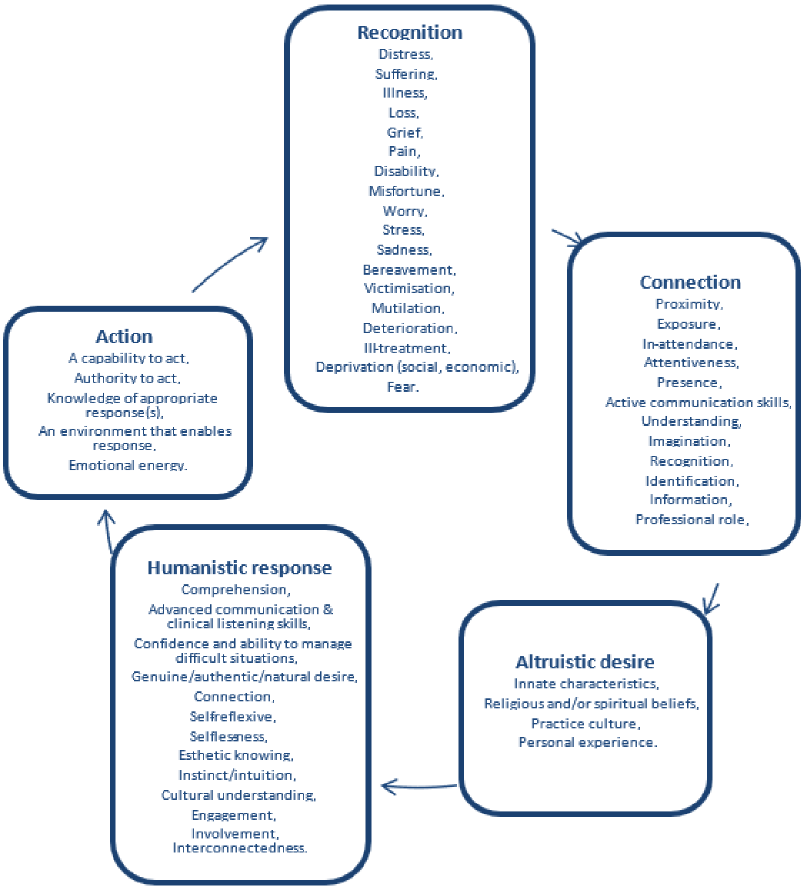


Figure 2.4: Five defining attributes of compassion and their antecedents

Consequences

Consequences are the events or incidents that occur as a result of occurrence of compassion:

Figure 2.5 details the consequences which transpire for patients when the five defining attributes of compassion occur.

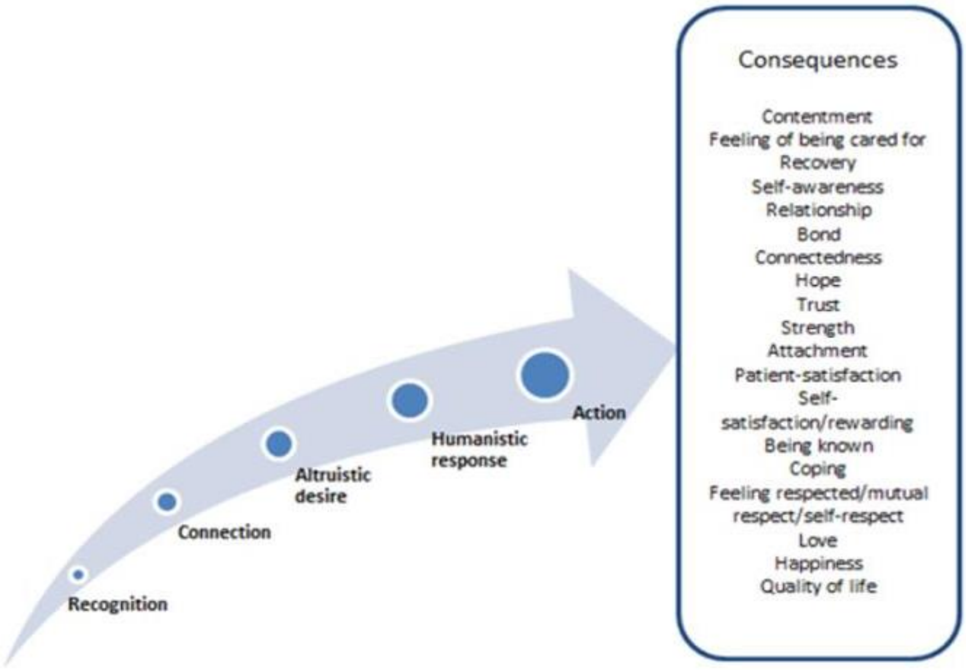


Figure 2.5: Consequences of the five defining attributes of compassion

Step 8: Empirical Referents

Empirical referents are categories of actual phenomena whose presence demonstrate the defining attributes and help determine the occurrence of compassion. The concept analysis ascertains the empirical referents of compassion can be structured into three categories: non-verbal, verbal and professional practice.

Non-verbal display

Compassionate behaviours included: eye contact [73], engaged body language [74], listening with full attention [47, 75, 76], and facial expressions which matched the subject of conversation [77]. All of these were deemed to display commitment and devotion by the health professional to what was being said, the significance of the topic and therefore demonstrated they were vested in them [78,79].

Verbal display

Compassionate behaviours included: being provided with clear, non-jargon, individual patient-tailored information, being given time and the opportunity to ask questions, not being spoken over, the professionals asking questions of them about their preferences and level of understanding [43,77,78,80-87]. The tone of voice and the language used was of particular importance in a professional's ability to portray compassion due to the effects of an imbalance of power between the health professional and the patient [75,87]. Belittling, judgemental attitude, oversimplifying and not taking the patient seriously were all perceived as uncompassionate behaviours [88, 89].

Cutting across both verbal and non-verbal display was a display of warmth through touch, tone of voice and body language. Warmth made patients feel comfortable and gave the feeling of being 'cared for' even if the health professional was not actively involved in their treatment [43,90]. Also underlying throughout was a desire for the health professional to show respect to the patient [91]. Patients wanted to feel like their opinions, beliefs and preferences were not only known but valued by those responsible for their care [74,76,82,88,90-92]. Patients wanted interactions in all formats to be non-judgemental and be both understanding and accepting of the circumstances surrounding their needs [93].

Professional practice

Compassionate behaviours included undertaking and completing any required standard tasks as part of the patient's pathway and treatment [86]. By ensuring that all process components have been completed prior to appointments prevents the patient facing additional distress of waiting, worrying about delays and being fearful of the consequences such delays could have on their prognosis. Patients want the health professionals to understand and appreciate the impact their current issue (diagnosis, bereavement, treatment etc.) is having on the physical, emotional and social rudiments of their life [46,47,76,77,94]. Furthermore, the practice of elementary tasks is deemed to be compassionate when delivered in such a way where a patient's dignity is maintained and considered as paramount [43,76].

One of the five defining attributes of compassion was a personal connection between the two parties [55,82,87,95]. Often this is based on shared experience, knowledge or understanding of the current situation. There are caveats however within this, as some level of professional boundary is required for health professionals to make balanced, informed decisions about the care they provide which are not based on previous emotive events, beliefs or feelings [92].

Limitations

Despite the implementation of a rigorous search and review strategy, consideration needs to be given to omission of possible sources which may have limited the rigour of the findings. However, a saturation of themes occurred across all of source categories denoting that further sources would not have brought additional themes to the analysis.

It may be argued that the use of Twitter did not align with the original aim to review compassion within a healthcare context. Twitter however provided a broader meaning to the term outside the published healthcare context as the Twitter hashtag collated accounts and posts from a wide range of individuals, newspapers, charities and organisations. Both Twitter and the dictionary definitions underpinned the review, clarified compassion outside of the healthcare environment by identifying patterns of use [39]. As such, this provided a boundary for understanding the differences between the concepts of compassion when used in different environments.

Summary

Employment of a concept analysis has distinguished compassion in healthcare from other contexts, establishing it to be composed of five attributes: recognition, connection, altruistic desire, humanistic response and action. Where compassion has previously been the focus of the concept analysis, the defining attributes have failed to be identified [40]. Classification of these not only enables the concept to be distinguished from other similar concepts [67] but by inclusion provides a model of compassionate delivery to identify if each of the five attributes of compassion is being displayed. This model of delivery can act as an exemplar of practice aiding professionals to understand the mechanisms of compassionate delivery. These practical and presentable elements of compassion within healthcare have unfortunately been omitted in previous concept analyses [96-98]. Associated meanings and behaviours have been outlined aiding an understanding of compassion. By providing antecedents and consequences which are derived from and relevant to health care practice gives real world contextual meaning to the findings. The findings however highlight the complexity of the term and subjective nature in which it is displayed and in turn perceived.

Contribution to the thesis

The concept analysis:

- Enabled the concept of compassion in healthcare to be distinguished from other concepts and from within other contexts.

- Collated current understanding of what compassion is and how it is displayed within a healthcare context by health professionals. Providing the thesis with an in-depth review of the literature.

- Importantly, the sources utilised conceded there is no one agreed definition of compassion in use, displaying congruence with the rationale for the research. Those which were referenced across the sources were generic dictionary definitions and not healthcare specific. Although some studies sought to understand compassion within healthcare, they did so from a singular cohort perspective either patients or healthcare professionals, not jointly.

The analysis confirmed that the concept of compassion is complex and subjective. To permit understanding of its different facets those aiming to define it need to consider perspectives from both sides of its delivery. This flaw in other studies supports the necessity to undertake research that aims to not only develop a healthcare explicit definition of compassion but one that has been co-constructed.

Research Aims

Based on the findings of the concept analysis the research aims to:

1. Generate a shared healthcare definition of compassion within the context of radiotherapy.

2. Identify how compassion is conceptualised and displayed within radiotherapy.

3. Develop a conceptual model of compassion.

Research questions

The thesis will achieve its aims by addressing:

1. How is compassion understood by patients and carers, student therapeutic radiographers and therapeutic radiographers?

2. How do patients and carers, student therapeutic radiographers and therapeutic radiographers believe compassionate behaviours are demonstrated?

Contribution to the research design

The concept analysis identified a gap in the evidence base; empirical work which sought to define compassion explored only a singular cohort perspective. The necessity to co-construct a shared definition became a key tenet of the thesis. Thus, co-construction using a co-production approach became central to the methodology and procedural design of the method utilised.

The findings provided a framework for the research method in the focus groups. A scenario resource was created from the contrary case and empirical referents were established as prompts.

The outcomes of the concept analysis became the basis for comparing and contrasting the findings of this research with what was already known [99].

Reflexive account

Undertaking a literature review is a time to get excited as it marks the start of the research journey and getting ‘your teeth’ into the project. Once I was underway however, I found it frustrating and at times overwhelming due to the volume of literature the searches were producing. Every article I reviewed added another ten or so more articles to the list to review and the pile was multiplying rather than decreasing. Despite a lot of hard work, I was getting nowhere fast. It was looking like the PhD would become a systematic review rather than a qualitative study. Adding to this frustration was the knowledge that literature reviews are traditionally a key part of every research process due to their importance in addressing the current knowledge base and situating the research. I was concerned that not following the tradition could be detrimental to the project.

Once I had investigated the process and use of a concept analysis, I started to feel much more comfortable with the decision to move away from the traditional approach. From a practical perspective the staged process made the literature more manageable, allowing me to draw out the key elements relevant to each stage. From a research perspective the findings from the concept analysis were highly valuable. Instead of looking at the concept overall it enabled the examination of the practical facets of compassion and the healthcare context in which they occur. The findings were therefore relevant to healthcare practices. These advantages were not at the expense of those advantages typically gained through a literature review. As the concept analysis still required an extensive review of a wide range of literature sources, I had full confidence in the ability of the analysis to be credible and reflective of the concept. Similarly reviewing each source independently facilitated analysis, including reviewing the methods of investigation and the conclusions drawn. On its completion I was happy that

I had made the decision to undertake the concept analysis and confident in its contribution to the research.

Chapter Summary

The chapter demonstrates how the concept analysis was important for obtaining current understanding of compassion within healthcare. It illustrated how researchers who have previously sought to define and understand compassion have failed to consider the importance of developing a co-produced shared understanding of the concept.

The principles of co-production are central to the thesis. The next chapter will detail the theoretical position of the research, providing the rational for the methods' procedural design.

Chapter 3: Methodology

Introduction

This chapter presents the interpretive framework and philosophical position of the research. It details the rationale and congruence of the methods of data collection employed within the interpretive framework.

Method of inquiry

A qualitative approach underpinned by social constructivist philosophy was adopted. Focus groups and co-production consensus workshops were the methods employed; both are consistent with the principles of co-construction. The following discussion justifies this approach.

Rationale

Although compassion is a central concept within healthcare and healthcare politics, chapter one identified its definition within this context is contentious and limited. A more pertinent issue is that it has never been co-defined by those with lived experience of compassion. To address this knowledge gap, the research sought to explore compassion and compassionate display from the perspectives of the three participant groups. The aim was to co-construct a definition and gain understanding of those behaviours which reflect compassionate practice from multiple perspectives. Qualitative inquiry was established as the most appropriate approach to achieve the research aims.

Creswell, describes qualitative inquiry as an approach for,

"*exploring and understanding the meaning individuals or groups ascribe to a social or human problem*" [99, p4].

Compassion within radiotherapy is a social phenomenon, its occurrence or absence derived from the meaning those in receipt or delivery assign to it. By empowering individuals to share their story and convey the context of their views qualitative inquiry facilitates an exploration of experience [100,101]. Exploration permits the researcher to gather the meaning those individuals assigned to their experiences of the phenomena of compassion within their social world [102]. The language used within the participant voice can answer the what, how and why of the compassion phenomena [103].

The aims were not to measure, quantify or enumerate individuals' experiences of compassion. The research was concerned with exploration of those individual's perceptions of those experiences rather than quantifying how many experiences of compassion they had received. Unlike quantitative approaches, a qualitative methodology would permit the exploration, description, interpretation and presentation of the participants' voice as a coherent definition of compassion and understanding of its presentation.

The following discussion sets out the philosophical assumptions and interpretive framework which characterised the nature of the research and the underpinning methodology [104,105].

Interpretive frameworks

Social Constructivism

The research adopted a social constructivist philosophical perspective. This perspective is congruent with research into the social sciences and is based on the principle that reality is socially constructed within a particular context. Social constructivism provided the theoretical lens of the study, shaping how the research problem was viewed and how the data was interpreted [104,105].

Philosophical assumption

It is important as a qualitative researcher to have an awareness of the personal beliefs and theories which inform the work. There is also a need for transparency, sharing of the knowledge with others of the process and any personal bias [99,104]. The philosophical assumptions of the thesis are based upon prior experiences, and the works and opinions of leading qualitative researchers, alongside discussions with key stakeholders. Together these influences have led to the consideration of how philosophy may inform the theories that influence the research process.

On this premise, this next section will detail the four philosophical assumptions which underpin qualitative research: ontology, epistemology, axiology & methodology [104]. Providing this thesis with an explanation of how each has influenced the approach to the research process and their alignment with the adopted philosophical position.

Ontology

"*All knowledge and therefore all meaningful reality as such is contingent upon human practices being constructed in and out of interaction between human beings and their world and developed and transmitted within an essentially social context* [105, p42].

In social constructivism the ontological nature of reality is one of multiple perspectives [104]. For every individual, constructs including objects, relationships and events have multiple and varied meanings. Each construct is shaped by personal experiences and social interactions [107].

Each participant having encountered and lived through their own experiences will construct their own meaning of their world and the concepts within it. The individuals own perception of compassion will therefore be unique to them. It is on this premise that the research could not align itself with the objectivist position. The individuals under investigation will not share one single or objective reality, neither is there one perspective of compassion shared by all waiting to be discovered [103,105].

Qualitative inquiry promotes exploration of these constructs through a process of discovery. By bringing the participant groups together, the researcher will hear the different individual viewpoints of compassion. This grants the research with an understanding of their realities, each shaped by the world in which they live and work [104]. Allowing for the co-production of knowledge based upon multiple realities.

The participants array of life experiences may potentially traverse the different participant groups. An individual participant’s construct of compassion may be based on multiple perspectives including their time as a student, their clinical practices or from being a patient or carer. Each of these will shape their reality of the concept of compassion, enhancing the diversity and richness of their own reality and the findings of the research [103,105].

Social constructivism emphasises the importance of culture and context, understanding what occurs in society and constructing knowledge based on this understanding [108,109]. Interaction between participants allows the exploration of compassion within radiotherapy and will provide a context specific understanding of human behaviour [103,105].

Epistemology

To be able to claim the knowledge generated from the research is valid, consideration of epistemology is vital [103]. Within social constructivism, justification of knowledge validity requires the researcher to ‘get close’ to the participants being studied during exploration of the phenomena [104]. Using qualitative methods of data collection will promote immersion into the concept under inquiry. Enabling the participants to attempt to understand their own construct of compassion, whilst the research attempts to understanding the participants own subjective meaning of compassion.

Exploration and immersion must also occur within an appropriate context. By recruiting participants with lived experiences of radiotherapy will generate data of the construct of compassion within the appropriate context.

Axiology

When considering axiology and the role of values, it is important the researcher acknowledges research is value-laden and that biases are present [104]. Social constructivism embraces these differences in values and worldviews. This embrace of diversity strengthens the benefits of qualitative research, collating data which is rich from heterogeneity of opinion.

It is also important for researchers to ‘position themselves’ in the study [104]. Specifying and acknowledging their own beliefs and values and how they shape the research process.

The findings will present an interpretation of the participants’ understanding of compassion and its presentation. Qualitative research enables the demonstration of transparency, portraying the relationship between emergent themes and the data collected by using direct quotes as evidence [104]. It must be acknowledged how the findings will not only represent an interpretation of the participant’s perspectives of compassion, they reflect the researchers position held in the research [104,110].

Methodology

Co-production

Social constructivism acknowledges that whilst individuals create their unique understanding of life, the process of interaction can generate a shared understanding that represents accepted meaning. The research is congruent with the philosophy that underpins co-production, aiming to develop a consensual definition and understanding of compassionate radiotherapy practice. The next section will outline the principles of co-production, how it aligns with both qualitative inquiry and social constructivism and its relationship with participatory research.

Principles

Co-production has traditionally been used for and associated with public services design and delivery rather than a methodological approach to research. As an early adopter, Ostrom advocated co-production would allow for a mix of activities that both public servant agents and citizens could contribute to for the provision of public services [111]. Co-production within public services has superseded the traditional design and delivery by professional and managerial staff in public agencies, moving towards services which are co-developed by users and communities [112,113]. Co-production within healthcare is underpinned by the premise that patients are not simply users of the service, instead should be regarded as active agents in their care [114]. As such, patients should be collaborated with during the design and delivery of services as engaged participants rather than passive subjects [111,115].

Within this research, collaboration was paramount, ensuring the findings were mutually reflective of those individuals with lived experience of compassion in radiotherapy. To facilitate a collaborative design, the TRs were engaged in the process as professional public service agents, the STRs as future professionals and the PaCs as citizens who desired to enhance the quality of the services they use [116,117]. The opportunity was therefore sought to take advantage of the underpinning principles of co-production by transferring its philosophy of collaboration into the research setting.

Through exploration of the experiences of the three different stakeholder groups an understanding of compassion and compassionate practice could be gained. Concordance then being sought across the three groups through the exchange of ideas and understanding during a collaborative process. Each group would provide their unique perspective on compassion and compassionate care as a constructed concept, enabling the emergence of a shared definition and mutual understanding of compassionate display.

As compassion is something received during the use of the healthcare service, it could be argued the research employs the traditional intention of co-production as a process of service review. The delivery of compassionate practice therefore designed by those receiving and administering the service.

Although a distinction between the three participant groups has been applied, there is a limit to what extent. Across society and indeed within the context of this research the argument can be made for fluidity of the groups through multiple life experiences.

Published works focus on the traditional use of co-production in service design. Their principles however can be transferred and utilised to support co-production as a methodological process.

Relationship with qualitative inquiry

Qualitative inquiry studies individuals in their own social setting, aiming to provide understanding of the meaning those individuals bring to their situation [118]. Positioning the research within a co-production methodology enables meaning to be explored and constructed through and by multiple perspectives. Co-production as a methodology wields strength from the diversity of individuals, recognising how knowledge held by all parties although different, is valuable and carries equal weight [119]. These principles align with co-production as the overarching methodology as it supports the ethos of the research and its ambition to bring together a range of participant groups to develop a shared understanding of compassion.

The diversity which can be achieved through co-production enables a wide exploration of concepts across multiple realities providing rich data. This richness increases further when participants are selected for recruitment based on their experiences of the concept under inquiry. Aligning with the perception of ‘experts by experience’, it recognises the knowledge held by participants through their lived experience(s) [119,120]. As reality is the mental construct of individuals and as such cannot exist outside of the minds that create and hold them. Diversity of participants can result in many constructed realities, some which may be conflicting and incompatible [121]. Co-production enables local consensus, an agreed truth amongst those participants at that given time and place.

The research was not only congruent with the philosophy that underpins co-production, but its key principle of collaboration resulted in integration into the research method design. The construction of a shared definition and understanding of compassionate practice required the participants to work-together to construct these findings. Co-production consensus workshops created an efficacious process, permitting the occurrence of collaborative working and co-constructed findings.

Co-production is an inductive method and methodological approach. Through exploration of the participant voice(s), findings are shaped, and subsequent phases of inquiry can be designed.

Relationship with participatory Inquiry

The involvement of participants in researching a topic based on their own experience suggests that co-production is based on the same principles of the three strands participatory inquiry, cooperative inquiry, participatory action research and action inquiry [122,123]. Overarchingly, participatory inquiry like co-production has an epistemological focus on experiential knowledge [103]. Addressing how the research can gain value from knowledge and individual understanding of how their reality is socially constructed based on their own experiences.

Whilst there are similarities, there are also differences between co-production and the traditional participatory inquiries. Participatory inquiry is based on the premise that participants are equal partners with the researcher [119]. Especially within cooperative inquiry, where everyone involved in the research is classed as both a researcher and a subject [103]. It is important to ‘get close’ to the participants to develop a deeper understanding. However, it was not the ambition of the study for the researcher to contribute to discussions, simply attending to facilitate data generation. Similarly, although designed with the input of patient and public involvement, the operational design of the research is not to be completed with the participants as full researchers [122]. For it was not the aim for the participants to co-construct or collaboratively undertake the research. Instead the research sought to generate a mutuality of meaning by using their individual constructs of compassion to co-create a definition. As such co-production is situated in the centre of a qualitative research spectrum for participatory involvement. At one end participants are merely subjects there to be studied, whilst at the other participants are co-researchers.

Traditionally associated with researching with groups who are under-represented, participatory action research sees the role of the researcher as one which liberates communities by research shifting the balance of knowledge [103,122]. Although at present, there is limited research that addresses compassion within radiography from a PaCs perspective, this participant group would not traditionally be classified as under-represented. There already exists a plethora of research on the care and experiences of cancer patients. Participatory action research aims to produce understanding that is useful for the group that are being worked with. Understanding of its display, alongside a definition of compassion within radiotherapy ~~cancer care~~ will provide its participants with knowledge that can be translated back into clinical practice. Subsequently aiming to enhance the compassionate care received by patients.

Action enquiry involves a conscious approach to action and change [103]. Once generated, the findings may identify the need for clinical practices to change if what is currently advocated does not align with the conceptual framework. But this is not guaranteed; the purpose of the research was collaboration to gain understanding not to evoke a change.

Like other participatory research methodologies, co-production creates empowerment for the participants [103,122,124]. Alongside, promoting participants to undertake research that is not only important and of interest to them it places them and their voices at its heart. This is not only communicated to participants at the beginning of recruitment but reemphasised throughout the organisational process of the research. By providing an appropriate arena, co-production enables participants to make a valuable contribution to knowledge, possessing the potential to shape care and delivery of care for future patients.

Summary

The ethos of co-production is to bring individuals together to share perspectives and use any collective knowledge generated to facilitate a partnership and to work in collaboration. The goal of which is the development or enhancement of services for mutual benefit. The previous two chapters highlighted the current gap in the current knowledge and evidence base. No definition or understanding of compassion within radiotherapy has been established that has been co-constructed. Co-production as a research methodology displays congruence with the social-constructivism framework. By acknowledging and respecting each individual and collective participant groups construct of compassion, the research can connect participants and utilise this wealth of rich and diverse data to co-produce a mutuality of understanding and conceptual framework. The development of this will improve the compassionate care and clinical services delivered to patients.

Methods of data collection

Focus groups and co-production consensus workshops were to be employed in the research. This section discusses their alignment with the philosophical position of the thesis and the rationale to employ these methods over others whom are also traditionally associated with qualitative inquiry.

Rationale

To facilitate exploration of the multiple perspectives of compassion, the method of data collection needed to achieve these key objectives:

1. Generate data by stimulating the participants to discuss their own social constructs, perspectives and experiences of compassion.

2. Allow the generation of data to occur within each of the three respective participant groups independently.

3. Enable the research to capture these perspectives in a format that would be reflective and true to the participant voice.

4. Support a process of analysis which established themes reflective of each participant group.

5. Generate findings independently representative of the three participant groups.

6. Facilitate the co-construction of findings, integrating the participants in the process of co-production.

Focus groups

A focus group method was selected over questionnaires and individual one-to-one interviews. Focus groups benefit from the social art of conversation promoting discussion. Group interactions create a more in-depth level of interaction between participants causing a higher level of disclosure compared with interviews [125,126]. Hearing the experiences of others can trigger participants to recall and share memories, making comparisons. Focus group can also aid their comfort to disclose through the confidence displayed by others or by it indicating it is a safe environment to do so [127]. Questionnaires were discarded from use due to the loss of social stimulus failing to provide the wide breadth of data. They can also be 'closed' in their focus, asking direct questions then failing in ability to follow-up or explore the participants answers. This reducing their capability to delve deeper into the concept of compassion.

A distinction between focus groups and other forms of group inquiry was required to ensure the selection of the correct method subtype. Morgan & Krueger broadly defined a focus group as:

"*a technique that collects data through group interaction on a topic determined by the researcher who typically takes on the role as moderator*" [126, p6].

Based on this understanding, nominal and Delphi groups and the observation of naturally occurring groups were excluded. Delphi studies create no actual group interaction. Consensus is reached through selection rather than through exploration of perspectives. This is contrary to the principles of socially constructing an understanding of compassion. In naturally occurring groups the topic of investigation is not defined by the researcher, therefore potentially generating data which is not suitable to answer the research questions.

Like focus groups, group interviews encompass both requirements, but the role of the researcher as moderator is changed. The desire is for a moderator to be a passive observer, simply there to oversee and guide the flow of discussion. Through the delivery of direct questions, they instead become the leader of discussion. The method needed to present the opportunity to explore complex attitudes and behaviours by the freedom of discussion rather than control the direction of discussion.

It is argued that focus groups can limit the research to only collect verbal data [126]. Verbal data on experience and perception of compassion was however sought rather than natural inquiry of compassionate display. Observation of practice would have been inappropriate as the research sought to understand and define compassionate practice as this knowledge does not currently exist within the context of radiotherapy. ~~cancer care.~~ Without this understanding, interpretation of observed behaviour as compassionate or non-compassion would have been unachievable. Therefore, causing the data collected to be ineffective in answering the research questions. Throughout the focus group discussions, descriptive examples of behaviour, alongside opinions can be disclosed which broaden the range of data obtained. As opinion cannot be observed, only researcher interpretation of behaviour would be gained through observation. Additionally, observation would not enable the perspectives of PaCs to be explored only the TRs and STRs. Fundamentally, eliminating a crucial dataset on the construct of compassion from those in ‘receipt’ of compassionate practice.

The research method also needed to be appropriate for the topic under discussion. The appropriateness of using a focus group to discuss the topic of compassion needed to be considered. The research was requesting participants to discuss matters of health and times of emotional and physical stress. Recall could have potentially been distressing to participants. Some researchers however consider focus groups are indeed a more suitable method for collecting data on sensitive topics than other qualitative methods. Sensitive issues may more easily discussed by focus groups evoking a feeling of ‘safety in numbers’, where raising a point could be less threatening amongst a group than alone [102,103,128]. Some information though may not be so easy to disclose amongst certain groups and consideration must be given to the ethical impact of any disclosures [103]. A pilot focus group which is detailed in chapter four was conducted to explore this issue.

Focus groups were to be a “self-contained method”, serving as the primary means of generating qualitative data [126]. The aims of the research need to be carefully considered so the format utilised will be effective for generating data appropriate to answer the research questions. This places additional emphasis upon the research design, the detail of which is provided in chapter four.

The spontaneity and synergy of focus groups engages the participants in conversation, and then by working together they co-construct discussion that forms a rich data set

[129]. As such, the principles of focus group align with the philosophy of co-construction and the interpretative format of the research [125,129-131].

Summary

Focus groups were incorporated into the methodological design of the research due to their ability to generate a wealth of socially constructed data. Their undertaking established findings that would be utilised to design, develop and undertake co-production consensus workshops.

Co-production

As well as being the methodological approach to the research, co-production was also employed as a method for integrating and co-constructing the findings.

A process of integration was required to amalgamate the three independent sets of findings generated from the focus groups for both research questions. The method needed to engage participants in a collaborative process, supporting them to co-construct a shared definition of compassion and compassionate practice.

Standard integration of findings conducted purely by the researcher on behalf of the participants would not have aligned with the principles of a co-production methodology. Participants would have been consulted on the findings rather than co-constructing them. This practice would have reasserted traditional roles and divisions present in research instead of following the principles of collaboration through dialogue, interaction and negotiation [122]. The findings becoming the researcher's interpretation of the perceptions of the three participants groups rather the construction based on mutual understanding and agreement.

Co-production workshops benefit from those in-depth interactions traditionally associated with focus groups [125,126]. These benefits enable the co-production attendees to share their opinion of the findings based on their own socially constructed perspectives and work together to integrate and construct the findings [132-134]. This results in an enhancement to the quality of the research through the inclusion of experiential expertise [135].

Chapter summary

The aim of the study was to construct a shared meaning of compassion and compassionate behaviours. Thus, the chosen underpinning philosophy is social constructivism where multiple perspectives exist and are shared within a group. So, if the concept of compassion creates meaning to social groups it is co-constructed. Methods that align with co-construction principles include the focus group and co-production workshops. The focus group brings people together who have a common interest and allows different perspectives to be heard (i.e. PaCs, STRs or TRs). In order to create a shared understanding across these three participant groups, co-production with heterogeneous composition allows concepts to be discussed and constructed as a collective understanding. The value of constructing a shared social principle is that it is more likely to be adopted in wider social settings.

The next chapter details the research process and procedural elements of the methods employed.

Chapter 4: Method

Introduction

Chapter four details the research processes undertaken across the three phases of the study. It describes the operationalisation elements of the research, including approvals, recruitment, data collection and analysis. The rational and development of each of the phases is addressed. Procedural elements of the method will be outlined, and the chapter is supported by reflexive commentaries providing insights into key decisions and challenges.

Method overview

The method consisted of three phases. A pilot focus group was undertaken in phase one, followed by the substantive focus groups in phase two and the co-production workshops in phase three (Figure 4.1).

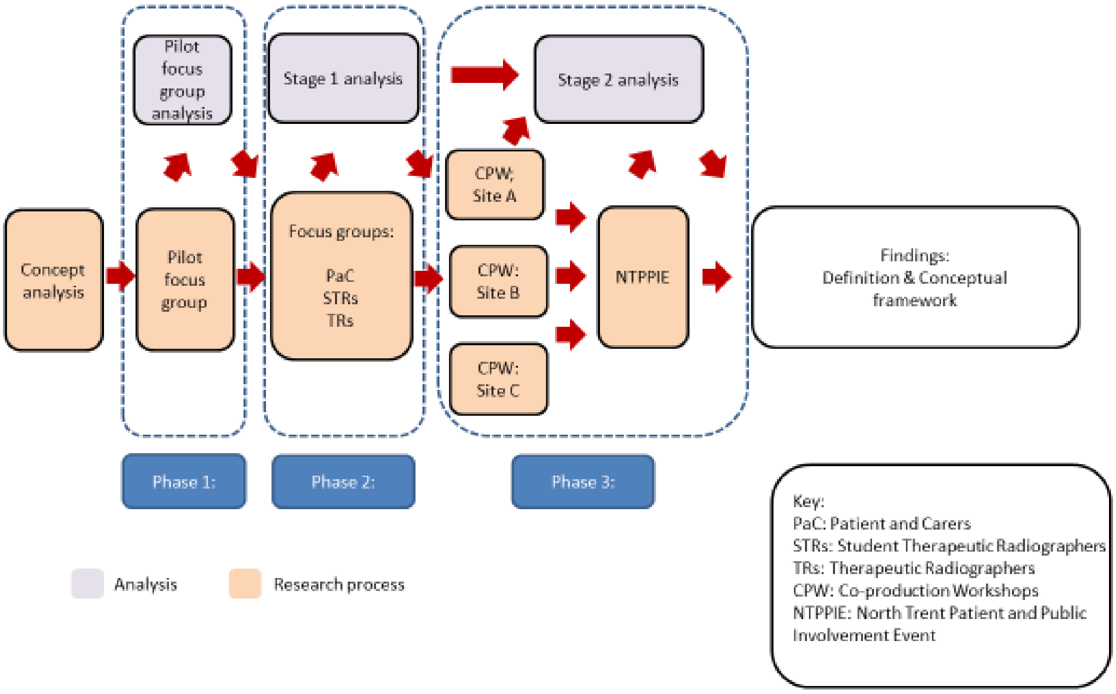


Figure 4.1: Research process

Research Approvals

The research process aimed to ensure the welfare of participants was maintained, all ethical approvals were obtained and protocols followed. Host higher education institutions research ethics 2015-16/HWB/HSC/36 (Appendix 2) and Health Research Authority (Appendix 3) were granted in addition to local research and development/innovation approvals at the three NHS Trusts involved in the study (Appendix 4).

To maintain confidentiality and anonymity, all corresponding documents were stored safely and securely within a locked cabinet at the higher education institution's premises. Site files were maintained and stored securely at each of the three clinical sites. All data was anonymised and stored on the higher education institution's password protected computer and backed-up each evening on their secure network.

Phase one: Pilot focus group

A pilot focus group was undertaken in phase one of the research process (Figure 4.2).

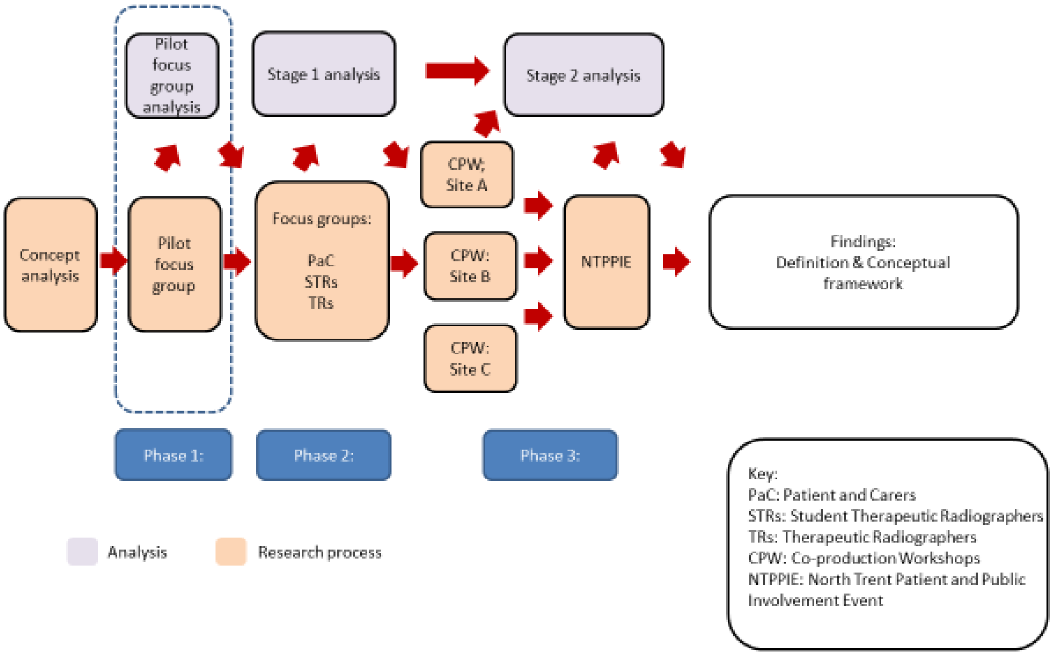


Figure 4.2: Phase 1 of the research process

Purpose

The pilot aimed to investigate the feasibility of focus groups as a method of data collection [136,137]. Providing the opportunity to test, develop, refine and adapt the prospective tool employed for data collection ensuring the method was purposeful and reliable [138]. The aim was to explore the thoughts of individuals, representative of the PaC community, regarding their involvement in a focus group. As established in chapter three, compassion as a topic of discussion may hold sensitivities. The pilot wished to establish whether the participants perceived compassion to be an appropriate topic to explore within the focus group method. The pilot also presented a personal developmental opportunity. Although experienced in qualitative research and conducting focus groups, it sought to ensure the skillset employed would warrant that necessary to achieve the level of facilitation required for the research [102,103,130,131]. For the pilot, a supervisory team member acted as moderator and provided feedback on the facilitation skills displayed [131] (Appendix 5). In addition, a transcript of the pilot enabled the trialling of thematic analysis to ensure the method of data analysis also aligned with the topic under discussion [139].

Setting

The pilot included participants who had been diagnosed with or were a carer for an individual diagnosed with cancer. This allowed exploration of the topic amongst individuals who had first-hand experience of compassionate or non-compassionate care within cancer services, although not limited to radiotherapy. This would mirror what was being proposed in the main study [102]. Based on this criterion the decision was made to utilise the partners in learning group involved in the academic delivery of the pre-registration radiotherapy and oncology programmes at the host higher education institution. This group was composed of individuals from across the UK who had received a diagnosis of and treatment for cancer alongside carers of individuals who had received a cancer diagnosis. Members of the group were involved in academic programme delivery, sharing their diverse range of lived experiences with the students across the three years of the programme.

Ethics and Recruitment

Host ethical approval was obtained for the pilot (Appendix 2). Members of the partners in learning group were invited by email to be part of the focus group. A convenience sample was used to select members who were planned to attend the university as part of timetabled academic delivery [102]. This provided both an appropriate sample of attendees, whilst reducing any expenses or inconvenience associated with attendance [131]. On receipt of an email response indicating their interest, the group members were sent via email, a participant information sheet (Appendix 6) and consent form (Appendix 7). These detailed the purpose of the focus group, what the pilot would entail and information relating to its voluntary nature. Informed consent was obtained on the day of the pilot with attendees given the opportunity to ask any questions about their involvement prior to signing the form. At this stage, their right to withdraw at any time was reiterated.

Structure

A focus group guide was utilised incorporating ideas from the concept analysis (Appendix 8). This provided clarity of the topic for discussion and structure to the session, whilst still allowing the attendees to have open and fluid dialogue [103,131]. The pilot was facilitated by the researcher and a moderator. The pilot was audio recorded and transcribed by the researcher *in verbatim* [102]. Thematic analysis was undertaken utilising Quirkos data management software [140]. Notes were made during the pilot by the facilitator and the moderator to record key points and attendees body language where appropriate to aid data analysis.

Results and findings

A total of five participants took part in the pilot focus group, for the duration of approximately seventy-six minutes. Sixty percent were female (n=3) and forty percent were male (n=2). All participants had received a diagnosis of cancer, the site of diagnoses were breast (n=2), testicular (n=1), kidney (n=1) and myeloma (n=1).

Three themes emerged from the data: topic, method and skills, the next section will discuss each respectively.

Topic

During their discussions, the participants used examples from their own experiences to support their thoughts around the meaning of compassion. Participants recalled their experiences of professionals, sharing both negative and positive examples of compassion and the circumstances in which they arose. Despite the personal nature of discussion, the topic did not generate any negative emotional response from the participants. Potentially indicating the topic could foster discussion without the participants becoming distressed or anxious.

Method

Overall, the participants were positive and supportive about the use of focus groups as a method of data collection. Participants could see the value of bringing together individuals to collectively discuss the topic. They voiced their appreciation of how together their different perspectives fuelled discussion, which would allow exploration of the topic in more depth. The participants acknowledged how hearing the views of others had triggered their own memories and thoughts. Giving acknowledgement to how multiple viewpoints and the stimulus of others had contributed to the richness, diversity and complexity of the discussion.

However, one participant expressed that they had found it difficult at first to share their thoughts as they were different from others amongst the group. They had not wanted to upset others or be upset themselves by stating a conflicting opinion. A second participant expressed similar feelings but had attributed this to knowing the other participants in the pilot.

Overall, the participants found the focus group a safe environment to share their experiences. These thoughts were mirrored by the facilitator and the moderator who noted how respectful of each other they had been even when opposing opinions had been shared.

Skills

It was during the participants' discussion of the value of diversity that they commented on the specifics of the focus group format. They liked the use of the two definitions and the request for their comments on each of these respectively, in turn appreciating how these gave the pilot a structure whilst keeping the topic broad. Their comments indicated they had valued this approach, allowing them to talk about what was important to them rather than the direction of discussion being led. The moderator had also identified this approach to be positive, commenting how the use of two definitions "*promoted discussion, this was particularly effective as participants discussed and debated different viewpoints*".

The format of the session was explained to the participants at the start of the pilot and ground rules were established during this time. As part of this, it was identified how there was no right or wrong answer, the research was only interested in their honest opinions. The participants spoke of how being informed of this had positively influenced their involvement in the pilot. Reporting how this practice had made them feel comfortable to speak out without concern of being judged. This discussion also prompted the participants to talk about 'agendas' and the difference it may make to a focus group if the facilitator had their own agenda. Although they knew and understood the pilot was based on the aim to develop the research method, the participants felt the agenda was not forced or used to influence the discussion. They were positive about the role of the facilitator and the way the pilot had been conducted. They said skills were demonstrated when their comments were picked up on, listened to and followed by prompts to elaborate. The participants commented this practice had been performed with the right balance, stimulating discussion without influencing it.

Although not the purpose of the pilot, there were also some general findings from the analysis which are worth noting. The participants commented they felt they had benefited from attending. Reporting how they had learnt something about involvement in focus groups and the topic of compassion.

Interestingly, the participant who spoke of their initial reluctance through fear of upset later reported a therapeutic benefit. Exposing themselves to that situation had ended up giving them confidence to speak up and disagree with the opinions of others.

Several themes specific to the attendees understanding of compassion and their thoughts of the existing definitions emerged. These were used to support the background and rationale of the next phase of the research.

Reflexive Discussion

The pilot provided the opportunity to explore the feasibility of focus groups for data collection within the research setting. Five key considerations were identified.

Although participants spoke about their own experiences it did not appear to evoke a strong emotive response. It must be considered that the participants attending the pilot were all part of the partners in learning group. As part of their involvement with the academic programmes they talk to students about their experiences of professionals and care, so are accustomed to talking about potentially emotive topics without becoming distressed. However, potential participants attending the focus groups in phase two may not have the same emotional levelling as those in the pilot and may respond differently in this environment.

The dynamic of the pilot remained balanced, with no one individual domineering or becoming disrespectful. As the participants are actively involved in the programme, they already know each other, in some cases for several years. This may have altered the dynamic of the discussion as they have previously developed friendships and working relationships. The moderator commented "*I thought the participants in this group were interested in the topic and showed a lot of respect for each other, which perhaps may not be the case with a different group*". Further stating "*Amy will need to prepare for situations where some participants dominate or have difficulty voicing their views*".

Some members of the group did not contribute as much to the discussion as others, but they identified this was through choice and not inopportunity. The moderator however commented how facilitation "*encouraged participants who had said little to share their views, and this came over as very supportive and ensured all opinions were heard*". Indicating if more challenging individuals are present in the focus groups, effective facilitation skills would be required to balance discussion, ensuring all participants voices are heard.

The participants were positive about the facilitation skills displayed. But as these individuals were known and had been worked with for several years, this may have influenced the dynamic and/or the feedback given. There was the potential for an unequal power balance, with the participants possibly perceiving the facilitator to hold a position of power due to the university role and leader of the research. This issue was accounted for by addressing it within the participant information sheet. It was explained the pilot was voluntary, was not related to academic sessions and their attendance or non-attendance would not influence future group involvement. This was stressed further within the introduction to the pilot where the points were reiterated.

After working with the group for over three years, a relationship between us had developed and in consequence there was potential for the participants to provide answers which they felt were acceptable rather than their own views. The transcript (I believe) identifies that this did not occur. There were several debates and conflicting opinions expressed throughout the pilot and times where participants were hesitant to speak out for fear of causing conflict amongst the group. Demonstrating the participants' comments were real, honest and their personal opinions.

Similarly, there was also potential for increased facilitator involvement due the influence of relationships. The moderator however commented "*Amy works with service users and has good communications with them, and I was struck how as focus group facilitator she adopted a more 'distant' communication that was respectful of each participant's viewpoint. She never expressed a viewpoint but acknowledged each person's contribution".*

Knowing the other participants was felt to have hindered one participant's ability to be open with their thoughts. They indicated this was through fear of conflicting opinion that would cause upset, rather than not sharing information or experiences through being uncomfortable to disclose. Some participants in the PaC focus groups may already know each other due to recruitment occurring through local support centres. Additionally, the STRs and TRs will know each other through training and working together clinically. Overcoming the influence of those relationships needs to be considered when designing the focus groups as well as any personal relationships of the researcher with the STRs and TRs established during training or clinical working.

Many comments about the success of the session as a method for data collection were related to the format of the pilot, specifically the way it had been designed and implemented by the facilitator. Perhaps then indicating the focus groups expediency would be a result of the existing skills of the researcher.

Considerations for phase two

Employment of a pilot focus group affirmed its appropriateness for data collection. Although the findings indicated no significant modifications to the research design were required, its undertaking generated several points for consideration when designing the focus groups.

Support

In order to reduce the potential for a negative emotional response:

- Ensure all written and verbal information is informative and clear.
- Inform participants that they can leave the focus group at any time.
- Ensure information relating to support services is available to participants.
- Build time into the end of the session for a debrief allowing the participants to talk as a group or with the facilitator or the moderator privately if they want to raise any issues.
- Inform participants that the focus groups are safe environment (part of introduction/ground rules).

Format

To ensure the focus groups effectively promote open, natural and participant led discussion:

- Begin the focus groups with an introduction and ground rules. Findings demonstrated this provided important information on the format and gave patients reassurances about their role.

- Keep the format developed for the pilot, utilise definitions/statements/scenarios. The pilot demonstrated this approach focused the topic and promoted conversation whilst keeping the discussions open and fluid.

Skills

Ensure the following skills are effectively employed:

- Observe and review the dynamic of the groups.
- Balance the discussion to promote inclusivity of all participants.
- Consider using in-direct interventions if required to re-direct the focus of discussion.
- Similarly, dynamics may obstruct discussion with some participants not feeling comfortable to initially discuss. This could be overcome by the development of prompt questions to initiate discussion.

Phase one summary

The pilot established focus groups were an appropriate method of generating discussion on the topic of compassion. The completion of the pilot aided the design of focus groups. Feedback from the participants and the moderator alongside analysis of the transcript were considered during the focus group development stages. These inclusions which enhanced the effectiveness of the method during data collection are positioned in the next section.

Phase two: focus groups

Focus groups were completed in phase two of the research process (Figure 4.3). Their purpose was to explore how STRs, PaCs and TRs would define compassion and obtain their perceptions of compassionate display.

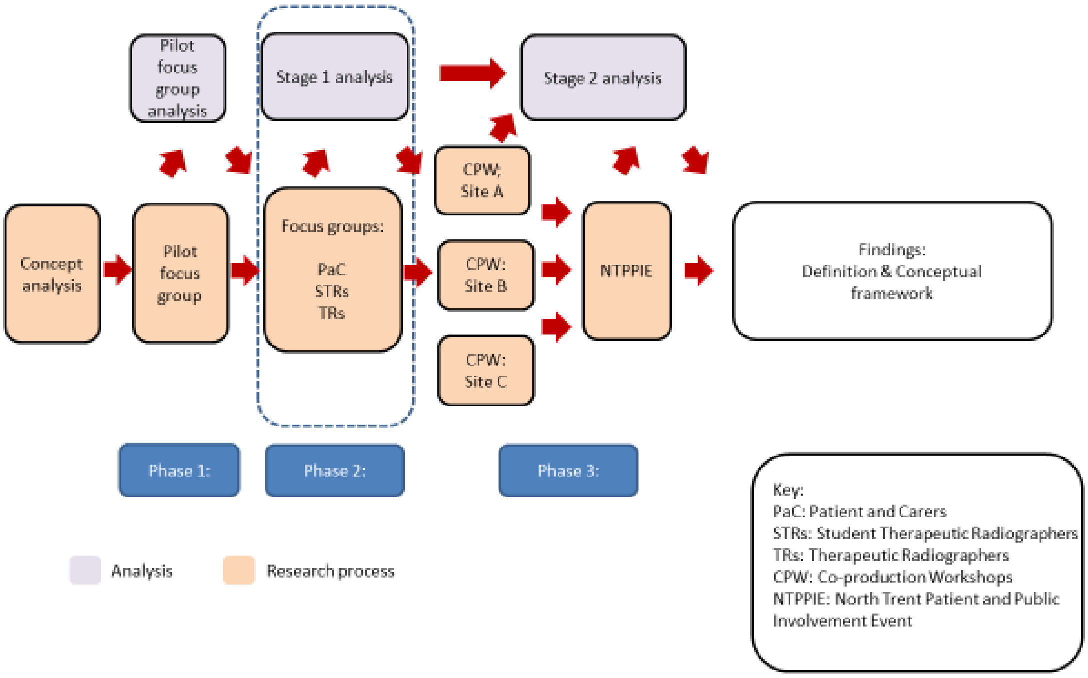


Figure 4.3: Phase 2 of the research process

Sampling and Recruitment

Sampling strategy

A purposeful strategy was employed in the selection and sampling of participants. The method was designed so that the focus groups were undertaken independently of one another, i.e. with no mixing of the three different participant groups. Three separate sets of findings were anticipated to facilitate co-construction in phase three. To obtain experiential data required for exploration of the concept of compassion, the narratives of those recruited needed to represent and have experience of the phenomenon [104]. Narratives come into existence not as a product of an individual, but as a facet of relationships or as part of a culture [141]. TRs, STRs and PaCs form part of collective cultures by their involvement in the radiotherapy environment. Subsequently, individuals from each group were purposefully identified as those who would have opinions of compassion in cancer care which could be explored [103,104,126].

The selection of participants would provide data from perspectives across three distinct groups: i) TRs as allied health professionals responsible for the effective delivery of compassionate care, ii) PaCs for whom there is an expectation to receive compassionate care, and iii) STRs to provide a unique third perspective to the data. The STRs not only have their own experiential understanding from prior experience, but they are also being ‘taught’ how to be compassionate and deliver patient-centred care by both the higher education institution and the clinical setting in which they train.

A convenience approach to sampling individuals situated within each of the three groups was employed [104]. Thought to be sufficient for exploratory studies, a convenience sample enabled all eligible participants to volunteer for the focus groups (Table 4.1). This increasing the volume of relevant data on the topic being generated [103].

Table 4.5: Focus group participant inclusion criteria

Participant group	**Inclusion**
Therapeutic Radiographers	Health and Care Professions Council registered Therapeutic Radiographer Working at one of the three clinical sites Ability to provide informed consent Ability to speak and understand English
Student Therapeutic Radiographers	Student Therapeutic Radiographer enrolled on the Higher Education Institutions Pre-Registration Radiotherapy and Oncology programmes Ability to provide informed consent Ability to speak and understand English
Patients and Carers	Patient who had received a diagnosis of cancer and/or family members, friends or partner of a patient who had been diagnosed with cancer. Recruited via local cancer support centre and not the hospital. Ability to provide informed consent Ability to speak and understand English

Recommended participant numbers for focus groups vary slightly across the literature, with most advocating small, modest groups of around 4-8 [102,103,130,131]. Each focus group aimed to include five participants, a strategy of over-recruitment provided a contingency for attrition and non-attendance. The ambition was for each of the three categories of participants to have a planned total participant number of fifteen to thirtysix [125,129-131]. Quoracy was considered on an individual focus group basis but required a minimum number of two participants for it to not follow an interview design.

Alongside inclusion criteria, issues of accessibility were also considered. In addition, individuals across the three participant groups would not be traditionally classified as a difficult to reach, high-risk participants [104] or naturally fall into the Mental Capacity Acts category of vulnerable participants [142]. By addressing these factors this reduced any potential barriers to ethical approvals and recruitment.

Participants in attendance at the focus groups were asked to complete a demographic questionnaire prior to commencement (Appendix 9). Diversity of participants within the groups, although desirable, was not essential as the researcher acknowledges a representative sample across all the demographics could not be captured.

Recruitment strategy

The following strategies were employed for the recruitment of participants:

Student Therapeutic Radiographers

Approximately one hundred and eighty STRs were invited by email to take part in the research. This number incorporated all students enrolled in years one, two and three on the pre-registration Radiotherapy and Oncology programmes at the host higher education institution. Students were asked to contact the researcher if they were interested in being involved.

Recruitment also occurred through presentation at an extra-curricular research seminar. The students were asked to leave their name, email address and year of study on a form provided.

Students who expressed an interest through either method were emailed the STRs participant information sheet (Appendix 10) and a copy of the consent form (Appendix 11).

A date for the focus group was also provided at this time so the students could check their availability.

Therapeutic Radiographers

Registered TRs employed at the three NHS clinical sites across the north of England were invited to attend a focus group at their site.

To be able to recruit TRs as a principal investigator at clinical site A, a research passport was obtained. TRs were invited to attend the focus groups by email and through minuting the request for recruitment within the radiotherapy department's staff meeting. TRs were asked to contact the researcher if they were interested in being involved. Those TRs who expressed an interest were emailed the TRs participant information sheet (Appendix 12), a copy of the consent form and a date for the focus group.

At sites B and C, recruitment was completed by a principal investigator employed as a research radiographer at the respective clinical site. The same recruitment strategy as site A was employed at both sites. Those TR who expressed an interest were emailed the TRs participant information sheet, a copy of the consent form and a date for the focus group by their respective site's principal investigator.

Patients and Carers

PaCs were recruited at the three clinical sites, via non-NHS support centres located on hospital grounds.

At site A, contact was made with the management team at the local support centre. They were provided with details of the research and an agreement made for their consensual involvement in the research. A recruitment poster was placed at the support centre (Appendix 13). Arrangements were made for attendance at a monthly coffee morning to speak to potential participants. A verbal lay summary of the research was provided alongside a date for the focus group. Potential participants were provided with the PaC participant information sheet (Appendix 14) and consent form. Participants were informed they would be eligible for reimbursement of any travel expenses to cover the cost associated with attending the focus group. The name and contact details (email and/or phone number) were obtained from those who expressed an interest. With their consent, PaCs were telephoned twenty-four to forty-eight hours prior to the session as a courtesy reminder.

The same procedures detailed above were undertaken at sites B and C by their respective principal investigators.

Consent

As detailed, participants were provided with their respective group's participant information sheet during recruitment. Participants were invited to ask questions throughout the recruitment process and on the day of the focus group. Informed consent was obtained from each participant prior to the start of the focus group and their right to withdraw consent at any time was reiterated.

A carer who attended the focus group at site A was registered as partially sighted, but this had not been disclosed prior to attendance. The participant had attended alone so to ensure the principles of informed consent were maintained the participant information sheet and consent form were read aloud. On receipt of verbal consent from the participant, the facilitator signed the consent form. This process was witnessed by the moderator in attendance.

Power-imbalance

During phases one and two the researcher was employed as a senior lecturer at the host higher education institution. Working in this position could potentially create an unequal power balance. Undertaking both an academic and a research role could have led to a perception of coercion through an exertion of pressure on the STRs. Several measures were undertaken to limit this perception:

STRs were informed that the choice to participate or not would not affect their academic training, grades or continuation on the programme.

Information and communication were open and honest throughout the whole process. STRs were informed how expressing an interest did not contract them to attend, the focus groups were voluntary, and they could change their mind at any time. Transparency extended to other lecturers and colleagues involved with the programme, who were provided with information regarding the research. This allowed for students to be able to discuss any concerns with a member of the wider academic team.

All elements and timings of the study were designed to create minimal impact upon the students learning experience.

Psychosocial support

Compassion can be an emotive subject to discuss and trigger negative experiences. In the focus groups, PaCs were going to be asked to disclose and discuss personal experiences relating to their own or a loved one's diagnosis of cancer. Similarly, the TRs and STRs were invited to share their experiences of treating and caring for patients with cancer. Discussing a topic which refers to times of ill health, emotional and physical distress could potentially cause psychological upset in the participants.

As outlined in the pilot study, the decision to undertake focus groups considered the sensitivities around the topic. It was imperative the recruitment and procedural delivery of the groups respected theses sensitivities.

The voluntary nature of the focus groups was reiterated at each contact with the participants, including face to face, email and telephone discussions regarding their involvement. Participants were informed they could leave at any time. Needing some time-out and wishing to return or wanting to abandon their involvement were both acceptable and in their rights as a participant. Information relating to local support centres was available for the TRs and STRs. The PaCs focus groups were purposefully conducted within their local support centre where counsellors and centre staff were present to provide support if any distress arose.

Data Collection

Segmentation

The method was designed so that the focus groups were undertaken independently of one another, with no mixing of the three different participant groups. Three separate sets of findings were desired to facilitate co-construction in phase three; to enable three distinct perspectives of compassion to be incorporated in the construction of the definition and conceptual framework.

Conducting them independently allowed the voice of each participant group to emerge and findings to develop that were reflective of that group. However, identification of differences or similarities between the three groups was not in itself an important distinction which needed to be made. The research was not concerned with making direct comparisons across the three. However, it was important that variable and disparate findings could be established to facilitate the co-production of findings.

Similarly, the STRs focus groups were conducted as year groups, with no mixing of years. It was felt this would make the students more at ease by removing the power imbalance intermixing years could create. Each year group may have held different perceptions of compassion, influenced by academic delivery on compassionate care and increased exposure to clinical practice during their training. Students may have felt pressure to make their insights conform to students in higher academic years or vice versa.

Homogeneity within a group can create safer environments for discussion [102,103]. The three participant groups each held different social roles regarding compassionate practice. As social differences could induce variance, who attends can affect what is said in the session [103,126,143]. Undertaking the focus groups in this manner removed some potential power-imbalances across the participants groups [102].

It was anticipated the PaCs would give reference to the care received during clinical experiences as had occurred in the pilot focus group. Positive and negative compassionate examples were shared contributing to the richness of the data. Discomfort at disclosing negative experiences in a mixed group may have influenced what was shared. Potentially fearing repercussions on current or future treatment, concerned at being labelled as difficult patient or not wanting to appear as ungrateful for care they received.

Mixing STRs with TRs at the clinical sites could have formed an imbalance of power. TRs responsible for a student's clinical training may have been present, making them feel reluctant to disclose personal examples regarding their own perceived failings. There was also the potential of being judged by the TRs, or their disclosure effecting their clinical training or qualification.

It is however recognised that all potential power-imbalances cannot be removed. Different grades of TRs may attend, creating a managerial hierarchy, which creates a fear of repercussions. Furthermore, negative examples of compassionate care provided by TRs may be about a colleague of TRs present. They may have feared being branded as a whistle-blower for what they had disclosed. The ground rules outlined later, sought to address these possibilities by establishing respect and confidentiality amongst the group alongside equality of opinion.

Conducting the focus groups

Location

All focus groups were conducted in a quiet and private room. Years two and three students conducted at the host higher education institution. Due to timetabling demands a mutually convenient date for the year one students could not be arranged during term time. This took place instead at clinical site C with the STRs who were on placement there. It was reiterated that attendance was voluntary and not part of academic or clinical requirements. Focus groups with the TRs were conducted at their respective clinical site and the PaCs at the non-NHS support centres located at the three clinical sites.

To accommodate attendance and reduce the impact on staffing in department, two focus groups with TRs were conducted at sites B and C. Eleven focus groups instead of nine were therefore completed.

A moderator attended each focus group, serving two functions. Firstly, to ensure the welfare of participants was maintained acting as an impartial attendee, secondly to be a note taker.

Focus group guide

A focus group guide was utilised in all sessions (Appendix 15). The methods demonstrated for strengthening the rigour and value were incorporated into the focus group design. The concept analysis played an important role in the development, the review of the literature created the framework used in the research method.

The guide provided structure to the sessions, aiming to foster interaction and stimulate discussion of an appropriate depth allowing exploration of compassion in radiotherapy [131]. The same guide was used for all eleven focus groups, so the format did not deviate between groups. This process ensured the findings were not biased across the groups by the facilitator providing varying information of the topic.

The guide was reviewed by the North Trent Patient and Public Involvement group prior to use. The group reviewed all documentation including consent forms and patient information sheets, to ensure they were suitable for lay use.

Focus group format

To ensure participants understood the purpose and format of the session, the guide provided a brief introduction to the research and the format to be undertaken. Housekeeping provided participants with health and safety (fire alarms, exits etc) and comfort (toilets, refreshments etc.) information. Ground rules were established, and agreement made amongst the group for respectful behaviour and confidentiality of details discussed [143].

The focus group was designed as two sections to ensure the focus group would generate data to answer research questions one and two. This allowed enough time for discussion without stopping the flow to move on to the second part. Cutting-short discussion could bias the findings by preventing the emergence of new topics. Adequate time ensured the participants could speak freely about the topic until saturation of discussion occurred.

Part one of the focus group

In part one the structure was designed to be broad, in the first instance asking participants; “what do you think compassion is?” The aim of this question was to obtain general understanding and opinions of what compassion is, generating data for research question one. This question intended to outline the topic of interest without influencing discussion, ensuring the interactions were spontaneous and participant led. This also eased the participants into the session [144]. Prompts were included in the event that discussion was not triggered by the initial question, as focus groups rely on interaction to provide data [126]. The prompts also were broad, for example, “*where have you heard the term before*?” to ensure the question did not hold influence or heavily sway the response.

Part two of the focus group

On discussion drawing to a natural close, the second part was introduced. The participants were asked to read the scenario of *‘Frank’* the contrary case developed in the concept analysis (Text box 4.1).

Frank was attending his weekly review with the specialist radiographer; he had a review every week as part of his radiotherapy treatment for prostate cancer. He'd been worried for some time about problems he was experiencing with his erection and had wanted to ask someone, but he had felt too embarrassed. His wife had told him that he must speak to someone at his next appointment as it was becoming a problem for them as a couple. Towards the end of his review the radiographer asked him if there was anything else, she could help him with. Frank told her about the problems he and his wife were experiencing when they tried to have intercourse, to which she replied it's just an effect of his diagnosis and the radiotherapy treatment. Frank expressed that he knew this, but his original consultant had said there were some options and maybe some medication he could take. Reluctantly the radiographer nodded and replied this wasn't her area and so would go and ask a colleague for some advice. The radiographer exited the room into the main waiting area; leaving Frank sat alone with the door open. Whilst Frank was waiting he could hear laughter, listening in he heard his specialist radiographer saying, (laughing)…I know tell me about it and it his age it….(laughter), yeh good point I'll tell him to google it there be plenty of stuff on the internet for that kind of thing……well yeh, I suppose whatever floats your boat (laughter).

Textbox 4.1: Focus group scenario 'Frank' the contrary case

After reading about '*Frank*' the participants were asked "*what are your thoughts of this event*?" This section aimed to stimulate the participants to reflect upon those behaviours experienced by '*Frank*' and offer contrary suggestions for the TR's behaviour. The aim was to generate discussion on those behaviours synonymous with compassion for research question two.

Prompts had been developed if participants did not naturally offer recommendations for the TR's behaviour. The facilitator informed the group how the concept analysis has demonstrated compassion could be displayed through verbal behaviour, non-verbal behaviour and practical tasks. They were asked to think about these three classifications and offer suggestions what the TR could have done instead to display compassion.

Stage one data analysis

Phase two of the research involved completing eleven focus groups across the three distinct participant groups and led to stage one analysis which entailed thematic analysis.

There are three distinct processes involved in qualitative data analysis: preparing and organising the data, reduction of data into themes through a process of coding, and the representation of data [104]. Likening the analytical structures that underpin data analysis to ‘scaffolding’, Spencer, Ritchie, & O’Connor stress the importance of putting the right structures in place to enhance rigour [145].

Preparation and organisation

The focus groups were audio recorded and transcribed *in verbatim* to confer rigour [102]. *In verbatim* transcription preserves the respondents’ use of language that reflects their own individual experience [146]. *In verbatim* also enabled a return to the data during stage two analysis [143]. The eleven focus groups conducted created five-hundred and ninety minutes of audio recording. With nearly ten hours of data, a pragmatic decision was made to use the services of a professional transcriber in order to reduce the time burden [102]. The transcriptions were anonymised, with any identifiable details removed where appropriate.

Notes were made by the facilitator and moderator to record any salient features of group dynamics and impressions of key points which engaged participants [143]. These were converted in to detailed descriptive accounts used to supplement the data analysis process [102].

Integration of the data from the three participants groups was designed to occur at phase three (co-production). The transcripts were organised into three groups PaCs, TRs and STRs, so each type of participant group was collated together. Each group was analysed as a collective set of data but independently of the other groups (Figure 4.4).

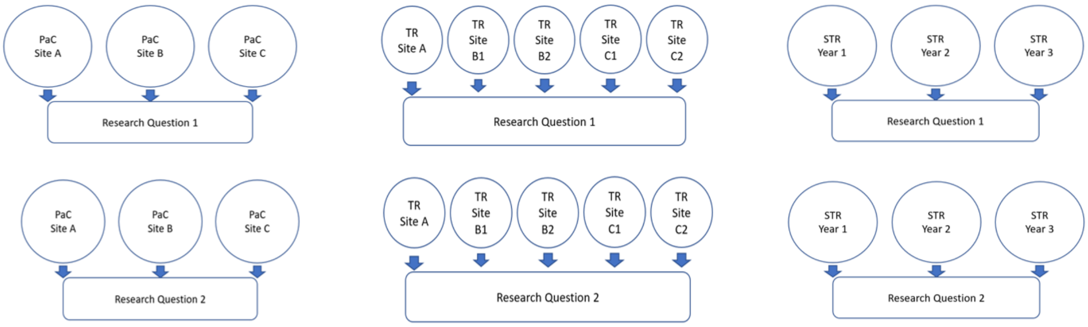


Figure 4.4: Categorisation and groups for data analysis

Quirkos data management software was employed during data analysis of the focus group transcripts. Quirkos enabled the eleven transcripts to be housed and organised within their representative groups. Full visual display of the transcripts provided easy access and quick interchangeability between the different participant groups.

Quirkos features tools which aided the process of organisation and analysis. Text was highlighted directly from the transcript using a ‘drag and drop’ facility. Whilst systematically reviewing the transcripts new codes called Quirks were created by highlighting and inserting relevant text. Where commonality of discussion occurred extracts from the transcripts were added to existing Quirk(s).

Familiarisation with the data

In order to compensate for the loss of familiarisation associated with self-transcription [143], several steps to promote ‘immersion’ into the data were undertaken:

Step 1: Every transcription was read in conjunction with listening to the audio recording to review the accuracy of transcription and ensure the reliability of the data [102,147,148]. Correct words and phrases, in-verbatim pauses/laughter/questions and the correct differentiation between facilitator/moderator and participants were all verified. A significant number of errors were identified during this process, which resulted in the transcripts being returned to the company for corrections. In order to ensure no further errors were present on the transcriptions all recordings were reviewed and then returned.

Step 2: On review and confirmation of transcription accuracy, it was uploaded on to Quirkos data management software.

Step 3: The audio recording and transcription were reviewed simultaneously [130], creating familiarisation with the data [149].

Step 4: The transcription was reviewed without the audio enabling focus to be on the written text.

Thematic analysis

Thematic analysis sought to identify and form patterns of meaning across the data set, aiding understanding of, and explaining the phenomena of compassion [102,139,150]. In accordance with the inductive nature of the research approach, categories emerged over the period of analysis directly from the focus group transcriptions. In this phase the analysis was not looking to identify a consensus regarding how compassion is defined or what behaviours reflect it [151], simply aiming to explore the differences of opinions across the individuals and participant groups. Thematic analysis was undertaken to examine, commonality, differences and relationships across the participants and participant groups [152].

Process of analysis

Thematic analysis did not begin until the completion of all eleven focus groups, as sequential analysis was not required. It was not the intention of the analysis to develop hypotheses or modifications which could be made to the remaining focus groups [102]. The research process sought consistency in the delivery of the focus groups and their generation of data to ensure equity across the different participant groups in alignment with the principles of co-production.

Two strands of data analysis occurred. The first to answer research question one, the second to answer research question two. The analysis strategy was originally designed so that the two research questions would be analysed simultaneously, but the vast number of codes emerging from the data made this process too complex. There was a risk the two research questions findings could become intermixed because of the volume of codes and limited number of colours within the software making it difficult to differentiate between them, potentially jeopardising the validity of the data analysis [149].

The analysis of the transcriptions was undertaken in two parts.

Part one: coding

The following procedures were undertaken to complete the analysis:

- A line-by-line review was undertaken, any relevant text was highlighted, and a ‘Quirk’ code created based on the content of the text.
- Discussions perceived to be related to the same theme were added to existing quirk categories [149].
- New Quirks codes were created when appropriate.
- This process was repeated a further four times to ensure data saturation of each transcript.
- The same process was repeated with each of the transcriptions. For example, year one STR followed the above process then year two, and then year three (Figure 4.4.). Additional Quirk codes were created when new themes arose within the discussions.
- Where themes were starting to emerge, codes were organised into loose clusters. This process organised the data into codes/themes for each participant group, for research question one (Appendix 16).

The process was then repeated for research question two (Appendix 17). Due to the experiential nature of the data, there was overlap across the two research questions. Discussion regarding participants’ views on what compassion is, was often supported by examples of compassionate practice and vice versa. Where this occurred, the data was coded and assigned accordingly, sometimes integrated into the Quirk codes of both research questions.

Part two: development of themes

The data codes for each participant group and each research question respectively was then reviewed. During the coding of the transcripts, emergent Quirk categories were labelled with language used by the participants. At this stage, the categories were relabelled where appropriate using inclusive language, aiming to incorporate as many distinctions in the data as possible [102]. It was important at this stage to review each group’s data codes to establish themes across them. To strengthen the reliability of the data analysis independent review of the transcripts was undertaken [147].

Using Quirkos, a system of indexing was established, visually reviewing the categories to establish, similarities, contrary and interconnectivity between categories [102]. The ‘drag and drop’ function was used to merge similar categories when duplicates were identified and designate categories as a ‘parent’ when subthemes emerged. Quotes assigned to each code were examined to ensure they were representative of the theme. If felt to not be reflective of the theme, these were removed or reassigned where appropriate. If a discrepancy between the researcher and reviewer occurred, a discussion of the theme/code ensued which was supported by the participant quotes. Any decisions were based on a mutual agreement.

Part two of the analysis process created thematic maps presenting the key themes and subthemes for each group for research question one (Appendix 18) and research question two (Appendix 19). The creation of these maps aided organisation of the themes and enhanced conceptual understanding of the data [149]. The detail of the thematic maps will be provided in chapter five.

It is important to note each group’s thematic maps remained separate at the end of the second part of the analysis as integration was to occur during the co-production workshops in phase three.

Data representation

The thematic maps were used to visually display the themes which had emerged from the data for each respective group. The maps represented what the participant group felt were the key components required to define compassion (research question one) and what represented compassionate display (research question two). Each theme within the map was supported by dialogue extracted directly from the transcripts.

A report was generated for each research question from Quirkos which collated all the quotes associated with each theme and subthemes. This data source contributed to the second stage analysis undertaken following the co-production workshops in phase three.

Qualitative validity and trustworthiness

Qualitative validity requires the researcher to check the accuracy of findings through procedural implementation [149]. Thus, ensuring the findings are correct from the standpoint of the researcher and the participants [153]. The following procedures were implemented to enhance qualitative validity.

Procedural implementation

To ensure authenticity and credibility of the finding's consideration was given to the focus group design, with strategies developed and implemented into the research process to ensure validity of the data and any emergent findings. Where appropriate this section is supported by a reflexive commentary demonstrating the implementation of strategies in practice.

Facilitation and moderation

The researcher's facilitation and level of engagement in a focus group requires a careful balance [125,143,154,155]. Too much involvement can direct discussion, findings could be deemed as influenced and biased. Too little can lead to discussions becoming too broad and removed from the research topic. A recurrent criticism of focus groups is their limited rigour, due to them being driven by the researcher as facilitator. It is argued however there is no hard evidence to suggest the impact of the researcher on the data is any greater than in other qualitative methods [126].

The focus group guide would only be successful in enhancing rigour if used in conjunction with effective facilitation. The facilitator needed to manage the group, stopping findings becoming weighted from the effect of negative group dynamics and the domination of discussion by individuals [156]. Balancing the discussion and ensuring equality without interfering with its natural flow or influencing discussions can be challenging but is essential. Effective facilitation skills needed to be employed across each of the eleven focus groups [143].

Disagreements and arguments deemed to be a potentially problematic situation for facilitators to encounter [144]. It can be argued how these situations are still producing valuable data for the analytical process [143]. Not so advantageous to the findings are those participants who dominate or interrupt the opinions of others or those who do not contribute. Competent facilitation can re-balance equality across the group by inviting other participants to speak and voice their opinion.

A key strength of the focus group method is its adaptability towards a personal research purpose [126]. By providing focus groups with a topic for discussion makes the data succinct with the research aims. The level of control the facilitator has on the discussion can however introduce bias. Heavily directing or influencing the discussion reduces the authenticity of the data, becoming researcher led instead of participant generated.

Ensuring the participants remain on topic is important, but deviation from the main topic should not always be considered as a negative occurrence. Over facilitation can lead to the loss of valuable discussion and potential findings by preventing participants to generate their own questions and concepts [126,130].

Accepting silence and ignoring the pressure to rush into using prompts is key, participants may be considering and formulating their answer. Using a prompt too soon may stifle and foreclose discussion [157].

All focus groups were conducted by the same facilitator to ensure any impact created by their style of facilitation was equal across all groups [158].

Sampling

The purposeful selection of participants alongside small sample sizes can affect the credibility of the findings. Transparency and understanding are required, recognising that the data is not fully generalisable to the wider population. By acknowledging the practice of segmentation and accepting the findings are representative of only a small sample of participants selected due to their experiences clarifies and enhances the rigour of the findings [147]. In this thesis, it is accepted how the co-produced discussion is only amongst those participants who were involved in the focus groups at that given time and place. The analysis however demonstrated strength and recurrence of themes suggestive of commonality and this will be addressed in the chapter seven.

Where possible and appropriate, opportunities to widen the participant pool were taken. Criteria for inclusion within the participant groups although was specific to them being a TR, STR or PaC was broad. Invitation was open to participants of all genders, races etc. all grades of TR and anyone with a relationship to an individual diagnosed with cancer.

The process was designed to include three clinical sites spanning across the North of England instead of a singular site to obtain a wider representation. Although this is still limited compared to the total number across the UK, many TRs will have worked or trained at other centres before working at their current centre. STRs represented not only the three academic years of the programme but attended from across the higher education institutions nine clinical training sites across the UK.

Without segmentation of ‘appropriate’ participants there is the potential for data to be generated which is not of value to the research. For example, if members of the general population had been recruited, they may not have experienced radiotherapy or a cancer diagnosis, so may not be able to discuss compassion within this context. Segmentation creates homogeneity which itself stimulates free-flowing discussion due to commonality within the group [126]. Homogeneity can provide the opportunity for comparisons to be made across the findings of different segmentations and this was apparent across the three participants groups.

Data analysis

Incorporating a strategy for secondary review of the data and its emergent findings enhanced the rigour of the research and reduced the potential of inter-rater-variability. Ensuring misinterpretation of the participant discussions did not occur therefore the emergent findings were true to and reflective of the participants discussions [102,147,151].

Involving another person to undertake a secondary review can have its limitations. It would be expected that the researcher has their own unique insight into the data, which would not be shared by someone who is independent [159]. The reviewer may therefore construct and assign their own meaning to the data base, creating their own interpretation. This may not however be a negative, instead adding analytical depth to data interpretation [102].

As will be identified later in this chapter, the co-production workshops were to serve as a process for obtaining member checking [147]. The tasks incorporated summaries of the focus groups key findings. This presented the research with the opportunity to ensure the emergent themes were reflective of the discussions.

Using Quirkos further enhanced the trustworthiness of the findings. The software works by allowing the user to highlight text and use a drag-and-drop method to allocate it to its relevant Quirk code. All quotes relevant to that code are there for accessible by clicking on the Quirk. If any difference of interpretation between the two analysists occurred, the participant quotes could be easily accessed and utilised to aid discussion until a consensus of meaning and interpretation was reached [147].

Peer debriefing and reflexivity

Debriefing has occurred throughout the research process between the focus group facilitator and moderator and the supervisory team. Open discussions have ensured the findings have emerged from the data, helping to ensure researcher integrity is maintained [147].

Completion of a research journal has provided a reflexive trail of the developing themes supporting the development of emergent categories and providing the opportunity to make comparisons across the data collection and analysis process [151].

Reflecting on the focus groups

Practicalities

Focus groups are reported to be a relatively quick, effective and convenient way to generate a lot of data in a short space of time [103,126]. The perspectives of multiple participants can be obtained in one session which may take weeks or months with other methods. As focus groups were to be undertaken at three different clinical sites with the three different participant groups, consideration needed to be given on the best method to maximise the effectiveness of the data collection. As the PhD was being completed on a part-time basis; limited time was available to travel to different sites frequently, so this had to be considered. Although a valid point, convenience does not simply come from being able to access multiple participants in one session. The volume of time and administrative effort that is required for the organisation of a single focus group is high [103] and often not appreciated. Many logistical factors can influence attendance, issues of participant availability, work and social commitments, access to locations etc. By the nature of the participant groups some patients and/or carers may have comorbidities affecting their ability to attend [160]. Additionally, there are costs associated with their completion, personal travel expenses, room hire, refreshments and travel expenses where appropriate.

To accommodate attendance and reduce the impact on staffing in department, two focus groups with TRs were conducted at sites B and C. Eleven focus groups instead of nine were completed, accentuating to demands on time and resources. The use of principal investigators at two of the clinical sites reduced some of the workload but overall, the focus groups were time consuming and challenging to arrange.

Focus groups were the most valid and valuable method for data collection, their undertaking would not change but consideration would be given to streamlining or potential reduction in number.

Facilitation skills

Although experienced in qualitative inquiry and facilitating focus groups, it was essential to certify facilitation skills were adequate to ensure the focus groups would yield sufficient data [102,103, 130,131]. Pilot testing had provided the opportunity to obtained feedback on the method of facilitation employed. This had been favourable with the moderator commenting on my ability to "*provide structure*", "*keep to time*" and "(say) *very little apart from asking individuals to expand or clarify*".

The moderator commented how respectful the participants had been of each other, expressing that "*perhaps may not be the case with a different group Amy will need to* *prepare for situations where some participants dominate or have difficulty voicing their views*". This feedback was addressed and although nothing can account for real world practice, numerous guides on how to undertake effective facilitation were consulted.

The moderator provided feedback on each focus group and the methods of facilitation used at each subsequent debriefing. It was commented how (I) had "*handled the participants well"*, "*kept the discussion balanced*" and "*effectively facilitated the group whilst remaining detached from it"*. With the completion of each focus group came an increase in confidence to undertake the next.

Phase two summary

The focus groups generated discussion on the topic of compassion and compassionate display within radiotherapy. This discussion provided a large volume of data, sufficient for a comprehensive process of analysis to be undertaken. The analysis resulted in findings to be established which separately reflected the perspective of the three participant groups for both research questions. Thus, enabling the research process to take forward and co-construct the findings in phase three.

Phase three: Co-production

On completion of the focus groups analysis, a method to integrate the findings from each of the three participants groups was required. During this process, it was vital the voices of each participant group would be independently heard whilst facilitating co-production of mutually agreed co-constructed findings. An expansive volume of data had been generated across each of the groups, so this phase also served a secondary purpose of data consolidation.

Phase three was designed to follow phase two, which was three co-production workshops, with the aim of gaining consensus across the participant groups. As a means of triangulation, the intention was to take the findings from the workshops to the North Trent Patient and Public Involvement group (Figure 4.5). The following section will detail the processes involved, addressing their role in the co-construction of findings and second stage analysis.

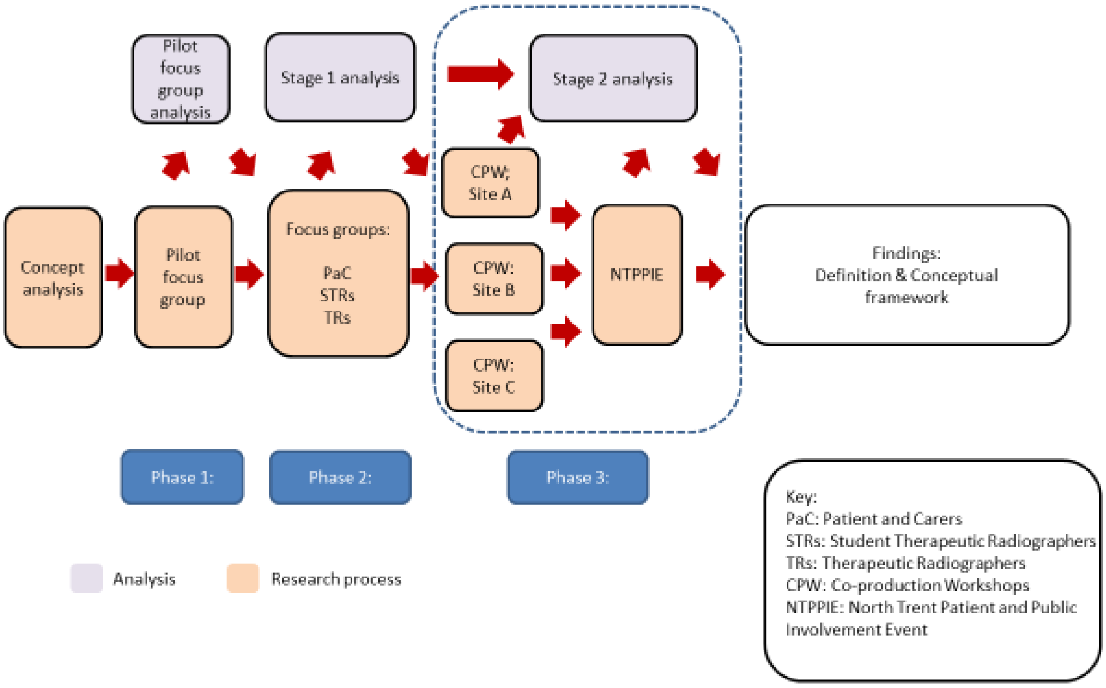


Figure 4.5: Research process – phase three

Co-production Workshops

Overview

A co-production workshop was undertaken at each of the three clinical sites where the focus groups had originally taken place. Having multiple workshops aimed to promote attendance by increasing their accessibility to the participants. Participants were required to work in groups to complete three tasks.

Sampling and Recruitment

At the end of each focus group in stage two, the participants were informed of the co-production workshops and their purpose. They were asked if interested in participation, to leave their name and contact telephone and/or email.

On securing a date and facilities, those interested participants were invited to attend via email or telephone. Contact was made by the principal investigator at each clinical site. The invite was also open to those who had originally expressed an interest in attending a focus group but were unable to take part at that time. Participants were informed how participation was voluntary and they could refuse to attend at any time. Travel expenses were offered to those choosing to attend.

Workshop format development

Until phase two was completed, the level of integration required was unknown. Similarly, what findings would require integrating could not be established. The process however needed to promote consolidation without diluting or losing valuable findings through over synthetisation.

The design of phase three was based upon four objectives:

1. To facilitate the collective working of the three different participants groups to agree and co-construct the findings.
2. Alignment to the philosophical principles of knowledge and understanding being socially constructed.
3. An ability to integrate the nature of the findings emerging from the focus groups.
4. The ability to generate responses to research questions one and two.

To ensure all four elements were achieved, co-production workshops were inductively designed based on the findings of phase two. They incorporated three distinct tasks, each generated emphatically from the focus group data [112].

Task 1a: Exploration of compassion themes

During the focus groups, the PaCs shared their experiences of communication. It emerged from the data the ways in which TRs and healthcare professionals communicate bad news to patients and those attending with them can differ significantly. Three extracts specific to these experiences were taken directly from the transcripts. Within two of these, the communication styles were perceived to be unmistakeable. In one, the participants who discussed this example clearly felt the healthcare professional’s behaviour was non-compassionate (Textbox 4.2). Whilst the other was regarded as compassionate by those attending the focus group (Textbox 4.3). The third however appeared to be ambiguous. The participants attending that focus provided different interpretations of the healthcare professionals’ behaviour (Textbox 4.4).

The extracts were modified slightly to ensure patient anonymity, remove any repetition and details which attendees may have found distressing. The structure was tweaked to make them easier to read and understand during the co-production workshops in accordance with the principles of lay-member involvement [161].

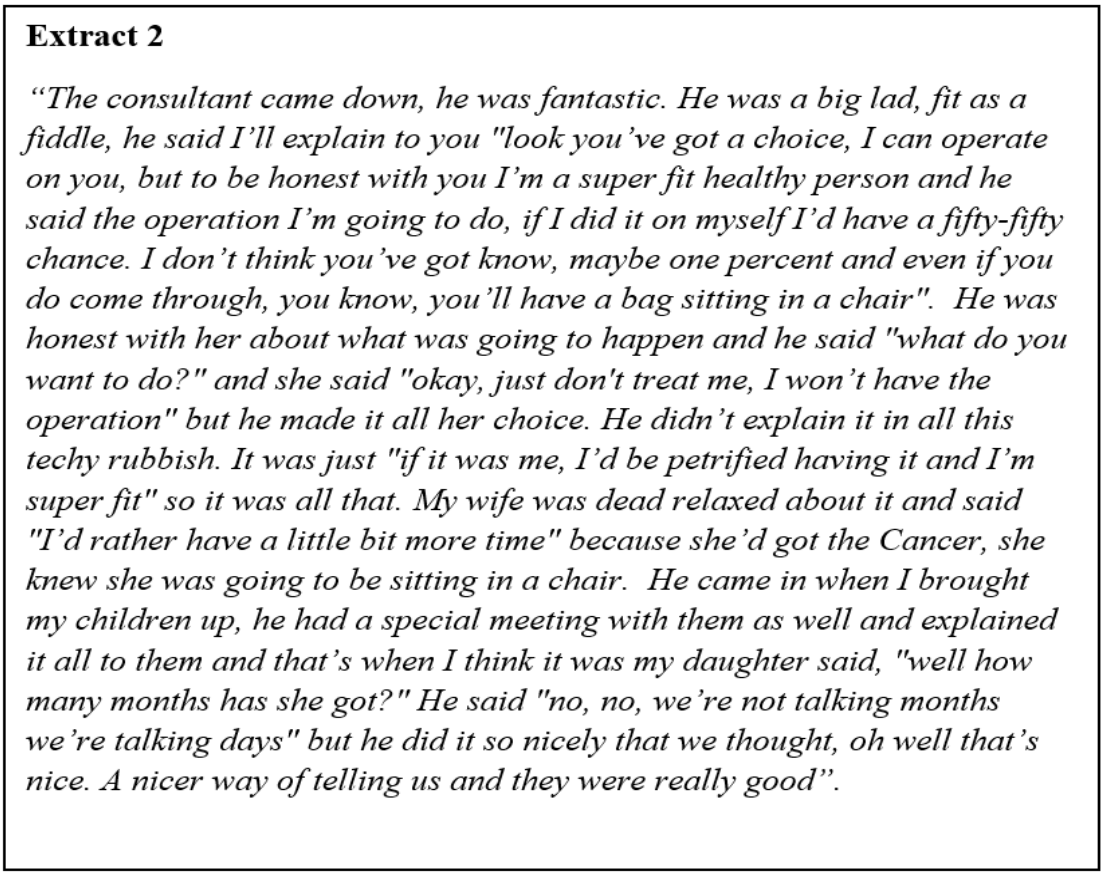
Discussion of these extracts was to serve two purposes. Firstly, used as an opener, intending to stimulate the participants within the groups who may not know each other to begin the conversation. Secondly, the extracts provided some context and background to the findings from the focus groups. The extracts gave an indication of some of the key themes on compassionate practice which had emerged from the data, thus, helping the participants to situate themselves within the topic area.

Task 1a was designed so that each of the groups within the workshop would review one extract within their group, discussing how it did or did not signify compassion and then feed back to the collective workshop participants.

> **Extract 1:**
>
> *“I was on my own with the Radiographer, she said "right I need to do an appointment for you for your result, can you come in next Wednesday at such and such a time?" and I went “no, I can’t, I’m in a meeting at work”,. She replied, “well you should come back for your result” and I said “but we’d been told that even if you have to have all these tests it doesn’t mean anything until you get a definitive diagnosis and that you shouldn’t worry, so there should be nothing for me to worry about as they haven’t even checked the sample yet”. She looked at me and said “having looked at your radiogram I’d be worried, I have done lots of these and looking at what I can see I’d be worried. Do you want that appointment next Wednesday?”*

Textbox 4.2: Extract 1 – non-compassionate communication

Extract one was selected as it was felt by the patient who shared it and other participants in attendance to represent non-compassionate practice. The participant believed her diagnosis was not communicated in an appropriate way and the radiographer’s approach resulted in the patient being unprepared to receive it, further adding to her distress. This was attributed to the way the radiographer had delivered the information. The participants believed it was outside of the radiographer’s professional role to communicate this, perceiving instead it to be the consultant’s responsibility.

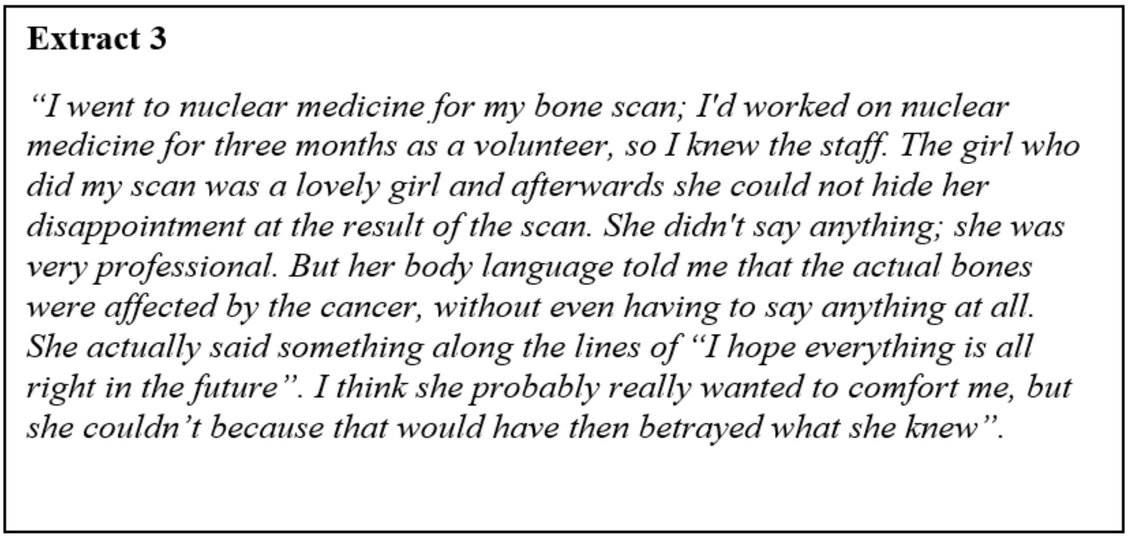


Extract 2

“The consultant came down, he was fantastic. He was a big lad, fit as a fiddle, he said I’ll explain to you "look you’ve got a choice, I can operate on you, but to be honest with you I’m a super fit healthy person and he said the operation I’m going to do, if I did it on myself I’d have a fifty-fifty chance. I don’t think you’ve got know, maybe one percent and even if you do come through, you know, you’ll have a bag sitting in a chair". He was honest with her about what was going to happen and he said "what do you want to do?" and she said "okay, just don't treat me, I won’t have the operation" but he made it all her choice. He didn’t explain it in all this techy rubbish. It was just "if it was me, I’d be petrified having it and I’m super fit" so it was all that. My wife was dead relaxed about it and said "I’d rather have a little bit more time" because she’d got the Cancer, she knew she was going to be sitting in a chair. He came in when I brought my children up, he had a special meeting with them as well and explained it all to them and that’s when I think it was my daughter said, "well how many months has she got?" He said "no, no, we’re not talking months we’re talking days" but he did it so nicely that we thought, oh well that’s nice. A nicer way of telling us and they were really good”.

Textbox 4.3: Extract 2 - compassionate communication

Extract two was selected as a compassionate example because the carer expressed how “*good*” the consultant was at communicating the news of his wife’s prognosis to them and later to their family. The carer attributed this to the directness of the information and honesty afforded to them. This coupled with the consultant understanding what his wife wanted and most importantly her being provided with a choice.



Extract 3

"I went to nuclear medicine for my bone scan; I'd worked on nuclear medicine for three months as a volunteer, so I knew the staff. The girl who did my scan was a lovely girl and afterwards she could not hide her disappointment at the result of the scan. She didn't say anything; she was very professional. But her body language told me that the actual bones were affected by the cancer, without even having to say anything at all. She actually said something along the lines of "I hope everything is all right in the future". I think she probably really wanted to comfort me, but she couldn't because that would have then betrayed what she knew".

Textbox 4.4: Extract 3 - ambiguous compassionate communication

Extract three was chosen as an ambiguous case because although the healthcare professional had not directly shared any information to the patient, he perceived her verbal and non-verbal communication had informed him of the bad news.

Task 1b: Constructing a definition (Research question one)

Research question one aimed to co-construct a definition of compassion across the three participant groups.

Analysis of the focus group transcriptions created three thematic maps. Each map contained the components which each participant group believed defined compassion. Across the three groups there were nineteen components in total.

This task was designed to achieve integration of the components which reflected the three groups' definitions. Each group in the workshops was provided with the combined nineteen components emerging across the focus groups as defining compassion (Figure 4.6). The participants in each group were instructed to work together to select which, if any, they felt they would choose for their collective definition of compassion.

Figure 4.6: Task 1b -Nineteen components defining compassion

Task 2: Agreeing Compassionate Display (Research Question Two)

The focus group analysis of research question two generated three thematic maps, one for each participant group. These contained categories of behaviours which each participant group felt represented compassionate display. These were collated and combined, totalling one-hundred and twenty-three. Whilst becoming a collective list and providing an overarching view of the key themes, this data however did not identify if there was a consensus of opinion amongst the three participant groups. One-hundred and twenty-three categories were also felt to be too many, hindering the development of a concise and effective conceptual framework. This task therefore was designed to establish a collective consensus on the key elements of compassionate display whilst eliminating those which may not be representative of it.

The participants in each group were provided with the one-hundred and twenty-three categories. They were asked to work together to collectively agree the top twenty which they felt were representative of compassionate display (Figure 4.7). Those selected were included in the analysis of the workshops (stage two analysis), those not selected were eliminated.

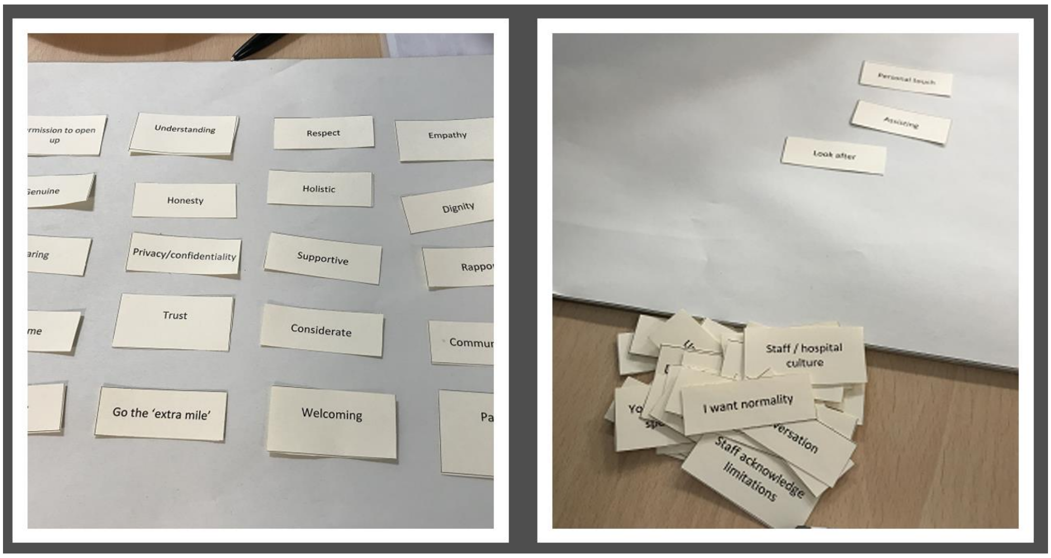


Figure 4.7: Task 2, categories of compassionate display.

In addition to facilitating the co-construction of findings, tasks 1b and 2 also served as a process of member checking. The key themes and findings emerging from the data were presented to participants who had originally been involved in the focus group. This provided an opportunity to review the authenticity of the themes developed [147].

At no point during the tasks were the participants informed from which participant group the findings had emerged from. This aimed to reduce any potential bias of participants selecting the key themes which had emerged from their own respective group.

Qualitative validity and trustworthiness

Many of the principles of qualitative validity identified within focus groups can be applied to the co-production workshops. Although the central aim was not to generate primary data, the outputs from the tasks and associated discussion still had to be captured to support the co-produced findings. Subsequently all tasks were designed to provide a physical output either written or diagrammatic. Attendees were encouraged to make notes and the workshops each had a facilitator and two moderators present to record any supplementary information.

Equality, co-operation and participation are essential to create meaningful involvement within co-production, and appropriate structures must be in situ to support those involved [162]. By knowing their opinion and contribution is valued, enhances attendee's level of engagement and can address issues associated with compliance and attendance [112].

Individual skills and abilities needed to be accounted for in the design of co-production tasks. For example, reading and writing skills may have differed across the attendees and this had to be considered especially as the attendees were required to undertake the completion of tasks [102]. The design aimed to ensure no participant was disadvantaged. The same strategies for inclusivity employed during focus groups were transferred to co-production.

Undertaking the workshops

The three workshops took place in a private and quiet room away from the main clinical department. The workshops were scheduled to last for three hours; this included a break for food and refreshments which were provided for the attendees.

On arrival the participants were purposefully given a table to sit at, allocating them to a group. This was done to ensure there was an equal mix where possible, of STRs, TRs and PaCs within each group. This aimed to ensure that when completing the tasks there was representative voices from each participant group. Each table had a moderator allocated to support the group work. Each group were provided with flipcharts, pens and sticky notes to aid completion of tasks and record discussions and ideas.

A co-production guide (Appendix 20) was utilised to direct the structure and timings of the workshops and tasks.

At the start of each workshop a brief overview was shared with the participants of the research conducted thus far. This provided the context and purpose of the sessions. It also served as a potential memory refresher for those that were able to attend the focus group and aid understanding of the research for those who were not present.

The format of the workshops was explained, addressing the expectation for them to complete three tasks and the collaborative nature of the tasks. It was explained that details related to each individual task would be given prior to the undertaking of each. This aimed to reduce the burden placed on the participants by providing too much information at once [163]. Mirroring the focus groups; housekeeping provided participants with information on health and safety (fire alarms, exits etc) and comfort (toilets, refreshments etc.).

Ground rules were established and agreed amongst the group to ensure respectful behaviour was maintained. It was expressed how no opinion, theme or finding was more influential than another. Privacy amongst the group and the information discussed inside the room was agreed.

The participants were informed that because the tasks had been developed from the findings of the focus groups it meant some of the things they may have discussed as an attendee could be voiced today. They were made aware these had been anonymised, but if they wanted to reveal it was their experience or comment there was no obligation to do so, it was their decision. This also meant the participants needed to be aware that difficult conversations may arise, and emotive topics discussed. They were informed they could leave at any time and that information relating to support services would be provided if required.

It was explained how the facilitator and moderators were there to listen and help, not give their opinion, it was the participants voice, their experiences and their opinions that mattered.

Site B workshop

The first co-production workshop took place at Site B. Participant numbers were enough to create three groups. Feedback from the participants alongside observations from the facilitator and moderators influenced modifications to the remaining two workshops. A summary of the key points of the workshop is now provided.

Task 1a

Once each group had finished reviewing their extract, the other two extracts were provided for them to read. This action was not designed to stimulate further in-depth discussion. It aimed to provide the groups with a context of the other two extracts in preparation for coming together as a collective group to review and feedback. Receipt of the contrasting extracts however provoked much additional discussion about their original scenario, providing them with a comparison. The timings on the day were altered to facilitate the participants to continue with their discussions as it appeared counterintuitive to the aim of the workshops to supress this. These discussions were captured on flip charts created by the participants and notes by the facilitator and moderator.

Due to the volume of rich discussion and data to support the categories during the deliberations of extract three, the decision was made that all three subgroups would review and discuss all extracts in the remaining two workshops. Modifications were made to the timings, as the workshop at Site B had demonstrated all tasks could be completed within the allocated time.

At site B the participants had been provided with one copy of the extract per group. It was observed how this practice increased the time taken to review as the participants had to pass it around the group to read. It also made it difficult for participants to refresh their knowledge of it if another member of their group was reading it. To reduce the time required to complete the task and aid discussion at the next two workshops a copy of each extract was provided for each participant.

Task 1b

All groups were provided with the thematic maps containing the components each participant group believed defined compassion. They were also provided with an envelope containing those same defining components of compassion cut into nineteen individual segments. The groups were asked to work together to select which ones, if any, they felt defined compassion. They were asked to use their flip charts to organise how they wished and tape their chosen segments down so a record of their choices could be kept. Like in task 1a, this task prompted much discussion amongst the groups.

Participants had been asked to leave any comments or feedback they had on sticky notes. One comment indicated there had been some confusion about this task (Textbox 4.5). In preparation for the following workshops the instruction for the participants were made clearer. In addition, a copy of them was provided to each group so they could refer to if required.

> *"I thought the task where we had to order the words together which we felt dealt with compassion and a patients experience could have been elaborated on a little more. I think some of the people in my group misunderstood the task".*

Textbox 4.5: Site B participant feedback

Task Two

The groups were provided with the one hundred and twenty-three categories emerging across the focus groups to represent compassionate display. The groups were asked to discuss and collectively select the twenty of them that most highly reflected compassionate practice. They were informed those not selected would be eliminated.

Some participants found this challenging, expressing their guilt at eliminating categories thought to be important by others. Other participants however were happy to eliminate categories, some of which they felt held similarities with others or were simply not representative of compassionate practice.

All participants within the groups worked together to select their twenty. They openly and respectfully discussed each category. They followed a process of discarding several categories immediately, deciding on potential categories that required further conversation and a group they had established as definitive.

Overall structure

It was observed how participants in the group overseen by the facilitator often directed their discussion towards them. This appearing like the participants were seeking approval or opinion on what they were saying. It was reiterated to the participants that it was their opinion that was of interest. Subsequently, for the next two workshops the facilitator did not stay with one group, instead they rotated round the groups to observe the discussions.

Site A workshop

The second co-production workshop took place at site A. Participant numbers were enough to create three groups. The workshops followed the modified format which had been developed on completion of the workshop at site B.

In summary, the modified format worked well, there were no further comments or feedback about limited understanding of the tasks demonstrating the modification had been effective. Each task ran to time, resulting in all tasks being completed.

Due to departmental staffing levels a couple of TRs and STRs had to leave before the end of the session. Fortunately, they were all in different groups which meant there was enough numbers within each group for their discussion and tasks to continue. There were also other TRs and STRs in those groups, so a representative voice was maintained. The discussions across all the tasks were rich and in-depth

Site C workshop

The final workshop was undertaken at site C. All tasks were completed in the allocated time. In comparison to the previous two workshops, this one was challenging to conduct with incidents and behaviours occurring, which had not been present in the previous two. These included issues with attendance and some dominance within the group, the issues around these are detailed below.

Participant attendance

There was a limited number of attendees (n=8) at site C’s workshop, compared to site A (n=16) and site B (n=15). Participant numbers were originally enough to create two groups. The workshop was also affected by several issues related to recruitment.

Patients and carers

During liaisons with the site's principal investigator, the purpose and format of the co-production workshops had been discussed. The importance of representation from each group had been established and incorporated into the recruitment strategy.

On the day of the workshop the principal investigator had explained there would be no PaCs from the focus groups in attendance. There would however be two department volunteers who had direct carer responsibilities for a family member with cancer, however they did not attend. This meant the perspectives of the PaCs were not represented during co-construction at site C.

Therapeutic Radiographers

Attendance for the TRs had been agreed with the head of radiotherapy and arrangements made to minimise disruption to service delivery. These arrangements had unfortunately not been communicated to the participants or the department. Many felt they had to leave the session early, feeling pressure from the clinical colleagues to return to their duties. This had a significant impact upon the format of the workshop. This coupled with the small number who had been able to attend resulted in the groups being merged after task 1a. TRs continued to leave and by the end there were only three participants remaining (Figure 4.8).

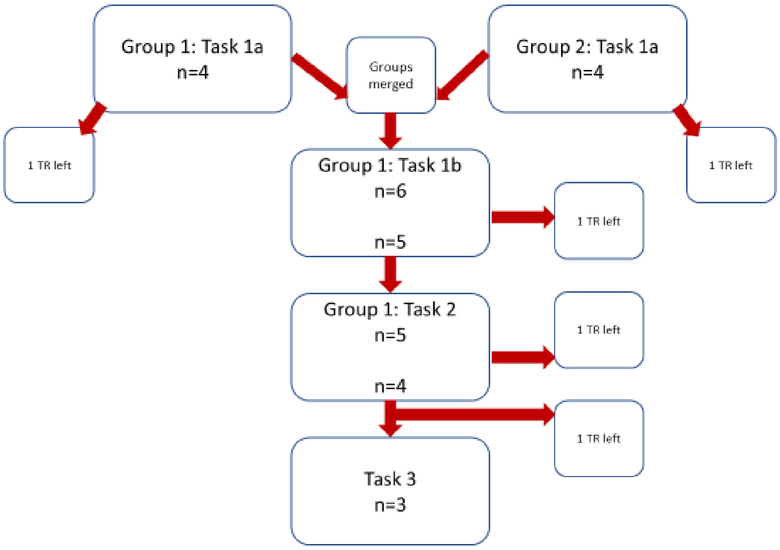


Figure 4.8: Structure and modification of workshop groups.

Dynamics

There was a significant difference in the way the groups worked together; the dynamics were not the same as what had been experienced at sites A and B. On arrival the attendees sat down and immediately got out their phones, there was no engagement or discussion with other people on their table. At Sites A & B all the participants had started chatting to one another, introducing themselves and having general conversations etc. (Table 4.2).

Table 4.2: Differences in dynamics across the three sites.

Site C	**Sites A & B**
On-phones	Friendly
Heads down, closed body language	Open body language
No chat	Chatting/engaging - finding out about each other

As the participants worked together, they maybe did not need to introduce themselves or feel the need to initiate general chat and the atmosphere in the workshop appeared to feel ~~cold and~~ impersonal whereas the other workshops felt welcoming and friendly.

Disrespectful Behaviour

During tasks 1b and two, the facilitator and the moderator were uncomfortable with one of the TR participants who became ~~very~~ domineering in the decision-making process. In the previous co-production workshops, all the group members worked collaboratively and mutually agreed their decisions. At Site C, one group member had tried to make all the decisions, instead of engaging others they made decisions on behalf of others. The facilitator and moderator tried to engage the other participants in discussion.

When reading out some of the behaviours arising from the focus groups that were reflective of the PaCs themes the participant changed the tone of their voice. Although it was not disclosed which behaviours came from which group, the language and phrasing used e.g. "I'm a human being", I'm not a statistic" and "I want normality" indicated they were from a receiver of compassion perspective. It appeared like the participant was mocking and being dismissive of those themes whilst placing them on the exclusion pile. The TRs behaviour appeared disrespectful towards the other attendees indicating their opinion did not matter. It was also discourteous to the focus group participants as these categories had emerged directly from their perspectives. Their behaviour suggested other people's opinions on what demonstrated compassionate display were not valid or as important as their own.

This behaviour influenced the way the group worked together compared to those the other workshops. Discussion was sometimes controlled by the one individual rather than being shared and they appeared to not listen or be interested in the opinion of others.

Professional behaviour

At the end, the group were asked if they felt the workshop would have been different if PaCs had attended. The TR who had dominated the discussion believed it would have been different in the following ways:

- They would have hung-back and not spoken so much.
- They would have let the PaCs express their answers as they have received direct experience of compassion within a healthcare environment.
- They would have been more respectful.
- They wouldn't have used some of the language which they had used.
- They would have made notes about what the PaCs were saying so that they could learn from their experiences.
- It would have altered the dynamic.

Although welcoming to hear the TR indicate they wouldn't have behaved like that if the PaCs had been in attendance, it may be argued how this does not excuse or nullify the disrespect they showed to the opinions of others whether present or absent.

Reflexive account

The workshop at site C was challenging to undertake and I had to work hard to ensure that everyone had the opportunity to provide their point of view. The moderator and I conversed about the domineering TR and how they had made us feel uncomfortable. We could tell though the body language and the low level of engagement from the other TRs and STRs in attendance the individual was making them uncomfortable to speak up and share their opinion.

Student Therapeutic Radiographers

A power imbalance was demonstrated during the tasks. One student who was firmly disagreed with by the TR did not speak again after this had occurred. A second STR tried to voice a differing opinion but then simply agreed with what the TR after they spoke over them.

Therapeutic Radiographers

The TR was a higher grade than any of the other TR who attended, creating a hierarchy, potentially reinforced by their specialist role. The TRs may have felt like they would be perceived as being non-compassionate if they expressed a conflicting viewpoint.

Why it was important for patients and carers to attend

Although processes were put in place to limit hierarchical impact, all power-imbalances could not be eliminated from the research. Involvement of the PaCs however I feel would have reduced the impact of hierarchy by the necessity for the TR to behave more professionally in front of the PaCs. The answers the domineering individual gave when asked this I feel demonstrate this.

Throughout the session it was apparent that the discussion and opinions given were very working/practical/role focussed. This sounds obvious as those in attendance were either working as or training to be a TR. Not having the PaCs in attendance made this issue more prominent. For example, the TR's expressed "*well we do that anyway*", "*that's standard*" and "*that's part of the role*". At no point did they consider that a PaCs may consider that element as compassionate and therefore is required to be undertaken as part of their role.

To me it was clear that having the PaCs missing from the workshop altered the outcomes of the tasks as their perspective was not always represented in the participants' choices. It also altered the dynamics and the behaviour of the group.

I also found the non-attendance of the PaC disappointing for several reasons:

- The feedback received from the workshops at sites A & B identified how much enjoyment the PaC had experienced by attending. They also expressed the gratitude they felt for being invited to take part. They were happy their views had been welcomed, valued and respected and they were contributing to research that they felt was important. It's was very disheartening to think this opportunity had been taken away from the PaC at this site.
- Listening to and learning from individuals' constructs of compassion based upon their experiences, belief systems and values are at the heart of social constructivism. To eliminate a voice from the construct opposed the ethos and the purpose of the research. Going against what I was aiming to achieve.

Volunteers in co-production

It has been proposed that people only volunteer to be involved in co-production because they have a material interest in doing so [113]. The co-production attendees were not offered a financial incentive to be involved. The PaCs were offered travel expenses to attend the focus groups and the workshops. Each PaCs however refused to accept or claim any money. They expressed that involvement in such an "*important piece of work"* was an "*honour*" and a "*reward*" in itself.

During the recruitment phase it was commented by patients how frustrated they felt when there were no clinical trials open to them. They explained this desire for enrolment was not down to a potential benefit for themselves (e.g. the chance of drawing the new drug arm etc.) rather the opportunity to improve the treatments and care for future cancer patients by generating the evidence base. This was mirrored by carers, friends and family members who welcomed the opportunity to be involved in research that could help others as traditionally research was not accessible to them. The numbers of PaCs volunteering to be involved during the research process, alongside the positive comments and gratitude received was often overwhelming. Hearing the level of support for the research affirmed the importance of the topic of compassion within radiotherapy and the potential impact its findings could have.

The gratitude for "*being allowed*" to be involved also confirmed the decision to undertake a co-production method. Being involved in co-production programmes is believed to make an important contribution to people's physical and mental health [120]. Co-production provided PaCs with an opportunity to contribute to a topic they felt passionately about, giving them a means to help others which to them was their reward.

Co-production workshops summary

Despite the challenges faced at site C, the use of the three tasks at the co-production workshops successfully integrated and consolidated the phase two findings. Although no PaCs representatives were present at Site C, this did not affect the conclusions drawn from the co-production stage as the findings were considered and combined across all the three sites.

Co-production data integration

Three co-production workshops were conducted; seven groups across the workshops completed the tasks, generating seven sets of co-constructed findings. A second stage of data integration was required to collate these sets of co-created definitions and mutually accepted categories of compassionate display. All notes made during facilitation of the sessions alongside those created by the participants were incorporated into this process adding to the richness of data.

Task 1b had enabled the participants to choose the components which they felt defined compassion. Once reviewed and duplicates were removed, seven components had been selected. Although these components were felt to define compassion, they were not a coherent definition which could be applied and understood.

Across the groups one hundred and forty categories of compassionate display were selected in task two. After duplicates were removed sixty-two behaviours remained. Participants had expressed during the workshops there were similarities in some of those categories chosen. Seven categories were merged with another category felt by the participant to represent the same behaviour (Table 4.3). Although **check for understanding** and **person-centred** had not been selected during the workshops the decision was taken to merge with check understanding and patient centred respectively. This would ensure the inclusion of the data from the focus groups would be incorporated into stage two analysis.

Table 4.3: Post co-production workshops category mergers and rationale.

Original	**Combined with**	**Rationale**
Taking time	Spending/giving time	Both represent allocating your time for another.
Hear me	Active listening	Hearing an individual is part of Active listening - to hear and acknowledge what is being said to you.
Not making me feel guilty	Non-judgemental	By being non-judgemental you are not judging or assigning your own beliefs on to that person to make them feel guilty.
Check understanding	Check for understanding	Both are the same thing; you are checking that they have received and understood the information communicated to them
Appreciation and support of family	Caring for carers	Both are the same thing; you appreciate what those in the wider network of the patient are going through and aim to care for those individuals as well.
Identification of needs	Appreciation of needs	Identification is part of the definition outline by the work, whereas this is a different concept to appreciate them not just find out about them
Patient-centred	Person-centred	Aligns with the humanistic element of the work focusing on the person rather than the patient.

After the categories were merged fifty-five behaviours remained (Figure 4.9). Although the behaviours which the participants felt were representative of compassion display had been established the breadth of these was broad. There were no commonality or relationship displayed across the findings and this was required to aid conceptual understanding.

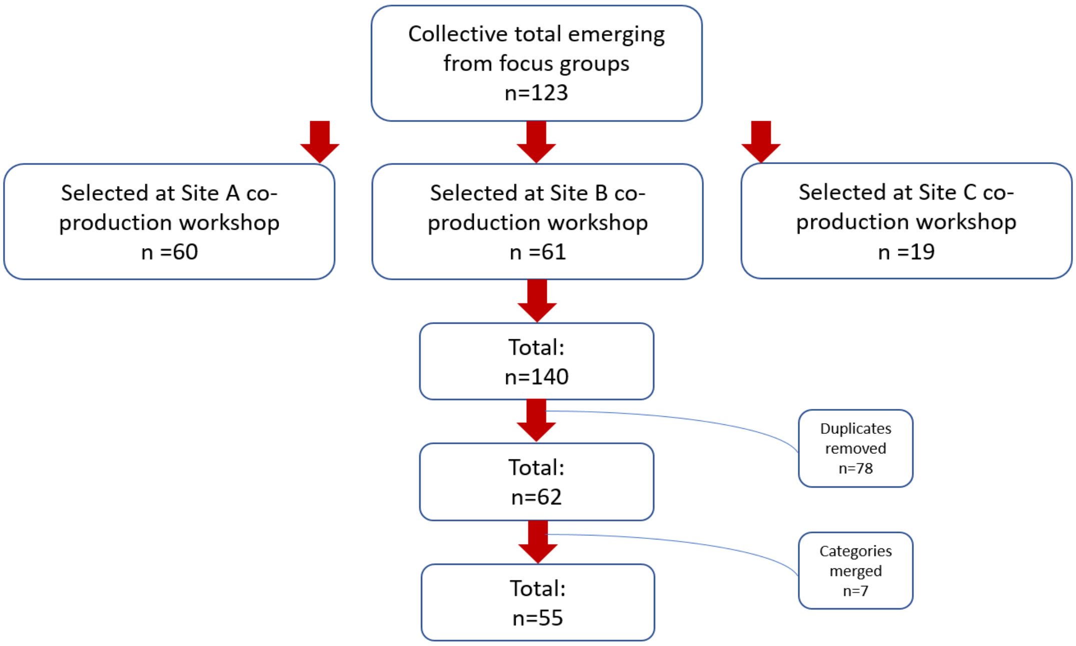


Figure 4.9: PRISMA diagram of exclusion process of compassionate behaviours

The North Trent patient and public engagement

Following the co-production workshops and process of integration, the co-constructed findings were taken to the North Trent Patient and Public Involvement group. This process served two purposes, firstly, to bring coherence to the co-produced definition. Secondly, to help establish themes and relationships across the fifty-five behaviours, aiding the development of a conceptual framework. It is important to note how the opinions from the group members were not designed to overrule the findings from the focus groups which were co-constructed during the co-production workshops. Its purpose was to support the stage two analysis, not to generate new meanings or interpretations of the findings.

The North Trent group had been involved to provide a lay perspective on the research design throughout the process. Bringing strength to the method by having a strong patient and public involvement plan, designed to span the length of the work [161,164]. The group is well-established, composed of people who have experienced cancer as a patient or carer.

Engagement event format development

Task one (research question one)

In the workshops all seven groups had selected **identification of needs, understanding of the person** and **meeting needs** to form part of their definition of compassion. This occurrence indicating all co-production participants believed these three were fundamental in defining compassion. These three behaviours became definition one, the core definition of compassion (Figure 4.10).

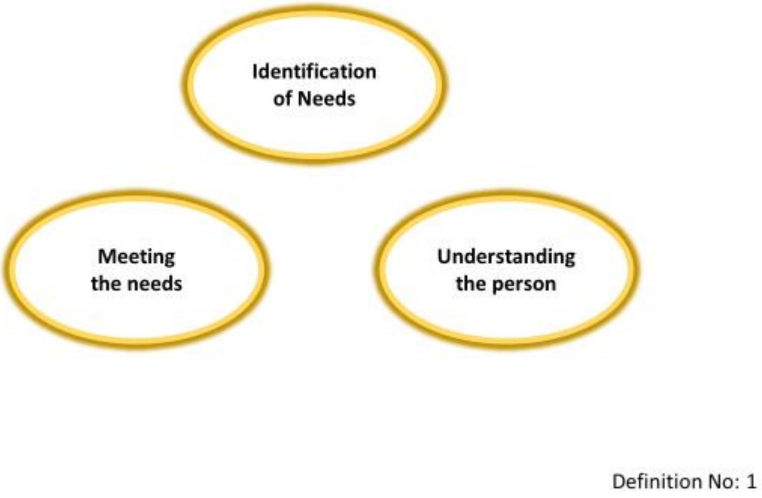


Figure 4.10: Definition one - Core definition of compassion

Communication, connection and listening emerged from all participants groups as codes during the focus group analysis. They became part of themes across the groups not distinct themes in themselves. Despite not being part of the original nineteen themes which emerged from the analysis, all the participants in the workshops noted these three were a component part of compassion. Theses perceptions were unanimous across the workshops. **Communication**, **connection** and **listening** subsequently became part of the themes alongside **empathy** which had also been selected. Their relationship with the other behaviours and preference of selection in the workshops was reviewed. These four were then used in combination with the core definition of compassion to develop a further four definitions of compassion (Figure 4.11).

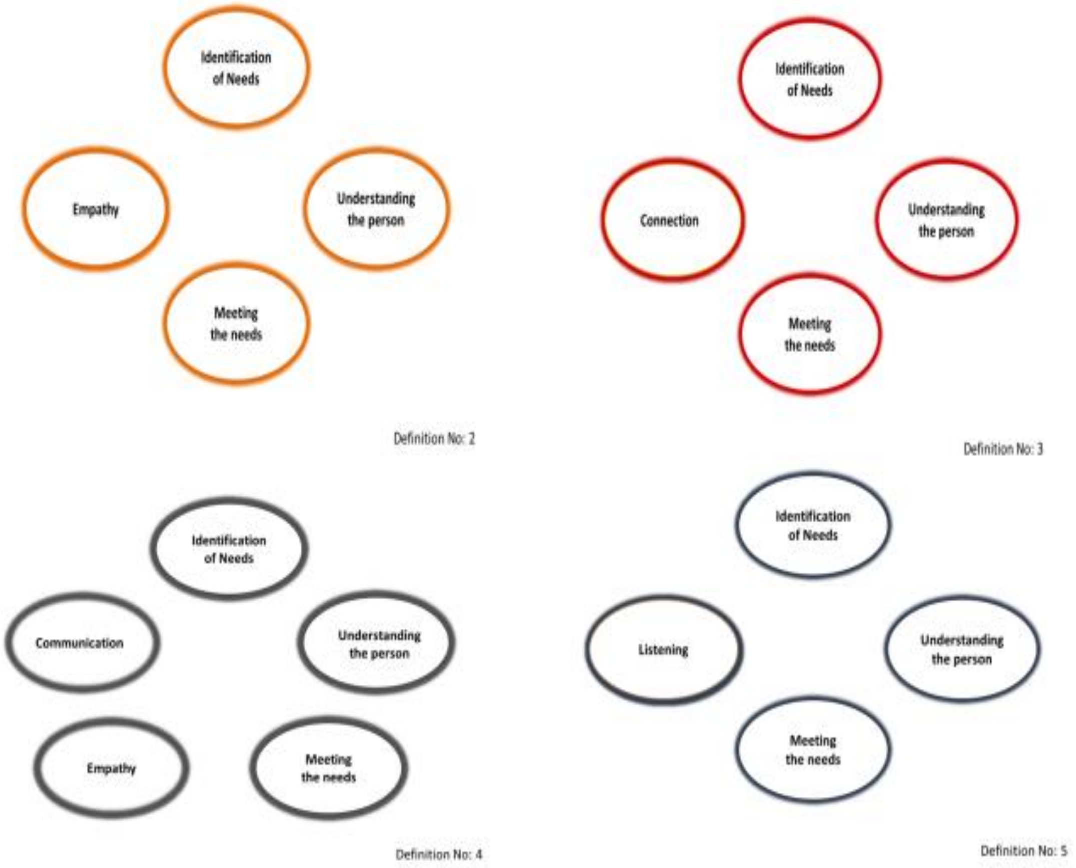


Figure 4.11: Definitions two to five of compassion

The five definitions were produced to provide the North Trent attendees with cohesive and manageable information. Members of the North Trent group were asked to review and discuss the definitions and consider how the seven components could be integrated to bring coherence to the co-produced definition.

Task two (research question two)

The findings consisted of fifty-five behaviours which participants considered to represent compassionate display. In preparation for the North Trent event these were arranged into loose cluster groupings (Appendix 21). These groupings were based upon stage one analysis of the discussions/themes from the focus groups and co-production workshops. The groupings were intended to be very loose and not definitive, aiding visualisation of the fifty-five individual behavioural categories.

Undertaking the engagement event

An agenda for the day was established (Appendix 22) and distributed to the group. The group members were also provided the extracts which were used for task 1a (Textboxes 4.2, 4.3 & 4.4) in the co-production workshops. The event started with an overview of the purpose and format of the event. This was followed by a discussion of the extracts. Mirroring the workshops, its purpose was to provide some context and background to the study and the focus group findings. The extracts gave an indication of some of the key themes on compassionate practice which had emerged from the data. Thus, helping the participants to situate themselves within the topic area.

Summary of the engagement events key points

For task 1, the attendees worked in pairs to review and discuss the five definitions. Together the group then deliberated each definition and the independent components of each. The attendees recorded their thoughts on the definitions and notes of the discussion were made by the facilitator. Collectively the group integrated those seven components, creating a co-constructed definition of compassion and this will be presented in chapter five.

During task 2 the attendees firstly worked in pairs to review the fifty-five behaviours in their respective clusters. The group then collectively discussed their perspectives of the position and relationships of these within compassionate practice. The group worked together to establish four themes. They also made a recommendation for the exclusion of three behaviours. Their feedback was incorporated into stage two analysis.

Stage two analysis

Stage two analysis was undertaken to consolidate the findings from phases two and three. As integration of the definitions occurred during the co-production workshops and gained coherence at the North Trent engagement event further analysis was not required for research question one.

Research question two findings needed to be considered within the context of the classifications and feedback proposed by the North Trent attendees. At this phase in the research the behaviours did not provide the findings with an understanding of how or why the participants felt these promoted or demonstrated compassionate display. This understanding was required for the development of a conceptual framework.

Process

Four sources of data were integrated during the analytical process (Figure 4.12).

Figure 4.12: Data sources utilised in stage two analysis.

Source one: Focus group analysis

Each of the thematic maps generated for research question two were reviewed to identify from which participant group(s) the behaviour had emerged (Appendix 19). A mind-map was generated for each of the fifty-five behaviours, this displayed the codes associated with each category and from which participant group they had emerged (Figure 4.13). Direct quotes by the participants were used to support the analysis.

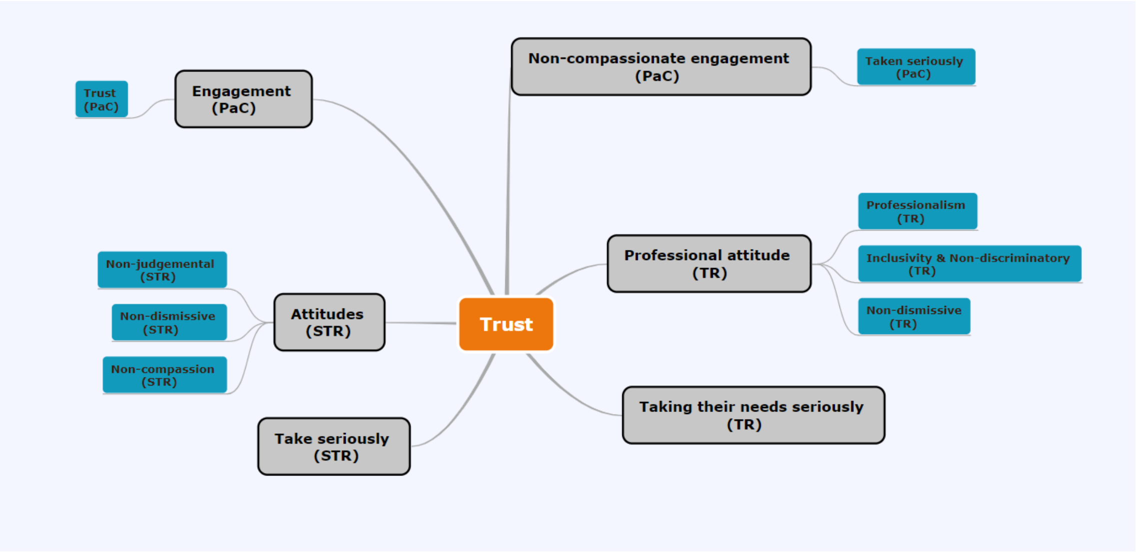


Figure 4.13: Trust mind map

Source two: Co-production workshop tasks 1a and 2

Notes made by the participants during tasks 1a and 2 were examined. These provided supplementary information regarding the perceptions of participants on the meaning and importance of the behaviours. These included notes the groups made during the discussion of the three extracts and additional notes participants made during task two. An example included a definition of person centred which the participants at site B in subgroup three constructed from the categories of compassionate display.

Source three: Task Two North Trent Extract Review

The four classifications of behaviours and notes made by the attendees obtained during the North Trent event were all utilised during the analysis. These were supported by notes made by the facilitator on the attendee's discussions of the three extracts.

Source Four: Facilitator & Moderator notes

Any relevant notes made by the facilitator and moderator were used to supplement the analytical process.

Process of analysis

All data sources were reviewed independently and then considered collectively. Each of the behaviours were summarised, any mergers, eliminations or groupings were identified during this process.

Chapter Summary

The three phases of the research incorporated robust methods of data generation, capture, analysis, integration, synthetisation and consolidation. Through a process of transparency, these procedural and analytical methods have ensured the data and subsequent findings addressed in the next chapter have maintained qualitative validity. Adhering to the fundamental principles of co-production has enabled the co-construction of knowledge and understanding of how compassion can be defined and displayed within radiotherapy. Chapter five provides a comprehensive overview of the findings for research questions one and two. It concludes with the development of a conceptual framework for compassionate display which emerged from the second stage analysis.

Chapter 5: Findings

Overview

This chapter presents the findings. The first part details the demographics of phases two and three. The second part presents a shared definition of compassion (research question one) and the behaviours that reflect compassionate display (research question two).

Demographics

Focus groups

Eleven focus groups were conducted, a total of sixty-seven participants attended. On average each focus group lasted fifty-four minutes, generating five-hundred and ninety minutes of data (Table 5.1).

Ten percent of the participants were male (n=8), eighty-eight percent were female (n=58), and two percent did not disclose (n=1) (Figure 5.1). TRs (n=27) accounted for the highest percentage of attendees, followed by STRs (n=24) then PaCs (n=16) (Figure 5.2).

Sixty-nine percent (n=11) of the PaC participants classified themselves as a patient and thirty-one percent (n=5) as a carer (Figure 5.3). Many of the ‘patient’ participants however indicated they also had caring responsibilities. A range of ethnicities were represented, with participants recording their ethnicity as; white-British, black-African, mixed white & Latin American, Pakistani, Indian, mixed and Scottish/Irish.

Table 5.6: Focus group attendance

Participant group	**Location**	**Participant numbers**	**Duration (minutes)**	**Moderator**
Year 1 STR	Clinical site C	11	47	Higher education institution lecturer
Year 2 STR	Host higher education institution	8	40	Higher education institution lecturer
Year 3 STR	Host higher education institution	5	41	PhD supervisor
TR	Clinical site A	6	30	Higher education institution lecturer
TR	Clinical site B	7	61	Local principal investigator
TR	Clinical site B	3	40	Local principal investigator
TR	Clinical site C	6	71	Local principal investigator
TR	Clinical site C	5	44	Local principal investigator
PaC	Clinical site A	5	58	Cancer support centre team member
PaC	Clinical site B	8	106	Local principal investigator
PaC	Clinical site C	3	52	Local principal investigator
Total		67		

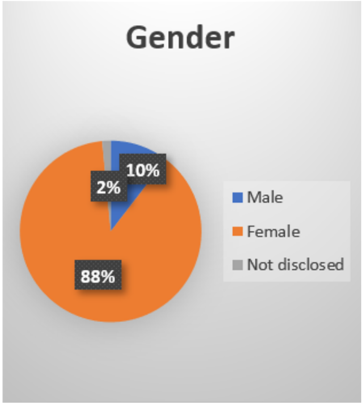


Figure 5.1: Focus group participants gender

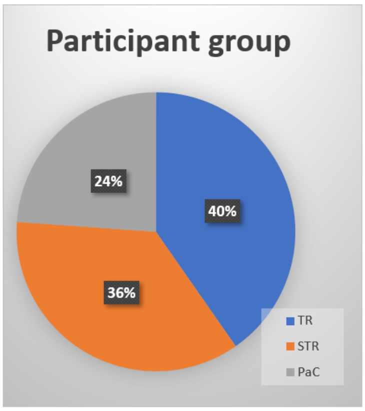


Figure 5:2 Focus group participant classification

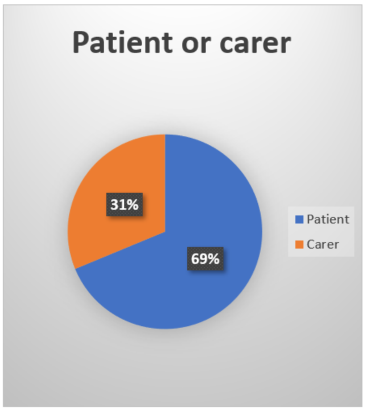


Figure 5:3 Focus group patient and carer classification

The research aimed to explore compassion and generate findings within the context of radiotherapy. The analysis of the focus group transcriptions established that participants’ discussions were not restricted to their experiences of radiotherapy. The recollections of PaCs involved experiences of theirs and others whole disease trajectory; from diagnosis to end of life. These experiences promoted reference to a large spectrum of health professionals who had been involved in their care or indeed the care of their loved ones. The personal experiences or observations of compassion from the TRs and STRs also included healthcare situations and professionals outside of radiotherapy. However, the findings detail how compassion was defined relevant to the radiotherapy context and what TRs behaviours were believed necessary to engage in to demonstrate compassion. Hearing the participants’ perspectives of other professionals contributed to the richness of the data. It permitted exploration of compassion in the wider context of cancer care and encompassed a broader spectrum of professional practices. Nonetheless, radiotherapy and specifically TRs, were the professionals under the lens of investigation. Only the perspectives of TRs and STRs, alongside PaCs were explored during the focus groups, and not other healthcare professionals.

Co-production

Three co-production workshops were conducted, a total of thirty-nine participants attended (Table 5.2).

Table 5.7: Attendance at the co-production workshops

Site	**Participants**	**Numbers**	**Moderator(s)**
A	Patient and carers	4	PhD supervisor Cancer information & support centre manager
A	Student Therapeutic Radiographers	4	
A	Therapeutic Radiographers	8	
B	Patient and carers	6	PhD supervisor Local principal investigator
B	Student Therapeutic Radiographers	3	
B	Therapeutic Radiographers	6	
C	Patient and carers	0	PhD supervisor Local principal investigator
C	Student Therapeutic Radiographers	2	
C	Therapeutic Radiographers	6	

Research question one: Defining compassion

Phase one of the study was preparatory in nature and is evident in the concept analysis and pilot focus group. This section therefore details the findings of phases two and three related to research question one and presents the consensus definition of compassion. Illustrated in figure 5.4. is the method of data generation, integration, analysis and co-construction of the findings for research question one.

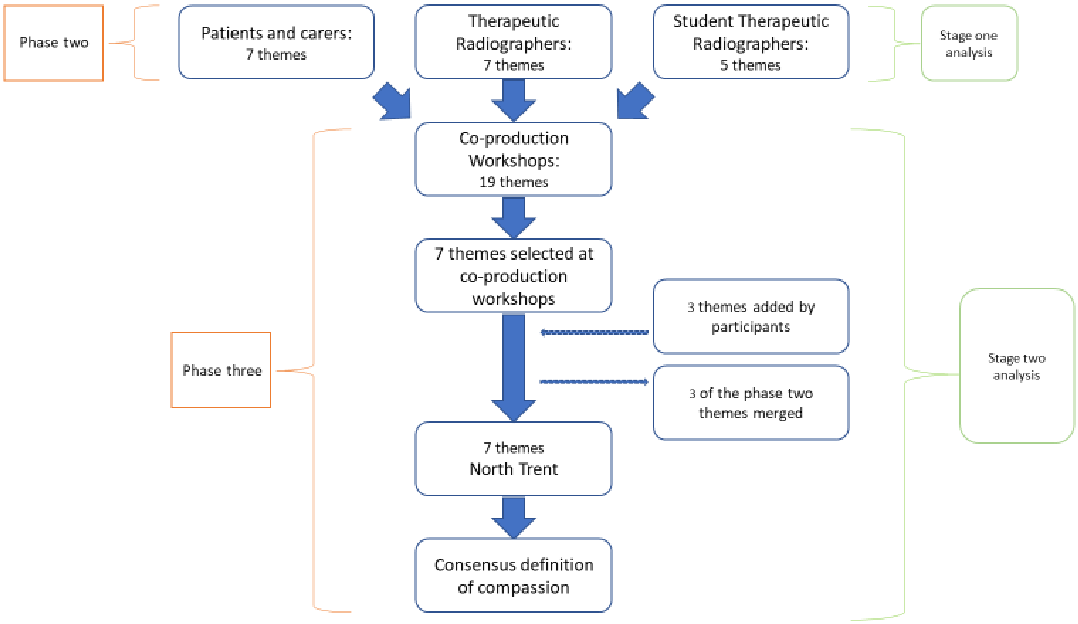


Figure 5.4: Method of data generation, integration, analysis and co-construction for research question one.

Phase two: Focus group findings

On completion of the thematic analysis of the focus group transcriptions, one-hundred and eighteen codes emerged that defined compassion. These were clustered to form nineteen themes across the three participant groups. Each theme was identified by the different participant groups to be a component of compassion.

Therapeutic Radiographers

Seven of the themes emerged from the focus groups with the TRs (Appendix 18). These themes were formed from a total of forty-three codes (Table 5.3).

Table 5.8: Research question one themes and codes - Therapeutic radiographers

Theme	Number of codes	Codes
Antecedent (event)	2	Positive Negative
Understanding the person	3	Individuality Knowing/awareness Relate
Meeting those needs	7	Having/taking time Doing something Make things better for them Extra mile Being supportive Being there for them Helping
Identifying what the person wants/needs/prefers	5	Taking on-board Taking their needs seriously/not judging Listening Allowing them to speak/express Communication
Conditions that promote connection	7	Natural Perception Being professional Not tokenistic Respect/dignity Time Professional standards
Attributes that aid connecting	5	Confidence Humanity Being caring

		Empathy Patience
Presentation	9	Little things Inclusivity and non-discriminatory How you are acting Emotion Show/display You be You have Treat Give

Antecedents

The TRs believed compassion was a response to a stimulus, this could be either a negative or a positive event.

"So it was just that extra thought that had gone into it. It wasn't just a generic card and chocolates: she really thought about what I needed and how it was working in my environment and it was really nice"

TR Site C2

"I noticed she was struggling and everybody was walking past her and she was sort of struggling in her wheelchair"

TR Site B2

Understanding the person

The TRs agreed that an aspect of compassion was understanding someone as a person and not just a patient; an appreciation of who they are as an individual and different to anyone else.

"That's why people who lack compassion and struggle in those situations or slip up because they're not relating to the patient, so they're not knowing what's appropriate and what's not, because they don't have that level of understanding"

TR Site B2

"There's obviously stress going on because we know mostly those people are not really like that, but they are just under a moment of stress, can't show compassion, so yes it does show more if there's no compassion than when there is compassion"

TR Site C1

Identify what the person wants/needs/prefers

Participants believed compassion requires the TR to identify what that patient's needs are, to not assume they will be the same as everyone else's who is in that situation.

"I think there are some people who don't want it, who just want to get in, get out and have as little conversation, as little contact as possible, and then there are other people that really need the support, so they are the people that you give it to more"

TR Site A

"Are we being compassionate at this moment, is it a compassion that the patients actually trying to achieve from us, and that's the hardest part to do"

TR Site B1

Meeting those needs

The analysis identified that a component of compassion is attempting to meet the patient's individual needs. This could be demonstrated or achieved in several ways.

"whilst I know in her best interests radiobiologically that we need to get on with this treatment otherwise you know it's going to be of detriment to her long term and the effectiveness of this treatment, I am not about to go and bolt her down on the bed and make her do her treatment, that's clearly distressing her to the point where she feels that she can't breathe, so that is compassion"

TR Site A

"knowing how to react to that situation, to help sort of make them feel better, make them feel more comfortable, help reassure them it's all about caring an being able to recognise"

TR Site B1

Conditions that promote connection

Compassion was regarded by the participants as forming a connection with the patient, a connection which is natural, built upon dignity and respect and part of their professional role.

“but, you were saying that you get to know the patient, you get to know what they’re like and your compassion builds”

TR Site B1

“and I think a lot of people who sort of choose working in health as a career, I think innately they are compassionate on the whole. I think I can maybe count on two or three fingers certainly across the radiotherapy appointment”

TR Site B2

Attributes that aid connecting

The participants felt that compassion utilises attributes that are inherent to individuals as human beings to form a connection to the patient. These include having confidence, humanity, empathy and patience and being caring towards others.

“to help sort of make them feel better, make them feel more comfortable, help reassure them, it’s all about caring and being able to recognise”

TR Site B1

“It’s automatic isn’t it, but it’s just judging that patient and what they need and treating them how you would want to be treated as well and be doing things that you would appreciate to try and help them through the situation”

TR Site C2

Presentation

The TRs perceived that how they present themselves to others can convey compassion. They regarded it as something that is possessed and therefore given, shared or shown to a patient.

“the patient perceives that you are showing compassion towards them”

TR Site A

Student Therapeutic Radiographers

Five of the themes emerged from the STR focus groups (Appendix 18), developed from a total of forty-three codes (Table 5.4).

Table 5.9: Themes and their associated codes – Student therapeutic radiographers

Theme	No. of codes	Codes	Sub-codes
Event	2	Negative Positive	
Recognition of needs	5	Emotional intelligence Relationship/friendship Understanding Knowing the patient Creating a bond	
Presentation	7	Role expectation * Something you be Something you do Universal compassion Genuine Something you have Something you show	*Value, Policy, Professionalism, Radiographer (4)
Meeting needs	4	As a human/person Different for different people Hard work Individualise	
Descriptive definitions	13	Patient outcome* Thinking about them A desire Concern for Emotional intelligence Being there Empathy+ Care/comfort ~ Relate to Sympathy Humane response Caring with a purpose Being kind	*Personal benefit (1) + Suffer with, Feel with (2) ~ More than caring, Being patient-centred, Whole care (3)

Event

Mirroring the TRs viewpoint, the STRs also believed compassion was a response to a stimulus, either a negative or a positive event.

"she's not that older than me and if it was me and she had been through it, like a whole double mastectomy and she had like chemo, the whole shebang and I was like if that was me and then people had told me well actually your whole Christmas is going to be ruined as well, I would be like oh my god, I would feel the same so maybe that's why I was not going to let it lie"

STR Year 3

"I think actually, if we can feel the positive in what the other person is experiencing then I think ultimately that makes us better as practitioners because that's our aim isn't it, to help people get better anyway"

STR Year 1

Recognition of needs

The STRs believed compassion entails recognising the needs of the patient. Recognition is achieved through an understanding established through an instinctive 'knowing' of the patient.

"I needed to like, tell the staff that it wasn't ok, like that we, like this wasn't normal, he was quite different. There was another member of staff who was also a really compassionate member of staff, she's lovely and she like kind of noticed similar things. So we went got him to see a doctor and I went with him.

STR Year 2

"Yes, like it's not like a blanket thing, like some patients don't want, I don't know you have to be able to like read people and know that some people just want facts and some people don't want chit chat and small talk. It is a lot of just reading people"

STR Year 1

Presentation

Like the TRs, the STRs perceived compassion as something that is possessed and therefore given, shared or shown to a patient. The STRs perceived that meeting the patients' needs is fundamental to a TRs professional role and should be genuine in its display.

"Because some staff will care, but then as soon as it means they're running behind, they're like, come on, come on, just hurry up. But then the compassionate would be saying, right let's sit down, have a drink, wait a few minute until you're ready, would be the compassionate thing to do"

STR Year 2

"I think he was looking for more of, of more compassion from the radiographer"

STR Year 3

Meeting needs

The STRs perceived a component of compassion is attempting to meet the patient's individual needs; and may be demonstrated or achieved in several ways.

"It's hard to just look at it as though you can make it less negative, it might still be negative but there's always work to be done and sometimes that might just be like support"

STR Year 1

"I think it goes back to, if you're in a routine and you're asking patients all of these questions, its then like adapting it to the patient, like we said before. Anyone could just like ask, like questions in a set order, but it's how you act on them, what the patients given you back"

STR Year 2

Descriptive definitions

A number of definitions were discussed that considered compassion as a holistic process that encompasses the whole of the patient. In addition, the STRs felt compassion should have an outcome for the patient.

"Like you can just care for someone by providing for their basic needs and kind of doing all those things, but to actually like be compassionate, is to like take it a step further and I think that takes a lot more"

STR Year 2

"It feels like caring with a purpose, you are caring with a purpose of getting a positive outcome or making and impact as such"

STR Year 3

Patients and carers

Seven themes emerged from the PaCs focus groups (Figure 5.7). These themes were formed from a total of thirty-two codes (Table 5.5).

Table 5.10: Themes and their associated codes – Patients and carers

Theme	Number of codes	Codes
Negative event	1	Negative event
Empathy	7	Pity Understanding Human to human Different from sympathy and empathy Sharing pain/emotions together Sympathy Fellow feeling
Presentation	9	You receive You need You be You feel You show You have You give Desire to alleviate Genuine
Either present or not	3	Levels Received Subjective
Identification of needs	1	Getting to know you/relationship
Action	5	Simple things Do something with sympathy and empathy Putting yourself out there Above and beyond Helping
Expectation of a Therapeutic radiographer	1	Caring

Negative event

Despite also believing compassion was a response to a stimulus, the PaCs opinions differed to the TRs and STRs, only discussing its trigger to be a negative event. Despite all three participant groups discussing compassion within the context of radiotherapy/cancer care, this disparity may be attributed to the TRs and STRs reflecting of the positive impact compassionate behaviours rather than what has triggered their occurrence. The PaCs also believed that it should be evident throughout their experience.

"sometimes, for another who is stricken by misfortune, accompanied by a strong desire to alleviate that suffering"

PaC Site C

"I think its compassion as well from the, from the first point of contact, from the first person you come to when you're diagnosed"

PaC Site B

Empathy

The PaCs perceived compassion to be a form of empathy, a sharing of the situation together. Whilst believing this, they also acknowledged that despite similar traits the two were different.

"he said well, my daughter reminds me of you and she really hates going to hospitals, she hates having any injections, she's always been really paranoid about anything like that and I would strongly, strongly advise her to go for it and I thought that was really helpful in a way, sort of just, he, not quite the same, I don't know whether that would be classed as compassion or not, but it was very much sort of like trying to put himself in my shoes"

PaC Site A

"They're not going to know how to approach the patient or what's the right thing to say to them. Because we've been through it, we know what we want people to say to us or not to say to us"

PaC Site C

Presentation

Aligning with the perception of the TRs and STR, for the PaCs compassion was seen as something that is possessed and therefore given, shared or shown to a patient. The PaCs also spoke in terms of it being received.

"my stay in hospital I was shown very little compassion"

PaC Site A

"others showing compassion and receiving it"

PaC Site B

Either present or not

For the PaC compassion was seen as a distinct occurrence; either being displayed or not. They identified no middle ground, TRs cannot be a bit compassionate, it was either present in their practice or not.

"They were great, so you've got these compassionate people in one place and it seems to me it's the ones that can"

PaC Site A

"You know very clearly when it's not there"

PaC Site B

Identification of needs

Compassion is concerned with identifying patients' needs. The PaCs felt this could only be achieved through the development of a relationship, permitting the TR to understand them and what their needs might be.

"They actually want to find out, find out how they can best help you and by finding out that and then doing that, that is the compassion side of it, as opposed to just a carte blanche or I'm really sorry or, you know, it is a way of going beyond that and saying, right, I want to find out how I can best help out that person"

PaC Site B

"Yes, I think it goes back to what you said earlier about understanding, about understanding what you're wanting and what you are needing at that time"

PaC Site C

Action

The PaCs believed that compassion involves action. This theme was similar to meeting needs which emerged in both the TRs and STRs focus groups. The PaCs however believed those actions needed to go above and beyond normal practice.

"They have to actually take an action that supports you in some way that's actually meaningful and what helps and what is appropriate to what's going on at that time"

PaC Site A

"If they are not following through that's the exact opposite of compassion"

PaC Site A

Expectation of a therapeutic radiographer

The PaCs expressed how they expected compassion, it being something that must be practiced by a TR (and students).

"There were one or two nurses that yes, but the majority, and I thought that was so sad when they are caring professionals"

PaC Site A

"I thought that, that was pretty general for all professionals, that that would be their aim"

PaC Site C

As detailed in chapter four, the nineteen themes were collated and presented to the participants at the co-production workshops in task 1b with the aim of agreeing a definition. The next section details the findings of the co-production workshops.

Phase three: Co-production workshops findings

A total of twenty-four themes thought to be a component part of compassion were agreed within the co-production workshops during task 1b. Once duplicates were removed, seven themes remained. Table 5.6 represents the strength of the theme at co-production.

Table 5.11: Themes selected across the three workshops

Theme	Site A: Number	Site B: Number	Site C: Number	Total
Presentation	1		1	2
Identification of needs	2	1	1	4
Meeting needs	2		2	4
Understanding the person	3	1	2	6
Recognition of needs	2	1	1	4
Empathy	1		2	3
Action		1		1

Analysis of the co-produced work created by the groups during task 1b identified the participants had annotated how they believed communication, connection and listening were component parts of compassion. The groups had included these on their lists alongside those selected from the nineteen presented to them.

Communication, connection and listening had emerged across all participants groups as codes during the focus group analysis. They each had become part of another theme not a distinct theme in itself. This was due to the analysis illustrating they were compassionate behaviours relevant to question two rather than research question one.

The perceptions were unanimous across the workshops with notes indicating how the groups felt they formed part of a definition of compassion. Communication, connection and listening subsequently became themes which participants felt were a defining component of compassion. This increased the number of themes to ten.

Based upon the feedback of the participants, several of the themes were merged, as it was felt some themes held the same meaning (Table 5.7). The merger of three decreased the number of themes down to seven.

Table 5.12: Themes merged at co-production

Original	Merged with	Reason
Recognition of needs	Identification of needs	Participants felt these both reflected establishing what the patient's compassionate needs were.
Action	Meeting needs	Action would be one of the ways compassion could be displayed when meeting needs.
Presentation	Meeting needs	Compassion could be presented by the process of meeting the patient's needs.

The co-constructed findings encompassed seven themes, defining compassion as: *understanding the person, identifying their needs, meeting their needs, empathy, communication, listening and connection*.

The definition however did not provide coherence or understanding of the relationship between the themes as components of compassion. To aid this, the seven themes from the co-production workshop were presented to the North Trent group (Figure 5.5). Details of this are presented in the next section.

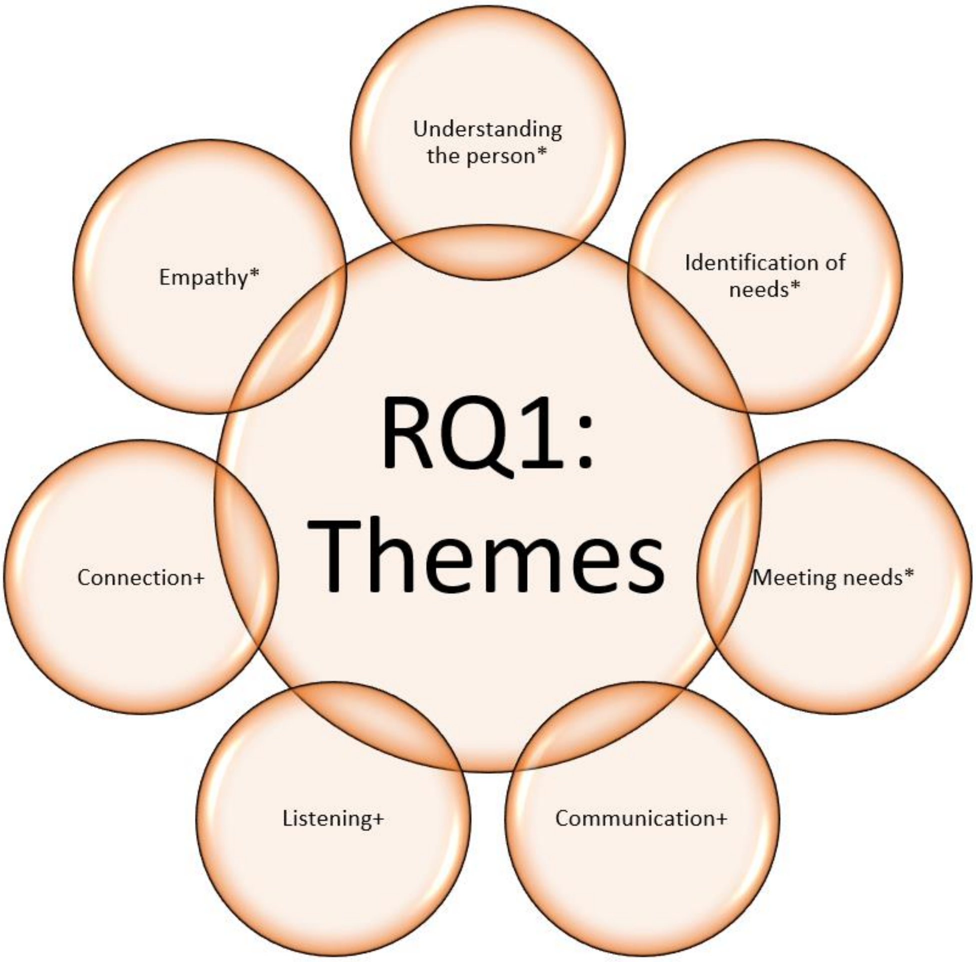


*Figure 5.5: Findings of the co-production workshops. *Original theme presented at co-production, + Theme arising from co-production supported by focus group stage one analysis*

Phase three: North Trent findings

Collectively the North Trent group perceived empathy, connection, communication and listening "*embodies*" compassion, calling them "*the internal component*".

Whilst identification of needs, understanding of needs and meeting needs are the "*physical representation*" of compassion, "*the external component*".

The participants believed without the internal, the external would not be "*effective*" or "*worthwhile*", and so could not be classified as compassion. Those internal components unite the three forms of presentation providing meaning to their undertaking (Figure 5.6).

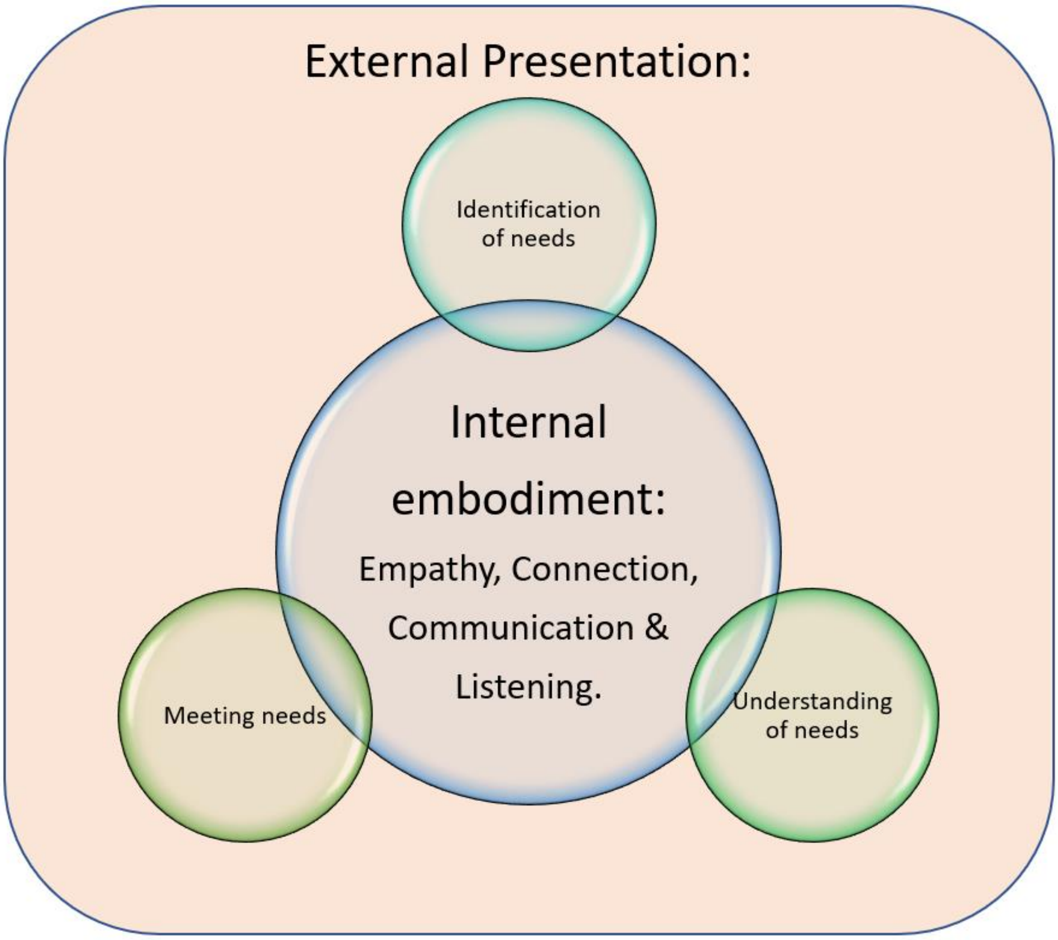


Figure 5.6: Visual representation of how North Trent attendees would define compassion

Consensus definition of Compassion

Through a process of co-construction and consensus a definition was created. Compassion can be defined as; *the intention to help, by identifying and understanding the individual with the aim of meeting their needs. It is characterised by unique interaction that promotes connection between individuals and is reflective of a genuine desire to help*.

Research question two: Compassionate display

This section details the findings of phases two and three for research question two. It presents the co-constructed conceptual framework of compassion and understanding of compassionate display. Figure 5.7 illustrates the method of data generation, integration, analysis and co-construction of the findings for research question two.

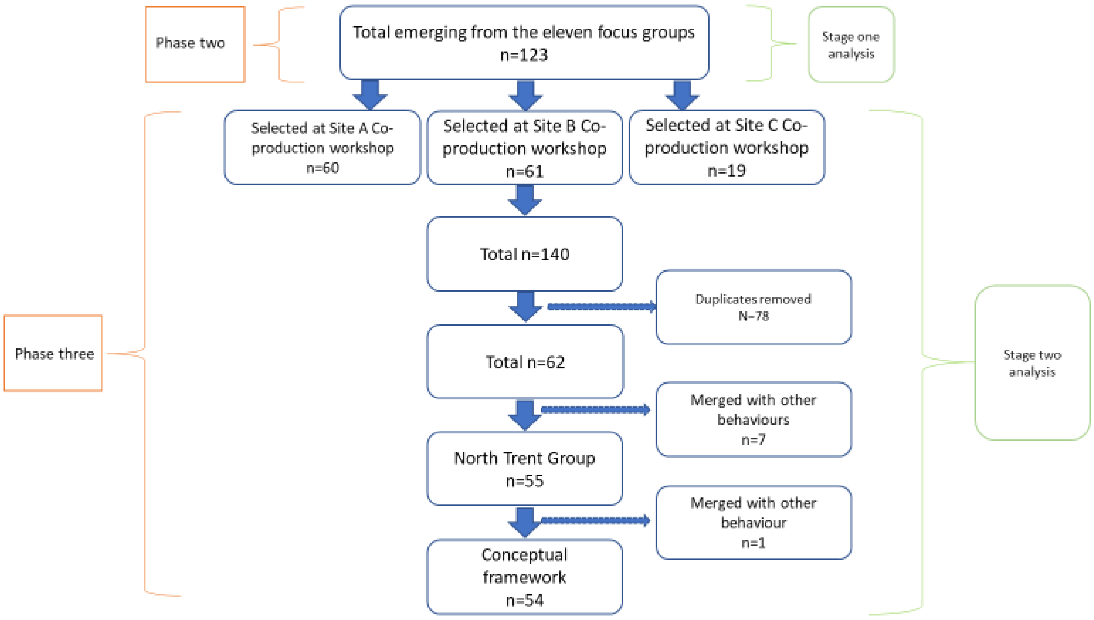


Figure 5.7: Method of data generation, integration, analysis and co-construction for research question one

Phase two: Focus group findings

A total of three-hundred and fifteen codes emerged during the thematic analysis of the PaC (n=131), TR (n=79) and STR (n=105) focus group transcriptions. During the review process some were amalgamated where appropriate. This created one-hundred and twenty-three themes which depicted behaviours the participants felt portrayed compassionate display (Appendix 23). To limit duplication, the behavioural themes were collectively formed from the findings of each participant group where the theme had emerged. Where appropriate, themes were relabelled to aid understanding during the co-production workshops.

Research question two aimed to identify how the participant groups perceived compassionate behaviour is displayed. Stage two analysis however identified not all the one-hundred and twenty-three themes could be classified as a behaviour. For example, analysis showed ‘empowerment’, ‘I’m not a statistic’ and ‘automatic’ were not a form of behavioural display. The analysis established that they instead fell into one of three classifications; an attitude, behaviour or practice. These three classifications formed the basis of the conceptual framework which will be discussed later in this chapter.

The one-hundred and twenty-three themes were presented to the co-production participants in task two. The following section details the findings of the co-production workshops.

Phase three: Co-production workshop findings

One hundred and forty behaviours perceived as compassionate display were agreed and selected across the seven co-production workshop groups. After duplicates were removed, sixty-two remained.

The sixty-two behaviours selected in the workshops were incorporated into stage two analysis. At this stage similarities in some of those themes chosen by the participants were identified, this prompted the merger of seven themes (Table 5.8). ‘Check for understanding’ and ‘person-centred’ had not been selected during the co-production workshops but the decision was still made amalgamate with ‘check understanding’ and ‘patient-centred’ respectively. This was to ensure the supporting participant quotes were included in the analysis of both themes. This meant the total number of themes presented to the North Trent group was fifty-five.

Table 5.13: Rationale for merger of attributes, behaviours and practices

Original	**Combined with**	**Rationale**
Taking time	Spending/giving time	**Both represent allocating your time to another.**
Hear me	Active listening	**Hearing an individual is part of active listening. To hear and acknowledge what is being said.**
Not making me feel guilty	Non-judgemental	**By being non-judgemental you are not judging or assigning your own beliefs on to that person to make them feel guilty.**
Check understanding	Check for understanding	**Both are the same thing. You are checking that they have received and understood the information communicated to them**
Appreciation and support of family	Caring for carers	**Both are the same thing; you appreciate what those in the wider network of the patient are going through and aim to care for those individuals as well.**
Identification of needs	Appreciation of needs	**Identification is part of the definition outlined by the work, whereas this is a different concept to actually appreciate them not just find out about them.**
Patient-centred	**Person-centred**	**Aligns with the humanistic element of the work focusing on the person rather than the patient.**

A matrix was generated (Appendix 24) displaying those fifty-five categories, site and frequency of selection within ~~the~~ each of the workshops. As the number of groups within each workshop differed, the number of times each theme was selected by a group is not comparable across the matrix. However, what the matrix does demonstrate the consensually agreed popularity of the theme. The next section details the findings following the North Trent patient and public involvement event.

North Trent findings

On review of the fifty-five themes, the North Trent attendees collectively felt three of the themes chosen by participants during the co-production workshops could be excluded from the findings. These were ‘hope’, ‘doing something’, and ‘willing’.

The group also perceived the themes could be grouped into four classifications:

1. Hospital environment – context where compassion is delivered,
2. Communication – delivery of compassion,
3. Empathy/Rapport – characteristics of TR and health care professionals,
4. Enhancing knowledge – the consequences of receiving compassion.

All of the recommendations provided by the North Trent participants were incorporated into the stage two analysis. Details of overall findings for research question two which emerged from the analysis are provided in this next section.

Stage two analysis findings

Following the process of analysis detailed in chapter four, four themes were excluded from the findings (Figure 5.8). In addition, a total of ten themes were merged with other themes, these are illustrated in Table 5.9.

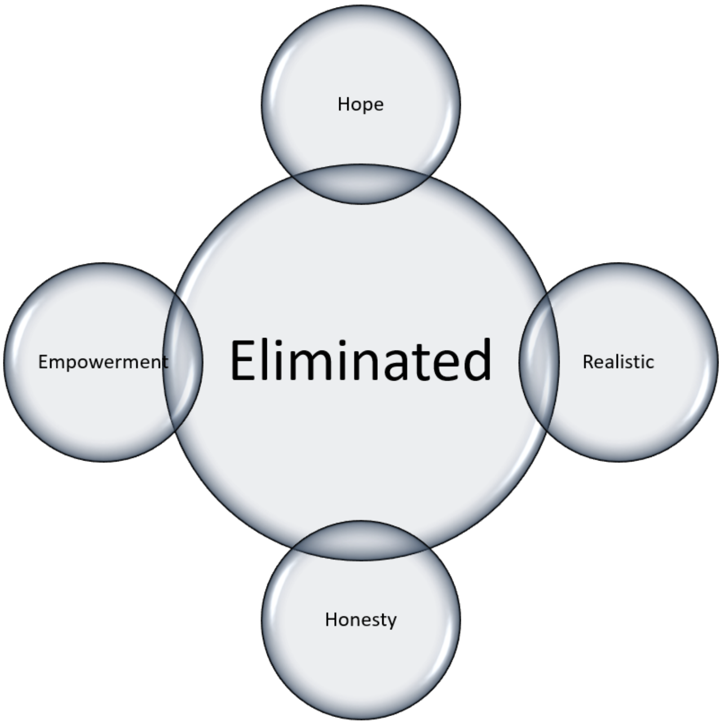


Figure 5.8: Themes eliminated during stage two analysis

Table 5.14: Merged attributes, behaviours and practices

Theme(s)	Merged with	Theme name
Reassurance	Encourage	Encourage
Reacting & adapting	Considerate	Consideration
Caring for carers	Caring	Caring
Not another number **Not a blanket approach** **Awareness of the person** **Holistic**	Person-centred	Person-centred
Sympathise	Empathy	Empathy
Patience	Spending/giving time	Being there
Doing something	Meeting needs	Meeting needs

Eliminated themes

Hope, Realistic and Honesty

Attendees at the North Trent event believed that ‘hope related to the potential for a positive outcome, resulting in patients "*hoping there will be a benefit"*, creating the "*potential of giving false hope which could be dangerous*". The North Trent participant discussions of ‘honest’ and ‘realistic’ also stimulated negative views. The attendees expressed that being ‘realistic’ and providing ‘honesty’ is “*not always wanted*".

Conflicts between the three themes emerged during the second stage of analysis. The PaCs had demonstrated during their discussions how they wanted honesty, to be informed of the truth about their situation. In combination with this they also wanted professionals to be realistic, to not amplify the positive elements of the information. Whilst at the same time giving them hope that it is the positive elements of what the professional is telling them that could be the reality. Within a healthcare context the three appear to be incompatible. It would be difficult for a TR to be honest and realistic whilst putting a positive outlook on the information they are providing without giving a patient false or unrealistic hope. Achievement of these by TRs would be very difficult due to the variances and balance required, thus contraindicating their place within compassionate display. It is also a professional requirement and part of the process of informed consent to patients to be provided with honest and accurate information. To not undertake this as part of routine practice would oppose both professional and moral codes of conduct [29]. Based on the conflict between the themes and the feedback from the North Trent participants, the three were eliminated from the findings.

Empowerment

Empowerment was eliminated as the analysis established it was not a form of compassionate display. Instead it may be a consequence gained by the PaCs when a TR is compassionate.

“..and sometimes I go to a consultant and want facts, I want information. I want to be able control my life, control the cancer and I want to be able to do that”

PaC Site B

After the completion of the second stage analysis forty-one categories remained, forming the conceptual framework detailed in the next section.

Conceptual framework

Through a process of consensus and co-construction a conceptual framework has been developed (Figure 5.9). The framework provides understanding of the attitudes which drive, behaviours that enable and practices which demonstrate compassionate display. The rest of this chapter provides an overview of the framework and the themes from which it was developed.

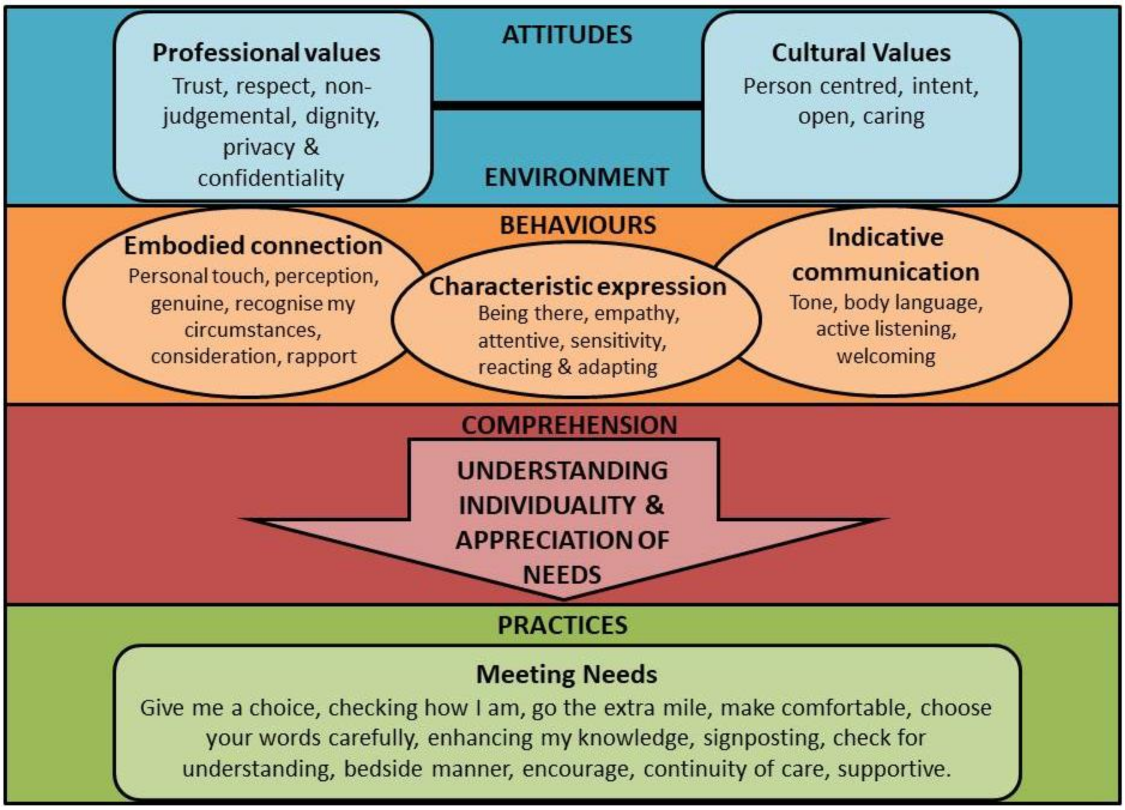


Figure 5.9: Co-constructed conceptual framework of compassionate display

The first part of the section will focus on the attitude component of the framework.

Attitudes

The findings demonstrated that attitudes underpin a TR's ability and desire to display compassion. Professional values and cultural values emerged as two classifications of attitude, both of which should be supported by and reflected in the environmental ethos of clinical departments.

Professional Values

Professional values became the collective category for six main themes (Figure 5.10). The analysis demonstrated a strong link between 'respect' 'trust', 'dignity', non-judgemental, professionalism and 'privacy and confidentiality'. All six were perceived to form part of professional practice and be an expectation of TRs. Their possession shows cohesion with professional standards. If absent, compassionate practice cannot occur as compassionate display is influenced through the possession of a professional attitude.

Figure 5.10: Professional values

Trust

Trust emerged in all three participants groups and is composed of two facets. Firstly, it reflected the PaCs desire to trust the competence of the TR to take theirs or their family's needs seriously and take appropriate action.

"Five times I went back to ask her if she would examine me or refer on for tests because I was having this pain. Five times I went and I have been going since October to now and she finally examined me a month ago and her whole demeanour was completely different as she had given me a sort of physical examination and she is referring me for urgent colposcopy"

PaC Site A

"He ended up having like a, he's had a DVT and it had gone to his lungs and he'd got blood clots in his lungs and that's why he'd had the swollen leg like the week before, which everyone had just dismissed"

STR Year 2

Secondly it reflected the sensitivities around the diagnosis of cancer and the necessity for the TR to respect these sensitivities. This could be on a personal level, with the PaCs trusting that the TR wouldn't judge, laugh or disrespect them during their interactions.

"Because they have mentioned all sorts there, including how olds he is and why is he still doing it"

TR Site C2

"That could affective like now, they've laughed at him about that, in the future if he has any problems it might affect, he probably won't say anything now because he'll just expect that same response again"

STR Year 1

In addition, it could also be on a professional level, PaCs wanting to be secure in the knowledge the TR would not break their trust by sharing information with others unnecessarily.

"So you've got to be compassionate in every way shape or form so regardless of whoever that was about its still inappropriate to discuss in ear shot of any patient regardless of who and what it was"

TR Site B1

The data suggests that patients perceive trust as an essential aspect of compassionate practice, regarding it as fundamental to healthcare and quality of life. The PaCs were however accepting that health care professionals are not infallible.

"Everybody is human, everybody makes mistakes"

PaC Site B

The PaC discussions demonstrated their ability for forgiveness and to overlook a failing when it had been a genuine mistake.

Respect

Respect emerged from discussions across all the three participant groups. Analysis of all the focus group transcriptions identified respect as multi-faceted, an umbrella term which encompasses the act of being respectful. Data-analysis demonstrated there were multiple ways to be respectful. These were not in relation to the ways respect can be shown; rather there are multiple different ways TRs need to be respectful of the patient. The findings show how every patient is unique and multi-dimensional. The participants identified that each dimension may require a different mode of respect and set of corresponding behaviours and practices.

Through the analysis it was identified the patients need to be respected in fours ways, as:

1. A human-being

"But the consultant did not even speak to me, he didn't even say a word to me. He didn't say to me I am going to draw on you because bla de bla de bla or whatever. I hope you don't mind, the pen might be cold, whatever. He just came in and walked out and you are just lying there feeling a bit abused really because you are just lying there and somebody's just come and drawn on you and walked away"

PaC Site A

"..and I thought I was being helpful when I said, when we started, I've got a hernia but its behind my heart. And he said, I'm not here to hear of any complaints, I'm only here to take an x-ray of your heart. And I felt so embarrassed"

PaC Site C

In these two examples the healthcare professionals were dismissive in their language and behaviours. Analysis demonstrated these behaviours made the patients feel uncomfortable as if they were foolish for expecting some level of interaction or to be treated like a human-being. Their accounts demonstrate how they wanted to be treated as an equal and be respected as such.

2. An individual with their own wishes, desires and preferences

"Feeling like you know best as a consultant and you know, overriding the wishes of the patient"

PaC Site A

"You know you feel like you want your own voice to be heard, that's, that would help. I think it would help if people just actually listened to what you are saying.

PaC Site A

Analysis identified how PaCs desire to be respected as an individual person with their own preferences and wishes. Discussions highlighted how respect should be present at every interaction regardless of whether they were significant junctures in their treatment or general day-to-day clinical situations.

3. As an expert in their own health, body and mind

"What I am trying to say is that there's too much of this labelling. You're a certain age so this doesn't apply to you, because that's happened to me. When I, the first surgeon I went to, I was forty-six at the time and he says you are too young for it to be anything sinister, and you know we shouldn't be treated like that you know. If you come with this set of symptoms, well statistics say you are too young, so we don't do this. Whereas you know, they should treat you individually"

PaC Site A

"I think my wife was unlucky because she went and one of the doctors she saw said oh you have only got a little, no its only just a tiny little lump there, nothing to worry about and twelve months later it was the size of a golf ball because she just happened to have one of those fast, a fast growth one, so, but there are also checks that are put in"

PaC Site A

The PaCs felt it was showing disrespectful behaviour when professionals did not take their health concerns seriously. The behaviour was perceived as dismissive and patronising. The analysis demonstrated the impact of hierarchies and potential power imbalances between PaCs and professionals.

4. A patient who needs their help and care

Analysis highlighted the vulnerability patients can feel by being reliant upon professionals to take care of them and provide medical treatment.

"Every single day they would bring her food, put the food in front of her, the food would go cold and nobody would feed her, and the food would just get taken away untouched. Every single day I would watch this woman and I couldn't do anything because I was like hooked to everything and ill myself and I kept saying no-one's feeding that woman, that woman keeps getting food given to her and she's not in a position to be able to eat it herself and one one's coming to feed her or anything and nothing happened and she was still, you know for days. I don't know she probably ended up dying of dehydration and starvation in the end"

PaC Site A

Participants felt it was degrading when patients became reliant upon another to help them complete the basic functions.

"Basically this guy had come in and needed his colostomy bag emptying and the nurses were going to do it but never did, but basically they were having a conversation between one another in clinic, they were sat in the waiting area saying why should we have to do this, you know bla. They've overheard and obviously, I found them in one of the clinic rooms coming out and I said are you alright because the daughter looked very angry and she then said well we overheard you speaking earlier saying why should we have to do it, so we've come in and we've done it ourselves. I thought that shouldn't have happened and obviously action was taken for it, but that patient and his family obviously felt awful. I mean the poor patient, all he wanted was his colostomy bag emptying and obviously, that wasn't provided to him and his daughter was angry because of the whole fact that people were talking behind his back"

TR Site B1

In the participant’s eyes, respecting a patient’s vulnerability and showing respect through the completion of tasks and caring for the patient was compassion.

As a registered healthcare professional TRs must behave respectfully towards the patient in order to meet the patient’s expectations of NHS care delivery and compassionate care. Similarly, personal respect is also required for compassionate display, respecting the patient as a human being and an individual person in their care.

Non-judgemental

Non-judgemental emerged from the transcriptions of the STRs and TRs. The groups discussed situations where they thought TRs (and other health professionals) had displayed judgemental attitudes towards patients. Although their discussions showed a strong consensus that this behaviour was wrong and unprofessional, it was clear however from their discussions that they sometimes found it difficult to not pass some form of judgement.

“Because obviously, it’s important not to judge people, and lets all be fair, we do”

TR Site B1

The cause of their judgemental behaviour was attributed to the spectrum of patients attending departments who may differ from themselves and the way they live their lives. These situations highlight individual differences within people as human-beings and demonstrate the complexities around caring for patients from across society. The findings reveal how the underlying attitude of the TR can cause them to be judgemental of the patient and in turn influence whether they are compassionate or not towards them.

“Sometimes your own opinions can kind of influence it because obviously in my case the radiographers just thought well its free healthcare and like why would you complain about this treatment that you are getting for free and it’s going to save your life and kind of just thought about it from a treatment point of view, like well you need to have treatment so, and then come for your treatment no matter what”

STR Year 3

When there is variance between the TR own values and those displayed by the patient, for example a lifestyle choice or the way the patient handles the situation, an internal dissidence occurs.

"Blood in his stools, blood in his urine and other bits and pieces and probably at the time they (TRs) *sort of said yes, that's normal. And then I think some people sort of look at him as a little bit of a, a bit needy, a bit of a moaner"*

TR Site B2

The TR in this example knows they should not be judging a patient within in their professional practice, but they can find it hard when it conflicts with their own individual beliefs. This dissidence creates a barrier to compassionate display, as the TR sees a person with an element they may not like (e.g. their personality, values, beliefs, behaviour etc.) rather than a patient.

The findings however demonstrate that what is compassionate is when the TR ignores their internal dissonance and aids or respects the patient despite a conflict between their beliefs and the patient's lifestyle. Perhaps it should however be argued that this is a professional obligation rather than a choice.

"Look at the Tomotherapy and head and neck patients you deal with, the real fringes of society. But we still, I think the way people on Tomotherapy deal with it, with their patients, it's just, it's exemplary. It really is a, you know, a great example to everybody to have the support of the patients, even though we're probably aware that they are probably still drinking, still smoking, still got the habits that got them into this position"

TR Site B2

Privacy and confidentiality

This theme emerged from discussions across all participant groups. Analysis established how an important aspect of compassionate display was maintenance of a patient's privacy and confidentiality. It was perceived to represent that the TR was being respectful towards the patient and their dignity. Failure to do so was perceived by all participants as unacceptable and non-compassionate.

"Instead of putting us somewhere you know, somewhere when they were telling my dad and me and my mom that he hadn't got long to go. They were no treatment for his brain cancer. Instead of pulling us out somewhere, they didn't and everybody and they put curtain around us and everybody heard what were in that ward"

PaC Site A

"Leaving the door open for a private conversation kind of leaves the patient feeling exposed"

TR Site C2

It was also seen to impact upon a patient's ability to trust other professionals and could potentially contraindicate their future experiences of care.

Dignity

Dignity emerged as a category across all three of the participant groups. The participants felt that clinical situations and the practices of professionals could make patients feel uncomfortable or vulnerable.

"So then even if we're just trying to chat away to them about what did you have for tea last night and they've 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

Dignity was perceived by the participants as something that should be preserved and that it was the responsibility of TRs to preserve it through consideration of their actions. The participants believed that TRs could choose whether or not to maintain dignity, therefore, its preservation being a conscious decision based on the TRs attitude of this practice.

"..she left the door open and things like that, if she was going to have a conversation about the patient in front of the patient and she didn't want him to hear she could've at least closed the door or something like that"

STR Year1

"You have to take your top off. You are lying on a bed completely, well they give you a wrap to put around you and then they open it out"

PaC Site A

Consequently, it was regarded as the responsibility of the TRs to ensure their actions or clinical practices did not promote this negative affect. For example, to try and maintain the patient's dignity this student overlooked the smell, hoping to indicate to the patient the odour was nothing to be embarrassed or apologetic about.

"Because her skin was broken it was very, very, it wasn't pleasant, the smell was unpleasant, but she was like, it's okay, you can wait, you can go outside and wait for me, I don't want you to smell this, it's not pleasant. I said no, no its okay, don't worry about it. And she was apologising all the time, I said no, don't worry about it"

STR Year 2

By TRs recognising the undignified situation the patient is facing and then desiring to preserve it through their practice was deemed to be compassionate. Non-recognition or even worse, choosing to ignore their undignified situation was perceived as non-compassionate. This behaviour would also be deemed as unprofessional.

Professionalism

Professionalism emerged from the discussions within the focus groups across all three participant groups. The themes of 'respect', 'non-judgemental', 'trust ', 'privacy and confidentiality and 'dignity' all emerged from same discussions from which professionalism was formed. When the participants discussed compassionate and non-compassionate display, reference was also given to them being professional or unprofessional.

"The consultant came and said, was chatting to her and saying well actually this probably wasn't very professional because he was talking to her in the ward when we could all hear and telling her, we have found this brain tumour, that's what's wrong with you. We need to do some radiotherapy and they moved her out and put her in separate room then. So that provably wasn't professional either talking to her about, they were telling her what was wrong with her while all the rest of us could hear"

PaC Site A

"Talking behind his back, it's really unprofessional"

STR Year 1

The analysis established the participant groups perceived a relationship between the two; to be compassionate is to be professional, and to be professional is to be compassionate.

The TRs discussed the professional requirement to be compassionate to all, accepting and not judging differences between themselves and the person within their care. TRs experiences often involved being on the receiving end of hostility from patients. Their discussions demonstrated how they felt compassion is displayed not just by their behaviours, but by overlooking negative behaviour towards themselves.

"She came across a little bit aggressive and she'd come in shouting and swearing and she wouldn't go in for her review, she wouldn't go and have her skin looked at, but she got angry when it was breaking down. And we just sort of supported her all the way through and dealt with each situation differently"

TR Site B2

By looking beyond the actions of patients and continuing to treat and care, displays they are a compassionate professional. Collectively 'respect', 'non-judgemental', 'trust ', 'privacy and confidentiality and 'dignity' all constitute a professional attitude. This attitude is one which the analysis has shown is not only an expectation of a proficient TR but one which is mandated by professional regulations [30].

Professional values summary

The findings show 'respect', 'non-judgemental', 'trust', 'privacy and confidentiality', and 'dignity' are professional values. Each value was mutually agreed during co-production as a form of compassionate display. The values were thought to reflect an attitude which fosters a professional and considered approach towards patients. When the patient can identify those explicit professional values in the TR who is trying to uphold them in their behaviour, it signifies they hold an attitude which is congruent with compassion. When this congruence is not evident in the TR’s attitude any subsequent behaviour would not represent compassion.

Cultural values

This classification is composed of four categories: ‘person-centred’, ‘intent’, ‘open’ and ‘caring’ (Figure 5.11).

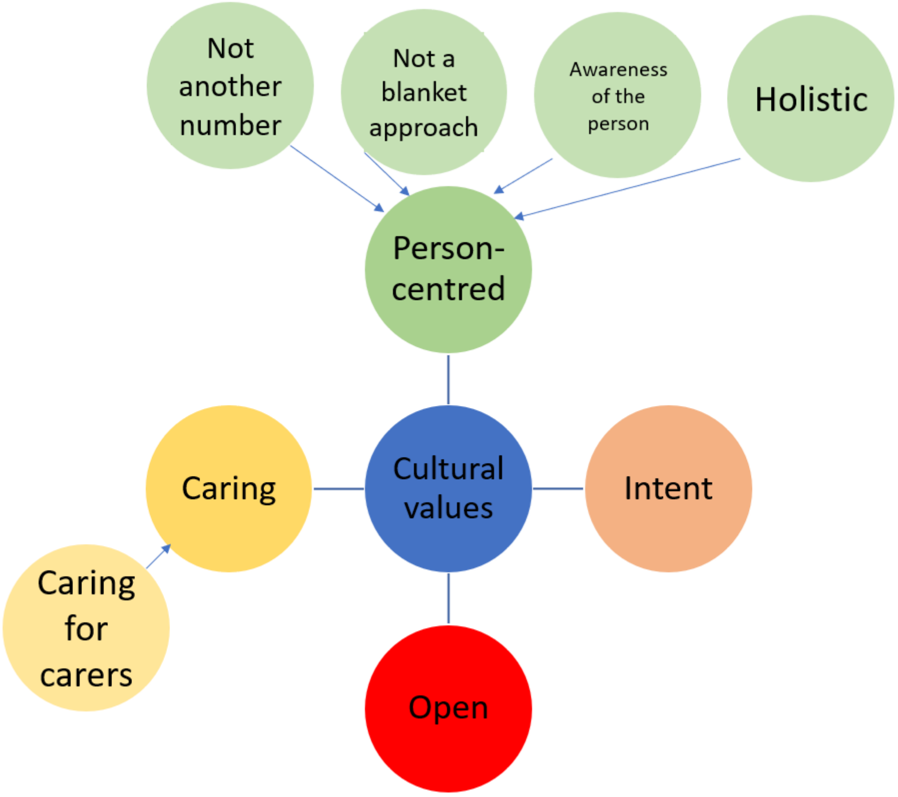


Figure 5.11: Cultural Values

Person centred

During the analysis person-centred became the collective category for the themes ‘not another number’, ‘not a blanket approach’, ‘awareness of the person’ and ‘holistic’.

Not another number (merged with ‘person-centred’) emerged from the discussions of all three participant groups. It was formed from the belief that patients should be treated as individuals, that their diagnosis should not define who they are.

"I think, yes, just building on what've you've said there, it's treating you as an individual. You know, not just as part of a room full of patients, do you know, it's especially just on the one-to-one appointments"

PaC Site C

"Being on a personal level with them isn't it and not just treating as a conveyor belt system"

TR Site C2

A loss of individual identity was blamed on clinical environments and the behaviours of TRs who practice within them. By cataloguing an individual person to a collective, they become just one of many.

"..and she said, well that one's ambulance, that one's a car, and what's that. And that was me"

PaC Site C

"We've got to see these like tumour sites in these patients, the patients then become the tumour site, not the patient"

STR Year 2

Numerous examples of how this could be overcome were discussed across the groups. These included, chatting with the patients, getting to know about them as individuals and calling them by their first name.

"..as we have just said by acknowledging somebody by their first name, you are acknowledging them and perhaps showing some compassion"

PaC Site A

"You do care about them and also their life at home, not just a treatment"

STR Year 2

A central component of maintaining individuality is the need for TRs to consider that how each patient wishes to maintain their individuality may be different to the next and that this must also be acknowledged within their practice.

Not a blanket approach (merged with person-centred) emerged from the discussions across the STRs and TRs participant groups and builds upon the concept of individuality discussed above. Rejecting the use of a blanket approach enabled the patient to perceive a TR's actions as compassionate. This was due to the TR recognising the patient is an individual and then applying a behavioural response to match.

"..what kind of compassion they want from you"

STR Year 3

The participants thought that by knowing the patient, the TR can apply their understanding of them during their actions and interactions together. Their compassionate response then becomes tailored to the patient in front of them, instead of a 'one size fits all'.

Awareness of the person (merged with person-centred) emerged from all three participant focus groups. It is also based upon the concept of patient individuality and builds upon tailored delivery. Participants believed 'gaining awareness' is what provides TRs with the knowledge to facilitate the delivery of a tailored response to each individual patient.

"So hopefully, by the end you know how to treat that patient, you know how to approach them, if you know someone's particularly emotional and have been throughout the treatment you know how to approach them and how to get them settled down you know, nervous patients stuff like that, as you get to know them you know what you need to do"

TR Site B1

"I spent most of my time with this particular consultant, and once she got to know me and how I wanted to be treated, that's when the compassion came in"

PaC Site B

Communication was regarded as key to achieving awareness as this enables the TR to engage with the patient and find out information about them.

"So, I think it's being able to, every day, just little things, like you have conversations with patients and just remembering sometimes that maybe they've said once. So, if they've said that on the weekend they were going to go and see their grandchildren, then you could ask on the Monday that individual question"

TR Site C2

"If patients tell you things, like they've got an exciting event coming up or something, even remembering that the next time they come in and just asking them about what they said. I think even that shows a bit of compassion because it shows that you are listening to them. That's what they want, they obviously want to be listened to, that's what you're kind of there for as well"

STR Year 2

By acting upon this information, the TR demonstrates to patients they are known. Conversely, when the TR demonstrated no awareness, the patients felt 'unknown'.

"That's because they don't get to know you"

PaC Site A

Analysis identified how knowing the patient aids the TR to exhibit compassion through personalisation. Whether the TR decides to utilise this information is what distinguishes their behaviour as compassionate or not.

The findings illustrate how 'awareness of the person', 'not another number' and 'not a blanket approach' all focus upon individuality and personalisation. All three being key components in the process which supports the TR to engage in compassion (Figure 5.12).

The three components of this process occur both sequentially and simultaneously. Thus, enabling the TR to know the patient, appreciate their individuality and then tailor their practices to their individuality, enhancing the ability of the TR to be compassionate.

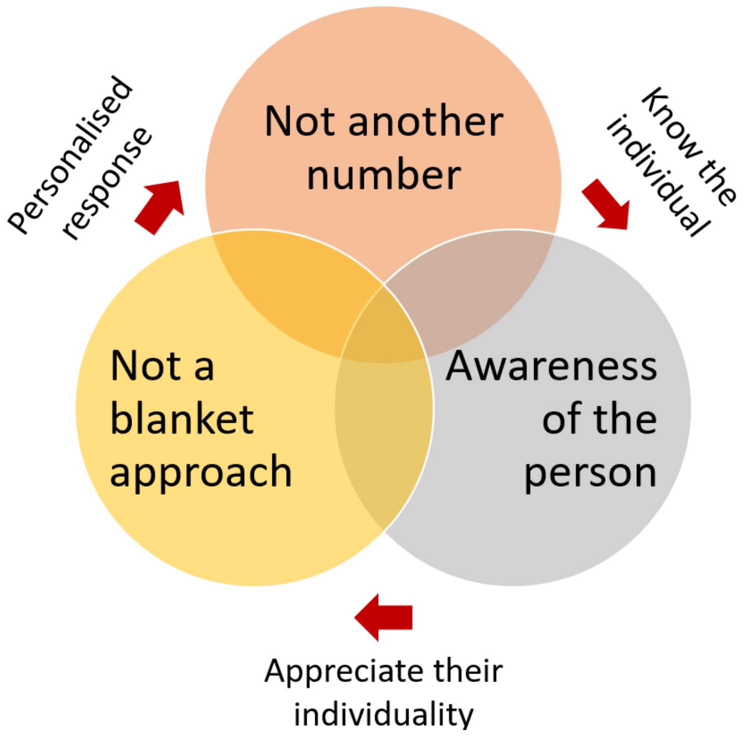


Figure 5.12: Process of personalisation.

Therefore, each theme in isolation does not represent compassionate display, but as a collective process they support the TR to demonstrate compassion. Importantly, the achievement of the process of personalisation is also essential for the TR's behaviour to be perceived by the patient as compassionate through them recognising the efforts to maintain their individuality.

Holistic (merged with person-centred) emerged from the STRs and TRs focus groups. The transcripts demonstrated they saw a link between holistic and care, but for care to be compassionate it must not simply focus on the physical delivery of treatment. Instead the participants advocated the care a TR provides should consider and address the whole of the patient and their wider needs.

"..not just about like the actual caring for that disease that that persons got, it's their whole life and how it affects them"

STR Year 3

"..kind of their whole care, not just what you're treating, like their mental wellbeing"

STR Year 2

Appreciation by the TR of the patient's individual holistic needs signifies they recognise the patient's individuality.

Considering the process of personalisation presented previously, the data suggests a holistic attitude is required to support this process. To portray a personalised compassionate approach, TRs must demonstrate it encompasses the 'whole patient', not just issues specific to the radiotherapy delivery (Figure 5.13).

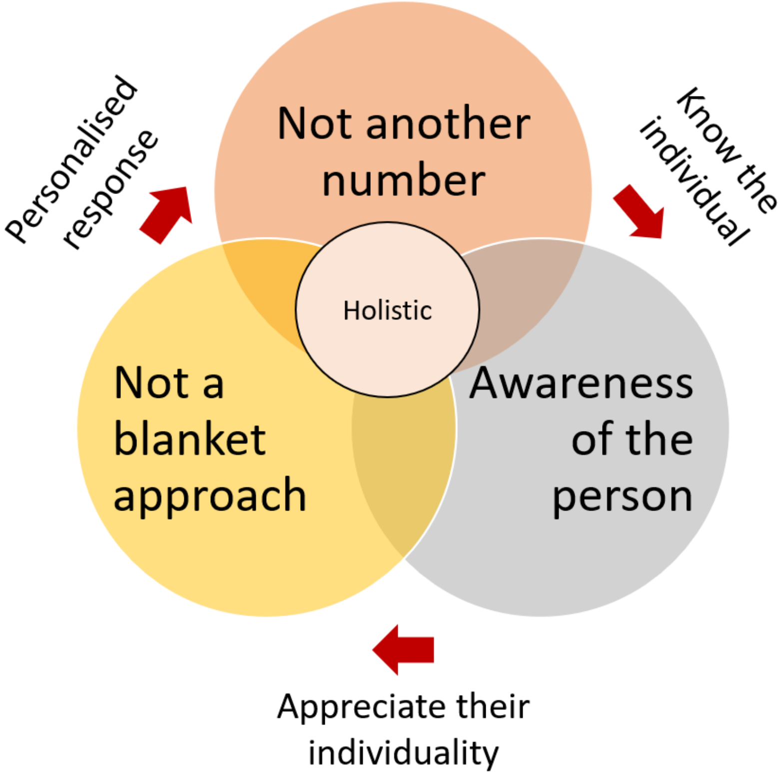


Figure 5.13: Process of holistic personalisation

Second stage analysis demonstrated the discussions by the PaCs from which person-centred had emerged, were the same ones as 'holistic', 'awareness of the person', 'not another number' and 'not a blanket approach'.

The PaCs examples of compassion, which they regarded as person-centred, demonstrated that TR engaged in the process of holistic personalisation.

"I'm not going to come and have a cup of coffee and I want you to tell me all about your fiftieth birthday and you know, things like that, that they remembered about you"

PaC Site A

Comparatively, where the TR had not been person-centred, they had not engaged in the process and their behaviour was subsequently classified as non-compassionate.

"One morning I felt absolutely shocking, I had to get out of bed, but like they will go around and say you know, can you get up please? Not, how are you feeling this morning, do you feel up to sitting out? It was you get out of bed and I have to say that throughout practically more of my stay in hospital I was shown very little compassion"

PaC Site A

"I am elderly, I'd got incontinence and I desperately wanted to go to the loo and he called me in and I said I'm really sorry I've got to go to the loo. Oh no he said. Well, if you do that, I won't be able to take your x-rays today, so I had to wait"

PaC Site C

The findings demonstrate being a person-centred TR signifies engagement in the process of holistic personalisation and consequently endeavours to treat the patient as an individual. Although the absence of a person-centred approach would not necessarily block engagement in the process, there would be no genuine intent for their behaviour to be personalised to the individual. Subsequently any outcomes resulting from the process would be superficial or a generic approach, not practices based on a genuine 'intent' to be person-centred, as will be addressed later. As a result of the analysis, 'person-centred' became the collective term encompassing those attitudes which promote and enable a compassionate response which is person-centred.

Caring

Caring emerged as a theme during the discussions in all three participants groups who felt having a caring attitude displayed the TR was compassionate. Caring was felt to be multi-faceted, the term becoming an umbrella to encompass the different ways TRs could care for patients physical and emotional (including mental) needs.

"Whereas someone's care you have to sort of care for them emotionally and physically"

STR Year 3

A caring attitude was thought by all participants to be portrayed through behaviour, i.e. how caring behaviours are delivered influence whether it is interpreted as compassionate (or not) by the participants. Thus, how compassionate care is demonstrated is paramount.

"Yes, I think it's just about showing that you're caring and understanding"

PaC Site C

"..what they thought about the care they received"

TR Site C2

How to display care was thought to be dependent on the 'type' of care required. Participants felt physical needs should be addressed with physical actions. Believing practical tasks would display a caring attitude to patients.

"The nurse was there, she said oh can I get you a drink of water, doing all the compassionate things they've been taught to do"

PaC Site A

The discussions indicated however that emotional needs require a more complex delivery. For a caring attitude to be displayed the patient would need to be supported and comforted.

"..the nurse was comforting and supporting her"

PaC Site B

"So, if you're feeling bad, I would try to comfort them as well"

STR Year 1

The findings would suggest the ability to support patients on this level signifies the TR has a deeper understanding of the patient. This enables them to understand their emotional needs and tailor a response which correlates to need.

"..and always giving them that level of care and never sort of thinking"

TR Site C2

"..providing that care they receive"

STR Year 1

It was felt emotional caring, could be displayed through physical touch, a friendly bedside manner and engagement in communication which shows congruence with compassion.

"I think something where, like, there's action, like even if it's just a squeeze of a hand or shoulder or giving you a tissue or patting you on the back or something"

PaC Site A

"Yes, it is time. And you can see in the face, as a body language, and you know that they're actually caring about you"

PaC Site B

There were however contraindications associated with the delivery of physical touch by TR which led to its elimination from the findings during the co-production workshops. Although all participant groups felt touch displayed to another that you care, it was felt there was a potential for blurring of professional boundaries, this will be discussed in chapter six.

By appropriately tailoring their delivery to match patients' needs was thought by the participants to represent the TR having a caring attitude towards the patient.

"I knew that she cared for me"

PaC Site B

"Because it is showing that you are caring for them"

STR Year 2

Caring it would appear could not simply be inferred, it needed to be shown.

Caring for carers (merged with caring)

Caring for carers emerged as a theme from the PaCs and TRs focus groups. Discussions addressed how any display of compassion must be extended towards the carers (including friends, family etc.) of patients. Participants outlined how the patient is the centre of care, whereas carers are an observer on the periphery of care, and often overlooked, not receiving any support during their time of need.

"And a lot of times you're, you're getting all the care in the world. You've got loads of people you can talk to and go to see if you have an incident or phone your breast cancer nurse or consultant or whatever. They have nobody but you, and they can't even talk to each other because it upsets each other"

PaC Site B

"..and clearly this isn't just about him now, it's affecting on the relationship as well, and his wife was obviosuly the carer and needed some support as well"

PaC Site C

The participants provided numerous examples of behaviours and practices which TRs could undertake to demonstrate they are caring for carers. But the analysis demonstrates it is the process of recognising that carers have needs and are affected by their loved one's diagnosis which reflects compassion.

"I think the carers need as much attention in fact more sometimes than the person who's been diagnosed"

PaC Site B

"Everybody gives everything to the patient, which is what we need to do anyway but everybody remembers the other half's that's there that's getting all upset or whatever"

TR Site C2

The findings demonstrate the TR needs to consider caring for carers as important, this enables their behaviours to be inclusive where appropriate of carer needs. By recognising a patient's wider needs, i.e. the needs of their carer, this displays the TR's caring attitude. The decision was subsequently made to incorporate caring for carers into the category of caring.

Open (previously called permission to open up)

This theme emerged from the PaCs discussions, their insights addressing a desire to be open in discussing matters of importance to them. Participants believed a compassionate environment which is influenced by physical and human components enables them to open-up. Both components are important and need to work in unison to demonstrate an environment which promotes both professional values and compassionate practice. Frequently, the PaCs would discuss actions that were or could be undertaken by TRs to reflect it was safe for them to be open.

"But the simple thing there is to ask people isn't it. Where would you rather be, would you prefer to have some privacy and be on your own or would you like to carry on being where you can see more people and potentially have a chat? It's easy enough to do, isn't it?

PaC Site C

"She said are you sure you're okay?"

PaC Site B

In the participants examples the TRs actions demonstrated they considered the patients preferences and provided them with a platform to be open. Thus, indicating the TR is interested, it is safe for them to talk, and their disclosures will be dealt with professionally.

To display compassion the TR must possess an attitude which considers this aspect of the patient's experiences to be important. They then portray through their behaviour they are seeking to actively promote and create an environment where patients are comfortable to be open. A decision was made to change the name from 'permission to open up' to 'open' as this captured clearer the meaning of the category.

Intent (previously called willing)

The theme termed 'willing' emerged from the STRs and TRs focus groups. It was perceived to be part of the attitude held by a TR which displayed commitment to the patient. Much of the discussion was based on 'Frank's' scenario and the reluctance of the TR to address his concerns and engage in his care.

"It's the reluctancy bit, as if, oh well I have now got something else to sort out"

TR Site A

"..the way they responded to the patient, like they shouldn't have reluctantly, like nodded in reply and said it wasn't their area"

STR Year 2

As indicated in chapter four, the North Trent group felt 'willing' should be eliminated from the findings. The group believed TRs *"are being paid, so you would hope and expect that they would be willing".* Although the focus group participants felt involvement in 'Frank's' care is important, their insights demonstrate that being willing is not purely the undertaking of the action. Analysis demonstrates willing relates to the desire of that individual TR to undertake the task supported by the physical display of that desire through their behaviours. For the participants the TRs reluctance displayed a lack of consideration and an inability or lack of desire to try to understand what 'Frank' was going through.

"Yes, she probably would or she'd probably have been more willing to help if he'd cried, I reckon"

TR Site B2

"You get the two kinds of people, maybe that some people just give in and would be like, that's it, so he was rude to me the first time, therefore that's it. I'm not even, give up with the patient now. Whereas other people would be like, will kind of probe more and try and help more and try and understand why they're like that, and then try and be more compassionate"

STR Year 2

This desire is better represented by intention and when intent is present in the attitude of the TR their actions are perceived to be genuine. The decision was made to rename the category 'intent' in order to better reflect the meaning of the theme.

Cultural Values Summary

The findings demonstrate ‘person-centred’, ‘caring’, ‘open’ and ‘intent’ were all considered by the participants to be cultural values. Each value was mutually agreed during co-production as a form of compassionate display. The values were thought to reflect an attitude which fosters an attentive and personalised approach to patients. Those same principles apply to cultural values as they did with professional values. When the patient can identify the TR considers cultural values to be important and is trying to uphold them in their behaviour, it signifies they hold an attitude which is congruent with compassion. When this congruence is not present the TR’s attitude and subsequent behaviour would not represent compassion.

Environment (previously called treatment environment)

This theme emerged from all three participant groups. The name of this category changed from treatment environment to environment. Treatment environment was thought to imply the clinical nature of an area whereas the category related to the collective ethos and practice of those within an environment.

The STR and TRs discussed how the radiotherapy environment could enhance their ability to be compassionate.

“How positive this place is compared to, you know you think its cancer, it’s devastating but yeah, I was struck by the positivity that’s here and I think that helps us in a lot of ways to be compassionate again towards patients”

STR Year 1

This benefit was attributed to the physical design of the department and the practices of the TR to promote professional and cultural values. The design included elements which promoted privacy and the maintenance of dignity or enabled patients to engage in chat and develop friendships.

"..they get changed and then wait in the waiting room like everyone's waiting together in the waiting room whereas here the patient gets changed in their own cubicle and they don't have to sit with everyone else". Because obviously they all know why they're there but it's one thing to know that you're all there for the same thing but to kind of see someone without their clothes and in a gown, it sort of takes away their identity and just puts them as a cancer patient or something. So, I know when I looked around … I found it quite daunting to think if that was my family member I wouldn't want them to go there because I just think it takes another piece of them away whilst they sit like an animal waiting for slaughter or something.

STR Year 1

"It was like a little club. They're all chatting and afterwards she said it was a pleasant experience"

PaC Site A

The findings from stage one analysis of the focus groups initially appeared to focus on the physical aspects of its design, how it integrates or isolates patients. Analysis of the discussions of the co-production in stage three however, identified clinical environments are perceived to reflect whether TRs care about a patient and their needs.

The co-production participants and members of North Trent expressed how they will always remember the location and setting of their treatments. The North Trent group suggested that "*treatment environment is an adjective of the noun culture"*. Furthermore, the physical environment on-view to them represents a department's culture and what it stands for.

An environment which is poorly kept was one example provided at the North Trent event to represent something deeper than it just being superficially unclean or untidy. Instead, this was felt to imply indirectly that TRs don't care about the patients by not being "*bothered*" about where their care is given. A second example was if departments were not using the environment where the patient's privacy and confidentiality and/or dignity was maintained then it could be perceived that staff do not think this is important. Again, this would signify the department culture and those staff who work within it, do not care about these values.

Second stage analysis of the focus group transcriptions displayed insights into the concept of culture and its role within compassionate display. Culture was felt by the participants to be reflected in the behaviours of the radiotherapy team. There were many examples of behaviours and how they represented the culture. The analysis identified the significance of the outwardly portrayed culture of the environment that could manifest compassion.

“Because the fact that they’re talking to another person gives you the impression that this is not the first time that they’ve had this kind of joke and laughter about”

PaC Site B

“Kind of a dodgy work culture in that place, you wouldn’t actually get that, I don’t know in department. It sounds like it’s quite like, you know, something wrong with the whole department if it was like that, the way that the staff were being managed and the situation was like, it’s extreme.

STR Year 2

One TR voiced they found compassionate practice ‘difficult’. They attributed this to language and cultural barriers making it challenging for them to understand and adjust to the individuality of each patient.

“I think that the biggest problem in actually displaying the accuracy and compassion is the diversity of the patient you get. We’re treatment roundabout forty average patients per unit. How do you actually find out which one out of those forty times six, is it six units, five units okay, finding out exactly those specifics okay and at the same time, adjust your compassion level to each one of them, that’s incredibly hard”

TR Site B1

The TR put forward the notion of compassion fatigue and burnout and how it may impact on a TR’s compassionate practice. The other participants responded swiftly to their comments and there was a noticeable change in the atmosphere of the group.

“But you do it naturally though; you probably just do it and don’t think about it”

TR Site B1

“F: But we are professionals and we shouldn’t, when we switch off it should be when we take our uniform off and head home”

M: And how often can we keep that up, that’s what I’m trying to get at?

F: That’s fine, I do it every day”

TR Site B1

There became an alliance between the other six participants and the individual who had disclosed this. The collective appeared upset that a member of their team was apparently not displaying the same level of compassion as others within the focus groups, and the wider team. This phenomenon demonstrated the passion and pride the TRs held for delivering compassionate care. The idea to them that within their department a colleague may not be practising to their standards was upsetting to them.

If TRs and the department in which they practice, collectively sign up to support values to achieve a culture of compassion and appreciate the importance and impact culture has then it signifies they hold the associated values as important. If they then behave accordingly, it demonstrates that their attitude is congruent with compassion. In contrast, where they do not consider these values are important, then their attitude is not congruent with compassionate practice.

Attitudes summary

The findings have demonstrated how professional and cultural values both need to be present for compassionate attitude to be portrayed. It is these values that are fundamental for establishing intent, an innate desire within the TR to be a compassionate professional and human-being. The findings, however, indicate that both sets of values are influenced by the environment in which the TR is practising (Figure 5.14). Their attitudes are shaped by both the collective culture and ethos within the environment and what the physical environment depicts about that culture. Although not technically an attitude, the environment needs to align with those attitudes in order to create a setting that promotes compassionate behaviours and practice.

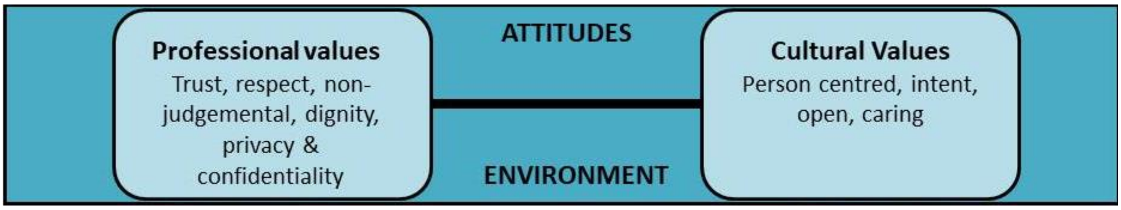


Figure 5.14: Conceptual framework – Attitudes.

This next section reports on the findings of the second component of the framework; behaviours.

Behaviours

Behaviours are the observable activity in which a TR must engage in order to undertake compassionate display. Their undertaking is influenced by and symbolises that the TR upholds those professional and cultural values. Subsequently, the behaviours enable the patient to recognise and interpret that the response is influenced by an attitude congruent with compassion. Three behavioural classifications were established through the analysis: ‘embodied connection’, ‘characteristic expression’ and ‘indicative communication’. Each classification and their respective themes will be detailed in order in this next section.

Embodied connection

Embodied connection is composed of six themes, genuine, perception, recognise my circumstances, personal touch, reacting and adapting, consideration and rapport (Figure 5.15).

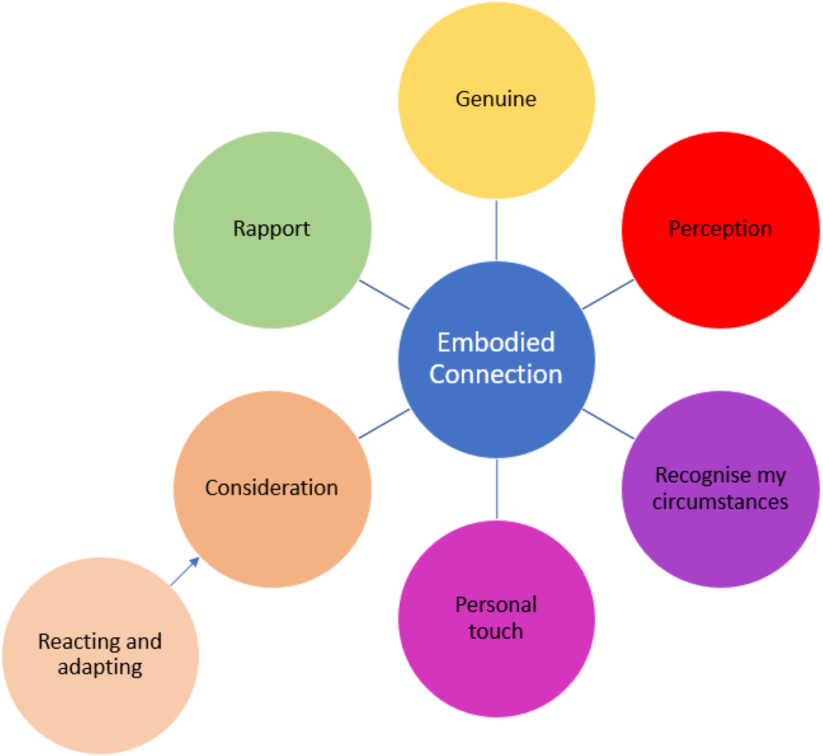


Figure 5.15: Embodied connection

Genuine

Second-stage analysis demonstrated how ‘genuine’ which emerged from the PaCs focus groups, is not in itself a compassionate display. Instead, to be considered as compassionate, the attitude, behaviour or practice presented by the TR must evidence genuineness.

“Actual actions I think you have with compassion rather than just being superficial about it”

PaC Site A

Exaggerated or ‘overblown’ behaviours were thought to reflect insincerity, and to PaCs portrayed the TRs as disingenuous.

“You can’t be overtly compassionate, can you? You’ve got to be the happy medium”

PaC Site C

Participants gave examples of where professionals simply ‘went through the motions’ doing or saying what they thought they should or been told to do. This signified insincerity rather than responding to the needs of that individual patient.

“Yes, even the consultant who says the right things, but you can get a feeling they don’t really mean it”

PaC Site B

Participants discussed how this often occurred when asked by professionals how they were feeling; disclosing they could tell if the professional was interested or listening to their replies.

“You know the difference when someone says how you feeling and you tell them whether, you can tell whether they mean it or they’re looking over your shoulder to the next person, oh are you really. No and then they start to, there is a way you can tell the difference”

PaC Site B

In a genuine display, the PaCs would want the TRs to respond in a manner which demonstrate desire or a regard for the purpose of the task.

“..and I’m genuinely interested”

PaC Site B

The findings demonstrate for PaCs to perceive TRs behaviours and practices as compassionate, they need to be based upon a desire to undertake them as part of a compassionate response. Where behaviours or practices are undertaken because it is a professional expectation or delivered superficially does not signify genuine intent.

Perception

Perception emerged from the PaCs and STRs focus groups. Analysis revealed perception is a two-sided concept. Firstly, it addresses the need for TRs to have an awareness of their own style of interaction and engagement with the patient.

The participants felt a genuine intent to be compassionate may be present, but the TR may not know how to display it. This was termed self-perception.

“Like you can see that they do try to maybe do some things but sometimes it might just come across as, in the wrong manner, sometimes”

STR Year 2

Secondly the professional must also have an awareness of the individual patient with whom they are engaging with. This enables the patient to recognise the TR’s display is person-centred. This was termed perception of others.

“I can think of two cases, two people within this hospital, and one consultant. One’s my husband and the news he received from the consultant he received the same way as you did….. The other one was my friend, who had the same consultant, but they were totally different kinds of people and she received the same kind of information very differently”

PaC Site B

Analysis shows the two concepts of perception are naturally linked. Participants insights highlighted there needs to be a congruence between both concepts for any action to be recognised as compassionate.

"So, it's not just about giving compassion, it's about how you receive it"

PaC Site B

The TR may hold self-perception i.e. be fully aware of their own style, and therefore believe their behaviour represents a compassionate display. However, if they do not have a perception of others i.e. an awareness of the person in front of them, then their behaviour may not be perceived by them as compassionate.

"Because it is, it's not always a match between the two. Because you, (participant) *saying the way the consultants might speak to you, you don't know what, they don't know what you're hearing is what I'm trying to say. You know, what is said isn't necessarily what is heard"*

PaC Site B

In contrast, the TR may have awareness of the individual in front of them but not self-perception. They would then fail to consider how their behavioural style is exhibited and their behaviour may not be interpreted as compassionate.

"But it's also transmitting that to some person on the receiving end. You know, you can feel it. You can feel for them but do they know that you're feeling for them, and does it matter?"

PaC Site B

Perception relates to the ability of a TR to understand and appreciate what behaviour is required as a compassionate response from two perspectives, their own and the individual patient. The two must occur harmoniously, for when a dichotomy exists the intent of the TR attitude to be compassionate unfortunately can be lost.

Recognise my circumstances

This theme emerged from the discussions in the PaCs focus groups and gave insight into their interactions with different health professionals. During the analysis it emerged how the patients particularly liked when professionals had an appreciation of and considered their circumstances during treatment.

"When I had, I think it was the first session, I think, or the second session of chemo, I was quite poorly. And for someone to say, what's wrong with you, it just made me so angry. Because you don't say' to somebody what's wrong with you, it's the whole point and you can see it as well.

PaC Site C

"Because you're going through so much and then you've got, like your emotions are so high and you're so sensitive to that time, sometimes you don't even know what's happened to yourself"

PaC Site C

Participants reported that on some occasions there had been little regard for how they were feeling. Professionals addressed the completion of tasks, whilst failing to consider their physical and emotional health.

"But for example in the morning you know if you put the lights on at half past seven and you are actually out of bed, regardless of how you felt you had to get out of bed, make the bed and you had to wash by a certain time and it's just when you think about how much of it is governed by task orientation"

PaC Site A

The participants felt it demonstrated the professionals did not know them as an individual person, thus demonstrating their attitude was not person-centred.

"It's a lack of appreciation and understanding"

PaC Site C

Similar to perception, this theme relates to the ability of the TR to consider the individual patient during their behavioural response. However, where this category differs is that consideration relates specifically to the situation those patients are facing. They want TRs to understand how much impact the diagnosis of cancer has on their whole experience.

Personal touch

All three participant groups perceived personal touch to represent a compassionate behaviour, believing it to have a positive impact on patients.

"I think it 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

The theme considers a TRs approach for recognising the patient as an individual human-being.

"Obvisouly its not always possible to remember every converstaion that you have with every patient because there are a lot in the day but just, you know, being able to pick up on certain things that, oh, well, that patient is the one that's got this going on in their life and you can ask them bout that and I think they like it because they just find it more like a personal touch to the treatment"

TR Site C2

Analysis identified that personal touch is displayed by knowing the patient not only as an individual patient but as an individual human-being and responding in a manner which recognised their individuality. Insights from across the transcripts identifies that a personal touch requires the TR to complete a four-stage cycle, of recognition and interpretation, knowing, remembering and displaying (Figure 5.16).

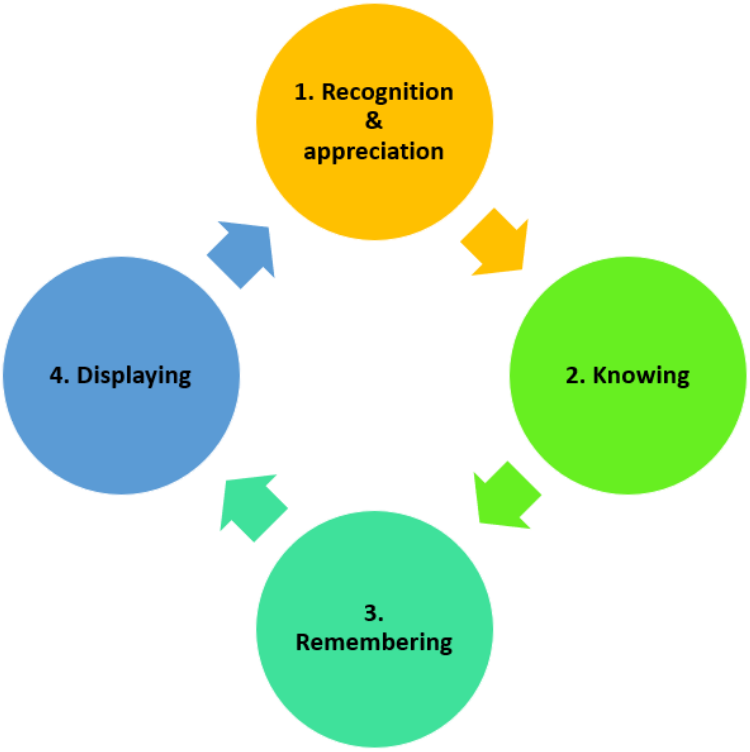


Figure 5.16: Cycle of personal touch

In stage one, recognition and appreciation, the TR must start by recognising and appreciating the patient as an individual.

"Simple things like when you're asking them a question about their day or their weekend or just about their life in general"

STR Year 1

Stage two knowing, in which the TR must begin to know the patient, establishing details relating to their lives as a person, not only a cancer patient making their behaviours person-centred. This was thought to be achieved by employment of effective communication skills.

"To pick up on little things like that and just things like if a patient normally comes with someone like a partner or a friend and then if they don't, it's the little things like that, so noticing that"

STR Year 1

Remembering is stage three, where the TR needs to then remember and recollect those details shared by the patient during their interactions.

Stage four involves displaying, where the known and stored information is then recalled, the TR then adapts their behaviour appropriately for this patient.

"It was my birthday and I had a pickline in, but at the time they didn't have a nurse who was trained to take bloods from the pic, so I have to have it taken from a vein and the nurse specialist…., she say's because it's your birthday.. I will take bloods from your pic line as opposed to being stabbed and she would even give you a birthday card signed by her and the consultant"

PaC Site A

Analysis identifies without the completion of each stage within the cycle, the behaviour of the TR would not represent a compassionate attitude. As a result, it would not be person-centred, failing to align with the patient's perception of compassionate display.

Reacting and adapting (merged with consideration)

Similar to person-centred, this theme emerged from all the participant groups and addresses the need to appreciate every patient is different. This should then prompt a reaction appropriate to their individuality.

"It's reacting, changing your behaviour accordingly to how they would like you to make them feel better"

TR Site A

"*Not like delivering one service, one same service for everyone"*

STR Year 3

Second stage analysis demonstrated this theme shares the same underpinning principles as person-centred. This reflects the attitude required for a genuine compassionate response to be fostered. Reacting and adapting however was shown to be behavioural, illustrating the manner TRs should conduct themselves when desiring to deliver a compassionate response.

This understanding was established from the TRs and STRs discussions where they used descriptive examples of behaviours to illustrate compassionate display.

"That old lady earlier, she stood waiting in the queue to come and I called her and she just, she were miles away and she came half way to the desk, so I took her name and then instead of saying to her, I actually just got up and walked round and spoke to her. She was seeing the Dr first, and I said if you want to just take a seat over there because you are seeing the Dr first this morning. I say, and then if you just come back to the desk and we will make sure you are booked in your treatment. But just doing sort of little things like that, if there's somebody in a wheelchair, I know we can't always, but I always physically stand up if I am on reception to make sure I say good morning"

TR Site C1

"I think it goes back to, if you're in a routine and you're asking patients all of these questions, its then like adapting it to the patient, like we said before. Anyone could just like ask, like questions in a set order, but it's how you act on them, from what the patients given you back"

STR Year 1

In their examples, adaptation centres upon two areas: a TRs level of engagement with a patient and the level of information they provided to a patient.

"It's probably dependent on the individual as well, so you could provide compassionate care to somebody who really wants to talk to you about something specific but then other people might not want to talk so much and want to kind of ignore what's going on, so therefore you might be compassionate if you just adhere into that as well to make sense"

STR Year 3

"The patients they're a little bit more sensitive that would maybe, you know the ones that would want to know the facts whereas you know, you kind of can filter your information and tailor make it to that patient"

TR Site C2

Their discussion demonstrated how they use their knowledge of the individual patient to adapt their communication style.

"So, choosing the right words once again is crucial in actually getting an understanding and getting him to talk, to break that wall by himself rather than you going there with a battering ram, an unwanted battering ram"

TR Site B1

Reacting and adapting is the observable activity undertaken by the TRs based upon their disposition to be person-centred.

Consideration (previously called considerate)

‘Considerate’ emerged from discussions within all three participant groups. The TRs shared some difficult situations’ they had faced with patients. Examples included when patients had disclosed intimate details about their sexual function or were struggling to hold their bladder during treatment.

“It’s really important to us, and I could have, like laughed along, but I was like you know, no. it is a quality of life issue. You know, we need to sort of accept that”

TR Site B2

“You have got to be compassionate and you do, but then people have been waiting. There’s patients that are waiting to wee themselves because they are trying to hold and they can’t”

TR Site C1

The TR felt in these situations’ consideration needed to be given for what the patient was currently facing. Their insights demonstrated if TRs are thoughtless and inconsiderate to the needs of patients and fail to consider the impact of the situation, they are actually being non-compassionate.

“They’ve sort of made this feel a bit like a nuisance really”

TR Site C2

The data shows when being considerate, a modification of behaviour occurs based on what the TR has identified to be the patient’s individual needs. The findings suggest consideration is a behaviour exhibited by TRs as part of a compassionate response. It is driven by the desire to be person-centred, as the TR considers the patients predicament and modifies their response, portraying they are sympathetic and sensitive to their situation.

By considering the patient, the TR can influence their own behavioural response to denote a compassionate display. The analysis illustrates how this theme shares the same principles as reacting and adapting

The two categories were subsequently merged and titled consideration, reflecting a thought process with has been actioned through behaviour.

Rapport

Rapport emerged from the discussions within PaCs focus groups. It was perceived by the participants as a form of engagement, a means to build a connection between the TR and themselves.

"I think that's really important having the same person that you go and see each time, so you can sort of build up a little bit of rapport with them"

PaC Site A

"And I think however long your appointment is, I don't know, say quarter of an hour, whatever it is, for a medical professional, you've got to get some rapport going – haven't you, pretty quickly. So that's a technique"

PaC Site C

Although rapport did not emerge as a main theme within the data, it was popular during the co-production workshops. It was selected at all three co-production sites in four of seven groups, making it the fourth highest category, equal to appreciation of needs and sensitivity (Appendix 24).

Secondary analysis identified that the characteristics of rapport are illustrated within other behavioural categories**.** In particular, 'rapport' alongside **'**personal touch', 'perception', 'genuine', 'recognise my circumstances' and 'consideration' all establish behaviours essential to both develop and demonstrate a connection with the patient. Connection enables TRs to 'know' about the patient and be able to utilise this knowledge to shape their practice.

Embodied connection summary

The behavioural classification ‘embodied connection’ encompasses the themes that symbolise those behaviours which enable a TR to display attitudes which promote cultural and professional values. The six behaviours of which embodied connection is composed were perceived by the participants to reflect a tacit knowing of the individual patient; an intuitive ‘togetherness’ enabling TRs to instinctively respond. Conversely, those behaviours enable the patient to recognise and interpret the response as a compassionate display.

Characteristic expression

Figure 5.17 presents the four themes of this classification.

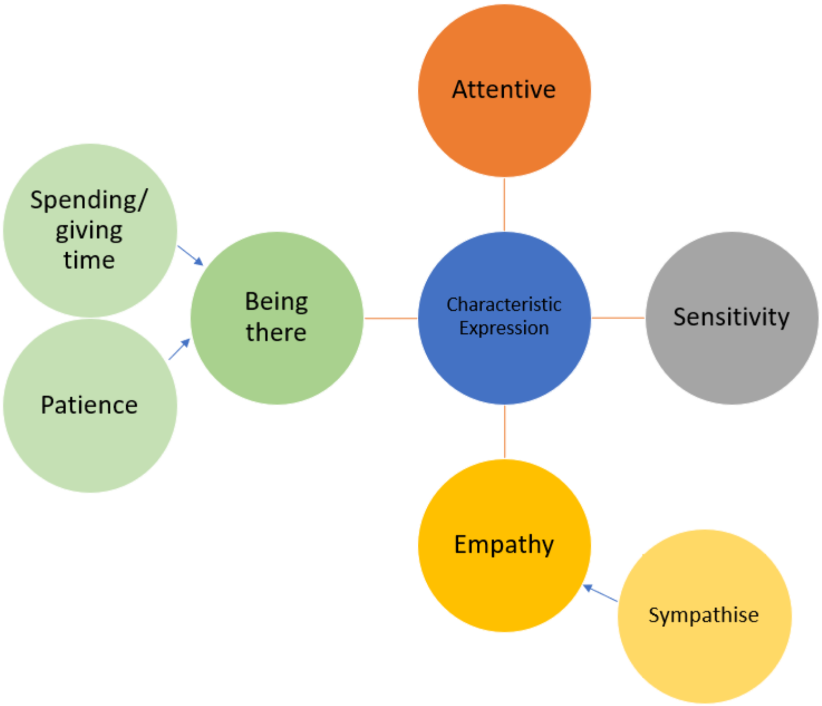


Figure 5.17: Behaviours - Characteristic expression

Attentive

‘Attentive’ emerged from the discussions of the TRs and PaCs focus groups. In their experiences, the PaCs expressed that when they perceived compassion had not been delivered, the professional had been distracted and did not give them their full attention.

“I was talking to somebody earlier today and they asked me how I was and I was trying to explain how I was, and as I was explaining they were looking over there and something was happening over there. So, I, they drifted in and out of the conversation. So, you can tell straight away”

PaC Site B

The participants’ insights demonstrated that if TRs are not paying them attention, it signifies that other people or things are more important. Although the PaCs appreciate everyone has needs, during their interactions with TRs they want to be the focus of the attention.

“If you’re talking or dealing with one person, you expect them to give you the same amount of focus”

PaC Site B

Distraction may also mean the TR is lacking in due care and attention, and as a result, may not be diligent in their duties.

“The nurse who was giving me the chemotherapy, somebody asked her behind her if she had children at home. And she carried on giving me the chemotherapy but talking to the person about her children and I said, actually, can I just stop you a minute, I said that’s burning. And she looked round and said sorry, Oh its fine and the carried on talking. Actually it wasn’t, it came back through and they had to stop and flush and she left the room crying, embarrassed because she had not given the time to the person she was dealing with, which was me, that was non-compassion.

PaC Site B

The participants insights demonstrated a lack of attentiveness, which represents a lack of intent to be compassionate as the TR is not committed to them.

Empathy

This category emerged from the discussions by the STRs and PaCs. Discussions regarding empathy were prominent during the focus groups with participants believing empathy is a core component of compassion. The STRs felt strongly that compassion could not occur if empathy was not present. In some instances, students thought them to be so inter-dependent; they were believed to be the same thing.

"The word compassionate in the sort of sentence I was using I could easily switch it out for empathise or empathy"

STR Year 1

Both participant groups felt the ability of a TR to put themselves in 'the shoes of a patient' provides the opportunity to see the world through their eyes. It was important to them that they could have a level of insight into PaCs lives.

"But it was very much sort of like trying to put himself in my shows and trying to, rather than just"

PaC Site A

"*You think about what they are going through and put yourself in their position and then how would you feel and how would you want to be treated*"

STR Year 3

Placing themselves in that position enhances the TRs ability to appreciate and comprehend what the patient is facing, all of which was perceived to facilitate understanding.

"Understanding someone, you known what the situation is they are going through"

STR Year 2

"Yes, he didn't understand why I, because I was borderline, he thought well don't bother and referred me to the oncologist to go straight to radiotherapy"

PaC Site A

The importance placed upon the concept of understanding has been common in the analysis of the focus group transcriptions. The participants in both groups articulated that empathy as an aspect of compassionate practice was in the understanding of that person's circumstances. However, the analysis shows that understanding alone does not promote compassion, the TR needs to utilise this understanding of the patient to shape their practice.

"And you are feeling some understanding and you want to have the right approach"

PaC Site C

"..put themselves in their shoes for that moment and thought if that was me how, like how could we possibly work it so"

STR Year 3

Empathy aligns with those concepts identified within the theme person-centred, which incorporate values associated with personal individualised care. Upholding those values, the TR shows congruency with an attitude which desires to engage in compassionate display, distinguishing their behaviour from obligation to genuine intent. Participants appreciated that no amount of empathy will allow TRs to fully comprehend every issue or situation the patient faces, this being unrealistic.

"Yes I think its just about showing thet you're caring an understanding. I know they're not going to understand 100%"

PaC Site C

"You can put yourself I the patients shows to an extent like"

STR Year 1

It is the ambition to try to achieve understanding, i.e. having an intent, which displays the TR is engaging in compassionate behaviour.

Sympathise (merged with empathy)

Sympathise emerged as a theme across the discussion of all three participant groups. The participants likened sympathise to empathy. They believed it formed part of understanding and being considerate to a patient's situation.

"Relate to them. If you've got experiences of your own, you can explain the problem, say that it's not just them going through this. Everybody has things in their life that they struggle with, even if it's not a cancer diagnosis. There are some parts of having that diagnosis that you can relate to in other ways"

TR Site C2

Relating to a patient allows a TR to understand the patient, their recollections helping to interpret how they felt or would feel in the same /similar situation. The participants' insights demonstrated, by obtaining understanding places TRs in a position to identify what help or support the patient needs. Subsequently demonstrating they are sympathising by having the desire to help as they appreciate their circumstances.

"You think about what they are going through and you put yourself in their position and then how would you feel and how would you want to be treated"

STR Year 3

The STRs spoke often about putting themselves 'in the patient's shoes', whereas for the TRs it was about the ability to understand and recognise the patient's sensitivity. This was perceived to be part of being able to read the patient, be aware of their current issues, wanting to make things better or at least no worse. Analysis shows the intended outcome for each of these is to demonstrate to the patient how they hold insight of their situation and the desire to aid as part of a sympathising response.

Due to the parallels between empathy and sympathise, the decision was taken to merge the two categories, collectively named empathy.

Sensitivity

The theme sensitivity emerged from the focus groups of all three participant groups. Analysis across the groups identified how sensitivity as part of compassionate practice can be twofold; an awareness of others and the way you treat another. An awareness of another aligns with the principles of empathy outlined above, the ability or inclination to understand the patient and their current predicament. To reduce repetition, this facet of sensitivity is not detailed, considering only the way you treat another within this theme.

During their treatment the PaCs had desired for the professionals to be sensitive to them in different ways. Parallels can be drawn with the theme ‘respect’. The findings demonstrate TRs need to display sensitivity to patients in three of the four facets of respect. Being sensitive to them as a human-being (1), as someone with thoughts and feelings, who experiences pain and emotions.

“You think about what they are going through and put yourself in their position and then how would you feel and how would you want to be treated”

STR Year 3

They desire the professionals to be sensitive to the fact they know their own mind, body and health and should be considerate of this, not dismissive (3).

“This person doing my biopsy because they kept doing it wrong. I mean I was in agony with the bloody needle going in and out”

PaC Site A

Sensitive also of the fact they need their help and are in a vulnerable position (4). So rather than ridicule or use them as a personal form of amusement, be sensitive to their situation respect them and care for them.

“And we can’t be certain they’re talking about the guy who’s just left but, again as you said just now, to then leave a room and then to be joking about even if it was another person is so insensitive”

PaC Site B

All participant groups agreed, sensitivity (or insensitivity) towards a patient was thought to be displayed through the behaviours and actions of TR and health professionals.

"I've had patients that discuss with me sensitive information and I tend to find that a hand on the shoulder, on the back makes them much more comfortable, you can just sense it sometimes in the way they approach, the way they talk and of course, you're asking the question, you know it's saying the right words as you quite rightly said, how to approach it. Would you like to be moved to somewhere more private rather than here and then take it away, it's just finding that right combination between all those three"

TR Site B1

"I've had a patient on the bed before, on LA4, obviously the people where we sit is at the bottom of the maze and you might have a bit like .... coming in and asking when a patients getting of the bed or whatever, she might crack a joke, you can hear them laughing outside but I'm in the room setting a patient up and all you can hear is people laughing. Like that's not, the patient knows it's not about them, but they can still hear that and that's not very nice for the, is it? They know it's not about them though and it probably doesn't bother them but it bothers me because I can hear that and I'm not even the patient, so I would then go out and ask them to be quiet because that's not showing care and compassion"

TR Site B1

The analysis demonstrates however, that sensitive behaviour cannot occur without understanding. As a TR cannot display and respond to patients in an appropriate and sensitive manner if they are not sensitive to and understanding of their situation. Although based upon the same principle of understanding another, the theme differs from empathy as it considers specific behavioural display which represents the TR is sensitive to the different aspects of a patient.

Being there (previously called spending/giving time)

Being there is a multi-dimensional theme; it emerged from the discussions across all three participant groups. Following the co-production workshops, two themes 'taking time' and 'spending/giving time' were merged.

The discussions across all the focus groups highlighted the allocation of time to an individual patient was a compassionate response. Analysis shows a compassionate display is not simply illustrated by the apportionment of time. In the discussions from which this theme emerged, being “there” was a key word used and denoted presence to the participants.

“Even if she was in any pain, because she knew that someone was there for her and we would listen to her”

STR Year 2

“And I think the main thing is being, just being you and being there, if they want to talk and being a good listener”

PaC Site B

Spending time with the patients provides the opportunity for the TRs to be actively listening, but participants believed it also indicates to the patients that active listening is occurring.

“Taking time out to listen to them”

STR Year 1

All participants believed active listening affords TRs with the opportunity to identify needs, consequently enabling the TRs to meet those needs.

“Because you’ve had that time to sit down with them, talk with them, talk with them, address their issues, find out exactly what makes them laugh and doesn’t make them laugh and the approach”

TR Site B1

“It’s just to be there for the patient and see what’s really going on”

STR Year 1

In addition to ‘being there’ providing the opportunity to communicate, for the PaCs it also signified a closeness between them and the TR. As a result, the PaCs felt secure in the knowledge the TR could be relied upon if they were needed. But when this closeness was not present the PaCs felt alone and abandoned.

“I know she’s there”

PaC Site B

"But at the time when I wanted help no-one were there for me"

PaC Site A

Being there was shown by the analysis to promote the formation of a relationship. Affording both parties with the opportunity to get to know one another and potentially connect.

"She got to know me and she knew about me and everything"

STR Year 1

"I was really able to build up a relationship by showing him compassion"

STR Year 2

Hurrying patients was seen by TRs and STRs to damage relationships. Feeling rushed portrayed to patients that they were not important, merely another patient treated as part of their workload.

"We were trying to get the 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

"I just want a chat, I just want to chat to someone, because she felt like we didn't give her enough time, you know, for her to explain what she was going through"

STR Year 2

'Being there' signified security to the participants, by showing the TR were displaying a personal approach and commitment to the individual.

"She just stayed an extra hour chatting with me"

PaC Site A

The STR insights indicated continuity of care is key to forming a relationship / friendship with the patient.

"That's where I think the time when you're getting the patient into the changing room is so valuable"

STR Year 1

"Someone's going to have to bring the patient round anyway, like I think that's a really easy time that you can show some compassion and say, how's your daughter doing, or you know, remember those things. I think just bringing the patient round is something that's got to be done and it's such an easy time to, yes to display that you do care"

STR Year 2

The decision was made to change the theme name, as spending/giving time merely denotes the allocation of time to the patients during their practice. Whereas 'being there' depicts the behavioural aspect of the category which permits the TR to connect and demonstrate their commitment to the patient.

Patience (merged with being there)

This theme emerged from the TRs and PaCs focus groups transcriptions. PaCs often felt that instead of being shown patience, they were rushed. Negative language was used to describe how the health professionals would cut short their interactions. Some of the PaCs experiences illustrated even a sense of hostility from professionals.

"It's very abrupt and they want to get you out of the door quickly"

PaC Site B

"So, and that wasn't a nice ending and I'd had such wonderful care, I've got to say that. Wonderful care, and then on the last day, to be sort of pushed out. You know"

PaC Site C

The PaCs insights of their experiences demonstrated these behaviours represented health professionals' disinterest. They felt labelled by their diagnosis and that health professionals made assumptions about them and the care they needed. They also felt the quality of their interaction was reduced, hindering the professional's ability to effectively manage the patient and respond to their needs.

You're rushing through something and you just throw away remarks, aren't you?"

PaC Site B

From a professional perspective the concept of requiring patience with patients who may be demonstrating challenging behaviours emerged from the TR discussions. They expressed the need to uphold their professional and cultural values when patients are rude, aggressive and purposefully non-compliant towards their care. They aimed to deal with these patients by persevering and having patience.

"By not reacting, again, that's showing compassion isn't it. Because if you react and say, well, I'm not going to, sort of I don't care about him particularly. You know, I think by you sort of accepting, by turning the other cheek, as it were, I think that's being compassionate. I think"

TR Site B2

The analysis illustrated patience signified 'being there' by the TR presenting their full attention to the patient. Patience was subsequently merged into 'being there'.

Characteristic Expression Summary

The behavioural classification 'characteristic expression' was formed to encompass 'being there', 'empathy', 'attentive' and 'sensitivity'. Engagement in these behaviours enables TRs to express the capacity to understand the patient in their care. Their presence symbolises that a natural and unconscious, caring approach is being adopted. Together they demonstrate how compassion is traditionally expressed through an awareness of what a patient is going through. Equally these behaviours enable the patient to recognise and interpret the response as a compassionate display.

Indicative Communication

This classification was composed of five themes (Figure 5.18)

Figure 5.18: Indicative communication

Tone

This theme emerged from the discussions across all participants groups. Tone was felt to form part of a compassionate display as it can influence the meaning or genuineness of what is being communicated. Subsequently it influences whether the patient deems TRs words to be compassionate.

"If you are very exhausted the tone in which you say that word 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 put a break on certain interpretations"

TR Site B1

"Yes, Yes and it's not always what you say, it's how you say it. Just your voice"

TR Site C1

Although the words consciously or subconsciously chosen to relay information or communicate will dictate meaning, the TRs and STRs felt the vocal tone will influence the intent of the behaviour.

"I think too often I see staff at my placement site, just sort of almost going into, what I consider to be like baby mode and just sort of treat them like, oh are you alright, you know. Not everybody needs that level of, and that's not being compassionate because you're not reading them as a person"

STR Year 2

"Some people are just really short with them"

TR Site C2

Discrepancy between tone and the intent of the spoken word has the capacity to create a conflict. The words used and the information communicated may be considered as a standard display of compassion, but if the tone denotes there is no intent to be compassionate then it will not be considered as such. Independently, tone does not display compassion; instead, it is a component of communication. Tone and communication therefore must be congruent in order to characterise compassionate display.

Welcoming

Welcoming was not a key theme, emerging only from the discussions of the STR. During the co-production workshops, it was however selected by two of the three sites and in three of the groups (Appendix 24). The theme reflected how TRs can engage with a patient to help make them feel comfortable and relaxed. The participants felt there is a need to make patients feel welcome, understanding often the clinical environment is alien to them.

"I returned and I saw her in the department and I said hi, like I saw her"

STR Year 2

"They might just like a little hello"

STR Year 2

Their insights portray welcoming as a communicative behavioural display, signifying to patients the intent to improve the circumstances they are currently facing.

Although not a key category, ‘welcoming’ is strengthened through its links to other categories. For example, the STRs discussions demonstrated they were person-centred, through their ability to read patients cues. Within their examples they expressed how often they had identified patients’ mental states (e.g. anxious or nervous). Recognition of this had then influenced their behaviour to identify and subsequently meet the needs of the patient. By adapting their behaviour to calm the patient and make them feel welcome by being friendly and welcoming, they were trying to reduce their anxiety (identification of needs, meeting of needs).

Body language

This category emerged from the discussions of all three participant groups. The theme encompasses the different forms of non-verbal communication. The perceived components of body language were discussed frequently throughout all the focus groups. This section will be structured to briefly detail what the participants felt constitutes compassionate body language and how the participants felt each signified compassion. Unless stated the discussion will have been across all three participant groups.

Analysis demonstrated the participant groups believed facial expressions and gestures, demeanour and eye contact were the three main types of body language.

Regarding facial expressions and gestures, the participants believed facial expressions denoted the attitudes, thoughts or feelings of a TR to another individual by displaying them visually.

“The radiographer sort of stood over her and physically rolled her eyes and tutted”

STR Year 1

A need to achieve congruence between the spoken word and facial expressions appeared to be essential for a TR to demonstrate their attitude is congruent with a compassionate intent.

"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

Any conflict between verbal and non-verbal potentially creates doubt regarding the sincerity of the behaviour.

"Your facial expression also needs to sort of go with whatever is going to verbally come out because then can't look shocked and then be all like say something that doesn't go with that expression"

TR Sit B1

Whilst neutral or appropriate facial expressions was perceived to demonstrate the TR was being professional, showing respect and not passing judgement on the patient.

"Can you keep your facial expression to a professional standard"

TR Site B1

Positive facial expressions and gestures were felt to display compassion, by their portrayal of traits of someone who is kind and caring, approachable and friendly.

"I think smiling is definitely a big thing like I've had two patients that have said on a morning, they were like seeing your smiling face makes my day and stuff that and it's like ah"

STR Year 1

"Yes, it is time, and you can see in the face, as a body language and you know that they're actually caring about you"

PaC Site B

Whilst gestures were thought to indicate acknowledgement of the patient, demonstrating to them they are present, hear what the patient is saying, appreciates their issues and is supportive of their needs.

"Responding, just a nod of the head to say that you're acknowledging what they're saying"

TR Site C2

Despite demeanour traditionally characterising facial expressions, the participants used the term to describe how the TR presented themselves to the patient.

"So obviously, you then have to, you don't realise sometimes that your demeanour changes towards them"

TR Site B1

The participants described the ability of a TR to display an open body language, to them this typified compassionate display; whilst closed body language created a barrier to compassionate display.

Like you said about body language, been open, just, I don't know how to explain good body language, not being closed off and just being willing to listen.

TR Site C2

"The patient looks concerned about something there's a way that you stand"

STR Year 3

The participants' insights demonstrated how a TRs demeanour can unveil their true thoughts and feelings.

"To be honest, he sort of told me my information and he seemed as almost as if he was made uncomfortable by my reaction, because he was trying to get out of the room as fast as he could"

PaC Site B

To look at, give and maintain eye contact with the patient during communication was felt to be a compassionate form of body language. Eye contact represented to the participants the TR was engaged and interested in what was being conversed, whereas a lack of eye contact portrayed disinterest.

"Look like you are actually interested in what they are saying"

STR Year 3

"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

The data demonstrates that body language is not a singular action, the three aspects of body language often occur simultaneously, as a consequence they cannot be considered independently of one another.

Analysis indicates body language forms part of a compassionate display by providing affirmation of professional and cultural values, therefore evidencing congruence to a compassionate attitude.

Active listening

This theme emerged from discussions across all three participant groups. All participants felt strongly regarding its importance in compassionate display.

"Sometimes just listening to somebody while they talk, just so they can get whatever they have got off their chest. That makes a big difference as well and I suppose that's what, part of what compassion is"

TR Site C1

The term active listening was adopted rather than listening because analysis showed what the participants were describing signified something much deeper than just the human mechanics of hearing.

"..where you are being taught how to listen and how to react to patients telling you things and what difference it makes if you are compassionate to their experience as a patient"

TR Site A

All participant groups believed active listening could be demonstrated by the TR being there and taking time to listen; this act reflecting confirmation of their commitment to the patient, to be there on a conscious and physical level. The allocation of time to a patient enables the TR to truly hear and process the information, aiding comprehension and fostering the ability of the TR to meet the patient's needs.

"And, you know, that ties in with the listening as well, it doesn't, but just having time for people"

TR Site B2

It was perceived by the PaCs to not only enable the meeting of needs, but in its undertaking could be a way needs were met. Participants reported a therapeutic benefit from being listened to.

"And sometimes having the time to listen is more beneficial than all the pills and potions in the world"

PaC Site B

"It just makes a person feel like, you know, somebody cares because you're just listening to them. Just listening to somebody makes a lot of difference"

PaC Site C

By actively listening, the TR can pick up on the verbal and non-verbal clues which may signify a conflict between what is being spoken and how the patient really feels. This again displays a deeper understanding of the individual patient and contributes to a person-centred approach.

"A lot of people do say things as a joke because they're scared to say them as well, so you have to also listen, like you did, to check that is it a joke or is it something that they're trying communicate with you"

TR Site B2

Inadequate or ineffective listening was thought by all participants to be a barrier to compassionate practice; believed to hinder the TR 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

You know you feel like you want your own voice to be heard, that's that, it would help. I think it would help if people just actually listened to what you were say"

PaC Site A

The PaCs insights indicated they could tell if a TR was truly listening to them or simply involved in a superficial process. The latter portrayed to the PaCs the TR is not willing to listen and do not have intent to be compassionate.

"I'll actually listen to what you've just said now. It's a difference and you can tell that with people"

PaC Site B

"I just think for one slice of one second, listen to me"

PaC Site B

Body language was thought to be a strong indicator of whether active listening was being practiced. Those behaviours outlined in the previous theme demonstrated attentiveness to the words spoken by the patient.

"There's things you can do to show that you are listening"

STR Year 3

The data suggests 'being there' in combination with the verbal and non-verbal components of communication are what signify active listening is present.

"Like you say, listening is really important. They ask you a question and they wait for you to answer, if you pause, they're not hurrying you along"

PaC Site B

Although important for the attainment of information aiding effective clinical management, active listening also achieves personalisation and demonstrates commitment to the patient and their need.

Communication emerged from the focus group discussions of all three participant groups. It is a collective term encapsulating the components of verbal interactions. Communication was a key theme throughout the discussions of all focus groups. Multiple examples of both compassionate and non-compassionate communication were highlighted and discussed. The North Trent attendees placed its importance within compassionate display high, with communication designated as one of four categories.

From the analysis it was clear how all participants groups felt communication was something much deeper than simply the imparting of information to another. Although felt to be a basic and fundamental component of compassion, analysis showed within compassionate display it is complex.

"Yes compassion kind of understanding the limitations between the two of you, how much have they been exposed to, and how much have you been exposed to and making sure that you are communicating effectively"

STR Year 3

The data shows communication with the patient provides the opportunity for TRs to obtain information, possibly about their health or side effects. Information gathering of this sort would form part of professional communication and enables professional practices for example signposting and implementation of support mechanism to be established.

"She will address that at review where they've got more time to discuss it"

TR Site B1

Alternatively, it may be general information being obtained regarding the patient's personal life. This kind of information gathering would form part of personal communication.

"Do they just need somebody to talk about something completely non-related"

STR Year 3

Analysis demonstrated how the undertaking of professional and personal communication enables TRs to gain an understanding and an appreciation of patient's needs.

'Chatting' was a frequent topic discussed by the STRs and TRs. They felt strongly that talking about informal, casual and often non-cancer related topics were a simple yet effective way for them to demonstrate compassion. Analysis shows 'chatting' is perceived to contribute to developing a relationship with the patient. Engaging in personal communication through this means has several potential outcomes. Firstly, it allows the TR to begin to know about the patient as an individual not just as someone requiring treatment and care. This signifies to the patient how their TR understands they are not purely defined by their diagnosis; they are an individual (person-centred). When 'chatting' involves inquiry by the TR into the patient's life external to the clinical environment, which then influences their communication this exhibits a personal touch. For example, remembering a detail about their plans for the previous evening, then modifying their behaviour means the TR is going through the process of holistic personalisation (Figure 5.16).

"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

In contrast, for those patients who did not want to 'chat' merely desiring professional communication, by adhering to their wishes they again were being compassionate. This displayed to the patient they had modified their standard behaviour to communicate in a way that matched their needs. Again, displaying a personalised approach and respecting their individuality.

Across the different participant groups, the attendees believed professional and personal communication could demonstrate compassion to patients in numerous ways.

The STRs and TRs insights illustrated how effective communication can demonstrate engagement, reassurance, encouragement, supportiveness and caring.

"Right, sit down with them in the waiting area and say like, you can do it, like you did it yesterday"

STR Year 2

"To kind of say well, I'm glad you knew about it, maybe check which consultant they were under and maybe refer them back to the consultant in the future or kind of as maybe give them a booklet, this I what we offer, if you want to have a think about these options and then you can discuss it further with the doctor when you see them"

STR Year 3

"I was trying to just be like compassionate I think because I was trying to tell him you know the side effects it can really get to you, everyone is different but anyway I will tell the staff what you are going through and maybe they can talk to you about this more"

STR Year 1

Equally, the insights provided the PaCs demonstrated how ineffective communication could portray insensitivity, a lack of care and concern for the patient.

"That's a horrible way of telling you"

PaC Site A

"They didn't communicate properly to him"

PaC Site A

Through their discussions the participants portrayed how communication represented compassionate practice not necessarily by the interaction itself but what can be achieved by its undertaking, i.e. its outcome. Therefore, communication contributes to meeting the needs of the patient. The TRs must have the intent to achieve a useful outcome from the interaction and in order to do this the TR needs to know what that patients' needs are, otherwise it would be an assumed need and not what is important to the individual. Knowledge and appreciation of needs are achieved through engaging in behaviours of communication which promote connection, therefore enabling a relationship built on trust and understanding to be established.

Principally, the TR needs to ascertain knowledge of needs and possess the intent to achieve the desired outcome through their use of communication. Further exploration of the data however, shows connection and intent are not purely enough for a compassionate outcome or display to be achieved. Participants felt language and body language were also essential in compassionate communication.

Language was felt by the TRs to influence intent. This point may seem obvious, but the TRs felt it was important to consciously consider your wording when undertaking both professional and personal communication (choose your words carefully). If not considered, those words employed could alter meaning despite a genuine intent being present.

"But it's like asking patients 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

"How do you choose which word, when to choose that word"

TR Site B1

As discussed, the body language adopted also influences the perception of the patient to the sincerity of the communication. Body language can also denote whether the TR is paying attention to the patient when communicating.

"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

By stopping and engaging with the patient demonstrates to the patients the TR is there for them, this denotes a genuine intent to be compassionate.

"You know if you need to talk or anything at all or if there's anything you want to ask, just ask, you know we will do whatever we can"

TR Site C1

Demonstrating compassion requires unity between the spoken word and the presentation of-self by the TR. If there is a conflict, and the information is not communicated in manner which is deemed genuine then the intent behind it is lost.

In summary, communication is representative of compassionate display through its ability to form and display connection and intent. It must be supported by an effective and appropriate model of delivery, equally displaying a compassionate intent.

The model of delivery requires more than a simple conveyance of information; it must combine tone, body language and the spoken word. If intent is there but suffers ineffective delivery, the intent is lost. Similarly, the outcome of the communication can be constructive, but if the TR holds no intent this is simply communication and not compassion.

Indicative Communication Summary

The behavioural classification 'indicative communication' was formed to encompass 'tone', 'welcoming', 'body-language', 'communication' and 'active listening'. When engaged in each behaviour this exhibits a TRs presence, connection and intent to be compassionate. However, a harmonious relationship in the behaviours is required for the patient to perceive the TRs behaviours as compassionate. The behaviours enable compassion due to the role communication plays in gaining knowledge and understanding of individuality.

Behaviours Summary

The analysis has established there are three classifications of behaviours essential for achieving and demonstrating compassion (Figure 5.19). Although interlinked by what those behaviours represent: embodied connection, characteristic expression and indicative communication are three distinct categories. However, it is imperative that all are present within the TR to facilitate compassionate practice. Behaviours can explicitly portray those attitudes which embody professional and cultural values.

Figure 5.19: Conceptual framework - Compassionate behaviours

Understanding individuality and appreciation of needs

This section will detail the two themes emerging from the focus groups, ‘understanding’ and ‘appreciation of needs’. These were not categorised as attitude, behaviour or practice, but the analysis identified these as essential components of compassionate display. The two collectively became understanding individuality and appreciation of needs.

Understanding

Understanding emerged from all three participant groups. PaCs alongside the North Trent group strongly believed that understanding was a defining component of compassion and without understanding, compassionate practice could not occur.

Throughout the focus groups the pronouns “their”, “they” and “them” were frequently used. These are possessive terms denoting ownership, indicating the participants felt the patient ‘owns’ their current situation, as they are the one living it. The TRs and STRs discussions show they recognised how the only way to know what is occurring for the patient is to find out. The analysis identifies that understanding is not as simplistic as finding out through inquiry. Understanding requiring engagement with the patient and appreciation of them as a person, their needs and the significance of what they are facing.

Understanding the person has been established a key theme throughout the analysis and underpins the theme person-centred. Whilst understanding displays the appreciation of differences, it places emphasis on how this understanding influences the need for a personalised approach. The STRs and TRs insights portray a contradiction with the main the principle of person-centred. As initially, there does need to be a blanket understanding of the patient’s current situation. Patients under a TRs care will (virtually) all have received a diagnosis of cancer and will be dealing with the impact a diagnosis has brought upon them. TRs need to have a general appreciation the impact the diagnosis of cancer can bring.

“You think about what they are going through and put yourself in their position and then how would you feel and how would you want to be treated”

STR Year 3

Patients will also be faced with their own circumstances that may influence their current situation. General understanding of what a diagnosis means to patients should be used in combination with understanding of each patient’s own situation.

“But that’s a fine line, isn’t it? Because the right thing for one person might be completely the wrong thing for somebody else”

PaC Site C

“She might have, or he, whoever, the specialist radiographer, might have realised that it was not a joking matter. That it was obviously having an effect on their life a lot more”

TR Site C2

Knowledge and understanding aids the adaptation of the TRs behaviours and practices towards the individual patient and their needs.

“It depends on yourself, sometimes you might want a bit of humour, sometimes you might not. You know, I just think it depends”

PaC Site C2

“I think if they continue to show that sort of front where they go right I don’t want anyone really to talk to me, then as (participant) says, I think it’s good then if you do take them as they want them, so don’t really engaged, minimal conversation. Obviously as them their date of birth and address, everything we have to do and then just go along with it and you sort of take it on their lead don’t you….. If you’re not talking I can read that, you don’t want us to talk to you so we’ll just ignore the pleasantries and we’ll go from there”

TR Site B1

The participants insights illustrate how TRs also need to recognise and understand there can be a variance within a patient, which requires modification of their behaviour daily. A patient’s needs may differ, or they may respond to the TRs behaviour differently depending on the situation they are currently facing.

"If you don't know yourself how you're going to be, or because you're going through so much and then you've got, like your emotions are so high and you're so sensitive to that time. Sometimes you don't even know what's happened to yourself"

PaC Site C

Similarly, the TR also needs to recognise and understand the impact their behaviour will have on the patient and how it will contribute to their current situation.

"Belittle his problems, I think that was the problem here that she was just kind of like waving it off but to him obviously it's a big issue"

STR Year 1

"It make a really big impact on patients sometimes. Its because they have asked for help or somebody's just not been responsive or just listened and it just completely switiches them off"

TR Site C1

By understanding a patient's individuality, the significance of their current situation and what their needs are at that time gives a TR a holistic understanding of the patient (Figure 5.20).

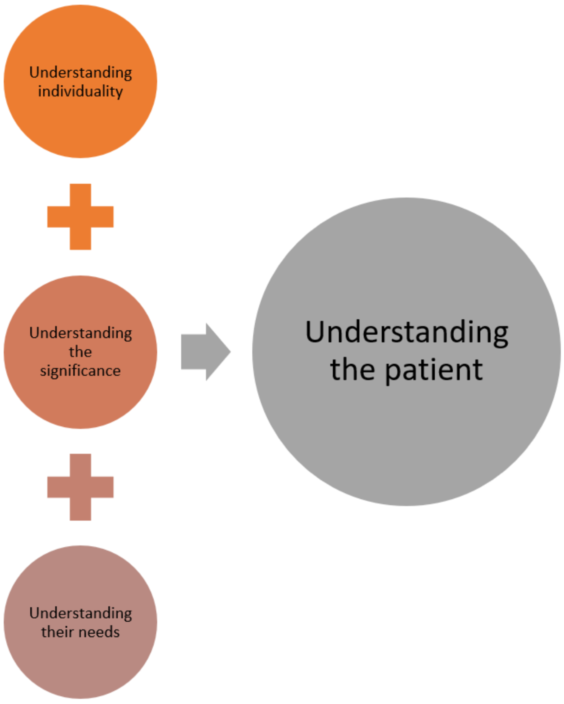


Figure 5.20: Components of understanding a patient

Importantly, analysis identified respect must also be shown if understanding is to depict a compassionate display. The demonstration of respect shows the patient the TR does not just understand, but they also value their perspective of their situation and their needs.

"If the outcome was the same, no, because then you're being betrayed by your own kind if you like. A male to male and you'd have thought there'd have been a little bit of bonding, a little bit of understanding from that point of view"

PaC Site B

"If the person I asked about reconstructive surgery had left the room and I heard them saying, oh at her age why does she want perfect boobs I would have walked out. I would have been totally embarrassed and not asked again"

PaC Site B

Understanding the patient becomes the basis for an appropriate response, influenced by considering the patient and their needs and what will be the impact of this behaviour. This demonstrates a display of compassion which is personalised to the patient and holds intent to meet their needs (Figure 5.21).

"But that's showing compassion to that person because you are doing what they would like you to do"

TR Site A

"Well you might define that as being compassionate, you're respecting his preference really"

TR Site B1

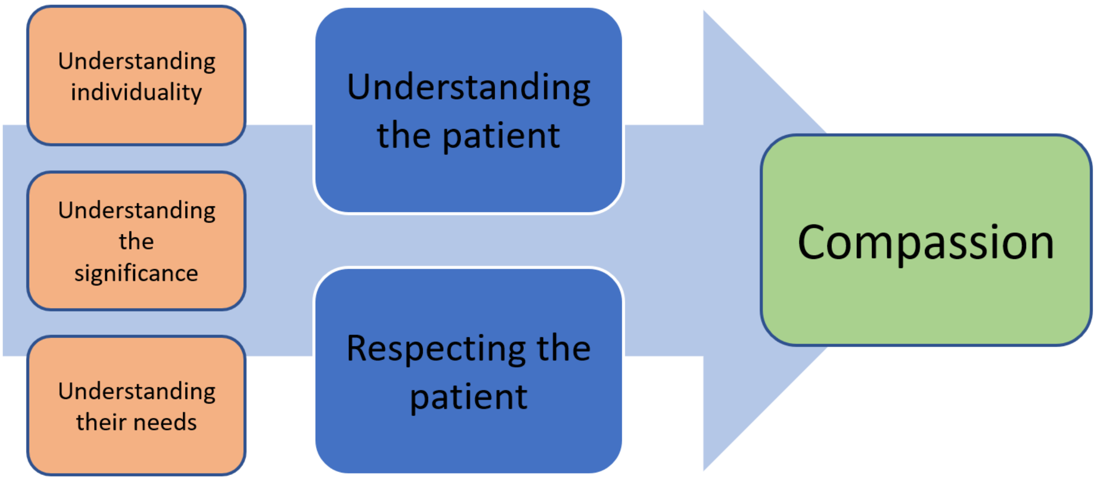


Figure 5.21: Process of compassionate understanding

Engagement in the behaviours categorised as: embodied connection, characteristic expression and indicative communication facilitate this understanding in many ways. As the TR 'knows' the patients, they can read their behaviours and body language and may look beyond the superficial responses given by patients and delve into their meaning.

"We had a lady a couple of months ago who was having breast treatment, but I was treating with a male and she was clearly uncomfortable and male a joke about it. And afterwards I'd asked her if she'd prefer just females and she said yes"

TR Site B2

"He was really showing that he needed someone to talk to"

STR Year 1

Through a TR having empathy with the patient they can enhance their own understanding of the patient by considering how they felt and the effect it had on them.

"Relate to them. If you've got an experience of your own, you can explain the problem. Say that it's not just them going through this. Everybody has things in their life that they struggle with, even if it's not a cancer diagnosis. There are some parts of having that diagnosis that you can relate t in other ways"

TR Site C2

Perception makes them consider and understand both their behaviour and how their behaviour will be interpreted by a patient.

"You can be compassionate but at the same time you can be uncaring because your own interpretation is completely different to what's needed"

TR Site B1

"I think you could always show compassion but to whoever you're showing it to might not perceive that as being compassionate either though so that's why you're always going to get these situations. You can't eradicate these like they'll always be someone who thinks you're not being compassionate enough"

TR Site B1

As established these behaviours present to the patient a TR who upholds those professional and cultural values essential for compassion to occur.

Appreciation of needs

This theme emerged from the discussions across all three participant groups. Identification of needs and appreciation of needs were merged post-co-production due to the parallels between the two themes. All participant groups believed meeting needs to be not only a defining component of compassion, but also a form of compassionate display. Subsequently, it was thought that a TRs ability to meet needs correlated with their ability to appreciate those needs. Put simplistically, all participants believed *“if you don’t know what those needs are, how can they be met?”*

“Finding out what’s important to them and finding out about their needs and how to meet their needs is really important”

STR Year 1

As established, having an appreciation of needs is an integral component for creating a person-centred approach that demonstrates individuality and understanding of the patient. Engagement with ‘embodied connection’, ‘characteristic expression’ and ‘indicative communication’ provides the TR with this appreciation.

“If a patient’s crying as well it would be beneficial to ask if they want to talk about it or not, but if they are firing them with questions and asking them what’s wrong, what’s wrong, what’s wrong, what’s wrong. I mean it could be as you said, silence, it could be just they want to release those tears they’ve held in for a while rather than speaking actually about their problems.

STR Year 1

“So hopefully by the end you know how to treat that patient, you know how to approach them. If you know someone’s’ particularly emotional and have been throughout the treatment you know how to approach them and how to get them settled down, you know. Nervous patients, stuff like that, as you get to know them you know what you need to do”

TR Site B1

Analysis identified how the failure to appreciate the needs of the patient acts as a barrier to compassionate practice. Failure to recognise them as an individual, displays a non-personalised display by the TR. If their response does not correlate with the patients need or is not respectful of their wishes, then the display will not be perceived by the patient as compassionate.

“They had to keep stripping the bed and instead of like getting to grips what was wrong with this lady”

PaC Site A

“I think in here (Frank’s scenario) as well it says that the radiographer said it’s just a side effect of his diagnosis and a lot of people will fall into that. When we’re busy or we’re rushing ad somebody say, you say to somebody how are you doing? Because you say it to everybody, and they say well, actually I’m struggling because I can’t get of the toilet. Oh it’s just a side effect from the treatment, are you taking anything? Yes, that’s fine, carry on with that but they’re probably, they’ve opened up to you, they’re wanting to talk about it. So brushing it off is not, is not the answer”

TR Site B2

Poor or limited appreciation was not only perceived by the participants as non-compassionate behaviour but could potentially be detrimental to the patient. Ignoring their needs may prevent them from disclosing in future interactions through fear of disregard or ridicule. This could result in future needs not being met or the wrong approach being adopted.

“*It makes a really big impact on patients sometimes. It’s because they have asked for help or somebody’s just not been responsive or just listened and it just completely switches them off*”

TR Site C1

“*Most men who suffer from any sort of disorder of this type are extremely embarrassed by the whole situation and to the point whereby they will not talk about it or won’t want to talk about it to anybody. But then to listen that’s somebody who you finally give that information to has then gone out and started laughing, would be, like, oh it would be horrendous*”

PaC Site B

Understanding individuality and appreciation of needs summary

Based on the analysis, the decision was taken to collectively classify understanding and appreciation of needs as ‘understanding individuality and appreciation of needs’ (Figure 5.22). Engagement in the embodied connection, characteristic expression and indicative communication provides TRs with comprehension of the patient as an individual. This provides TRs with knowledge and essential insight into patient needs and enables them to establish practices that aim to address those needs.

Figure 5.22: Conceptual framework – understanding individuality and the appreciation of needs.

Practices

Practices are the observable tasks or functions undertaken by the TR that are perceived to exhibit compassionate display. This classification was composed of thirteen themes (Figure 5.23).

Figure 5.23: Practices

Bedside manner

This theme emerged from the focus group discussions across all three participant groups.

Bedside manner is the way a TR should conduct themselves whilst addressing a patient within their care. The participants' insights established that a compassionate bedside manner reflects the attitudes held by the TR. Unfortunately, during the PaCs discussions, their experiences recalled negative examples where aggressive and rude behaviours had been displayed.

"I said to him that if it was your wife and he actually got quite angry with me. He wasn't sympathetic, he didn't have any compassion. He just got angry and said but if you have Chemotherapy you risk the chance of getting neutropenic sepsis and you might die"

PaC Site A

"..who told the patient who had had a stroke quite forthright and without sort of any feeling, if you have another stroke Mrs so-and-so you will not be resuscitated"

PaC Site B

The PaC's discussion indicated they desired calm, polite and friendly practice, rather than abrupt and aggressive directives. It was often the attitude of the professionals which caused the most upset and offence.

"There was one consultant and my wife just absolutely really hacked off by him with his attitude and it was I'm telling you this and this is what's going to happen"

PaC Site A

"That's going back to what you said about nurses having different attitudes to different patients"

PaC Site B

Undeniably, abrupt, rude or aggressive behaviours for reasons relating to professional values would not be part of a compassionate bedside manner. When considering those cultural values, all participants believed these should reflect that the TR has a caring attitude. Whereas those attitudes demonstrated within the PaCs examples demonstrate the opposite. The perspectives of the PaCs mirrors those expectations outlined by the TRs and STRs, desiring professionals to have a friendly and kind bedside manner, which reflects they have a compassionate attitude.

"Like staff were really kind"

STR Year 2

"... was just so sweet"

STR Year 3

In summary bedside manner is the manifestation of professional and caring attitude displayed through practice.

Check for understanding

Check for understanding emerged from the discussions in the PaCs and TRs focus groups. The TRs insights demonstrated that check for understanding is not simply undertaken to obtain information, but a practice which aims to improve the patient's situation. By asking more questions the TR will get to know more about the patient, what their issues are and identify their current level of understanding.

"Taking the time to go and speak to them and make sure they understand, even if you have to tell them everyday"

TR Site C1

"You just have to delve deeper into what they already understand don't you"

TR Site A

This practice was considered by the TR to aid them to gain a deeper understanding of the patient. Following the process of holistic personalisation, the TR could then modify their behaviour or practice based on this information displaying a personal touch (Figure 5.13).

Check for understanding from the perspective of the PaCs also reflected how their situation could be enhanced through communication. The difference, however, was this addressed how their situation should not be made any worse through misunderstanding. In one example, a patient spoke about the understanding her and her husband took away from her consultation about her diagnosis.

"And he was hearing if she had this and if we do that, the prognosis is good. I didn't hear those words at all"

PaC Site B

In another example a patient who attended the focus group with his wife spoke of what they both heard during the consultation when they were informed his cancer had spread.

“Because that’s all she heard. She didn’t hear the bit about no, well, we can keep your treatment and it will go on for years and years. She was still thinking, hang on a minute, this is terminal cancer. So, you know, she started this grieving process almost like accidentally”

PaC Site B

In both experiences the two individuals present heard a different message than their spouse. Consequently, the patient (example one) and the carer (example two) left the meeting with the wrong understanding of the information provided to them. One heard the prognosis was poor, whilst the other heard the prognosis was good when the converse was true. In their discussions, reference was made to it adding to their worries, the patient fearing she was going to die. This demonstrates the potential for psychological ramifications to be faced by patients when there is little comprehension of what has been communicated to them.

From both perspectives, ‘check for understanding’ establishes a way to meet the needs of the patient. The TRs see this chance to modify their approach so they can more effectively meet their needs; whilst the PaCs see it as an opportunity to meet their need for clear information which they understand.

Signposting

Signposting emerged from discussions across all three of the participant groups. The theme was associated with the completion of a task in its entirety as a response to meeting the needs of the patient. This was thought to be a fundamental part of professional practice. Discussion within the groups demonstrated the diversity of situations and scenarios where signposting was needed alongside individual management of the complex needs of patients during their cancer pathway.

For all the focus group participants, the act of signposting to another person or service indicated a desire to ensure that the patients' needs were being met. In most cases these discussions were stimulated by examples where patients were having an adverse physical experience or emotional response.

“Yes, I think even if it isn’t their area of expertise they should know where to signpost the patient. Even if it was just, oh I’ll go and get one of my leaflets I’ve got in the back cupboard somewhere. It’s better than saying that or you know, saying there’s a Macmillan centre upstairs, they can probably answer your question a bit better. Or do something practical rather than just passing it off as nothing when it’s an issue, they should know that”

STR Year 2

“Send them to someone who is specialised in that area where their job is to support in a mental way. So, I think there is more than one solution really”

STR Year 1

When discussing referrals and signposting, participants used words such as: reassure, support and help, indicating the act of signposting is synonymous with caring for the patient. Where appropriate signposting did not occur, it was perceived the TR did not care.

“Sometimes even if we can’t do anything, telling a patient that we’ve either referred them or made quick notes in their, what is it, Mosaic whatever can reassure them that you’ve done something even though we’re not the right person….Evidencing that you’ve listened to them and taken it onboard”

STR Year 1

“If we can’t look after them in that way, but we know somebody who can. So it’s just getting them the help”

TR Site C1

The TR is considered to be avoiding a professional responsibility, by 'passing the buck' to another professional expecting them to refer instead. Disappointment was felt by the participants when TRs failed to provide professional care and services to patients.

“Actually if they didn’t know at all and said, like it’s a really good question, like I’ll go and find, but like, but made sure that they knew that like it was really okay for them to ask about that and not just sort of pass it off and try and get them to look at Google”

STR Year 2

“My GP said oh well if they think you need a physical examination they have got people at their end that can do physical examinations, you need to get them to sort one out for you at their end”

PaC Site A

Signposting however needed to be undertaken appropriately, to be based on the needs of the patient and the skillset of the TR. There was acknowledgement across the groups that some TRs may not have the correct skill set or time to spend with the patient, resulting in them referring to someone who may have. But what the data identified what is not considered acceptable is just referring anyway, effectively 'passing the buck'. For a TR to perceive a practice as not be part of their role was considered dismissive, unprofessional and uncaring. Ensuring patients have in place all the right components to their care was felt to be a fundamental responsibility of a TR.

The STRs and TRs insights illustrated they believed the patient's health is in their professional hands, recognising they take responsibility for their actions and the needs of the patient. Correct, timely and effective signposting was shown to form the basis of this. If not undertaken and was deemed a conscious decision made by the professional, this represented unprofessional practice distinctly lacking in person-centredness. To fail to signpost is to show no concern for patient at that time or the resultant consequence they face from the omission of the other services or professionals.

Enhancing my knowledge

Enhancing my knowledge emerged from all three participant groups. It addressed the necessity to provide patients with information during clinical interactions. All participants identified how information could be administered by using verbal and written methods.

The use of verbal was often thought to be required when explaining or advising patients, whereas written was often perceived to be supplementary to verbal. Offered as something the PaCs could take away and digest in their own time.

"He explained it, he explained everything to her"

PaC Site A

"But we can say well we can get you a bit more information on that"

TR Site B1

In situations where their knowledge had not been enhanced, the PaC attributed this to a direct failure of the professional to provide information.

"Nobody had told you how and it were going to be like"

PaC Site A

"You would think your department, your radiology department would have literature to hand"

PaC Site B

All participant groups appreciated that TRs and other professionals could not know everything. They also all believed an attempt should be made to find it out, perceiving an attempt signified intent to try help to enhance their knowledge.

"Even if it's just a leaflet with some information on or if you can book another appointment"

STR Year 1

The participants discussed an array of areas where a patient's knowledge could be enhanced. These included but not limited to, information about their treatment and care, to help them be prepared and knowledge of other services available.

"And explaining just a little bit of why you're there or what they're going to do and actually what they're going to do because that didn't happen either. I mean I just assumed obviously with it being an ultrasound it was my heart full stop"

PaC Site C

"Just thought, I mentioned earlier about you, you know getting more advice from more doctors and stuff. I thought that was really helpful because my nurse specialist she went over to come and make, you know, get me to talk to other consultants"

PaC Site C

The examples discussed by the participants enabled an exploration into why enhancing my knowledge is perceived as part of compassionate practice. Analysis shows it pertains back to the desire of the TR to take a person-centred approach to helping the patient through their treatment. Despite information-giving being perceived as being a core duty of a TR, the intent behind its provision is why the PaCs would perceive it as compassionate (or not). It could be argued how the intent behind any information is to enhance the knowledge and understanding of the receiver. The difference however between this and enhancing my knowledge as a compassionate practice is the understanding the TR has of the patient in front of them. The PaCs considered that when information to improve their situation (or make it no worse) was provided, the TR was being compassionate. This demonstrates intent and congruence with those core professional and cultural values.

"I was told to bring somebody with me to that appointment, so my husband went with me to that appointment"

PaC Site A

"I mean, my lovely consultant said to me do me one favour (participant name), don't Google anything about breast cancer, because you'll end up with, you know, it will make it worse"

PaC Site B

"Yes, and having things explained, because I've always found if I know I'm reassured otherwise I'm worrying and thinking I'd rather know than not"

PaC Site C

Enhancing a patient's knowledge has the potential to reduce stress, anxiety, hurt and harm arising from their cancer diagnosis and treatment. The practice was therefore endorsed by the TRs and STRs and desired by PaCs as part of compassionate care.

Checking how I am

Checking how I am emerged only from PaCs focus groups. Through their discussions the participants had indicated they appreciated professionals calling upon them to check how they were. Questions would often enquire about how the patient was feeling whilst undergoing their treatment.

"They were fantastic, and they kept coming round, checking that you're alright, how are you doing"

PaC Site A

“Oh how are you feeling, are you alright with this and they kept coming round checking on (them, making) sure everybody was comfortable and happy”

PaC Site A

PaCs expressed they could tell the difference between ‘checking’ as part of a professional duty and checking out of genuine interest. The participants were happy that despite how busy the staff and the department was, the TR had attended and spoken with each of distinctly to ask if they were ok. This conveyed they were focused and interested in them as an individual. This practice moved away from task-focused, instead providing the person-centred care system which the PaCs desired.

Choose your words carefully

Choose your words carefully emerged from the TRs and PaCs focus groups. The TRs felt information should be delivered in a considerate manner, PaC’s agreed but also wanted any medical information provided to be lay. Their insights illustrate if a TRs communication does not match this, it can cause distress to the patient and signifies a lack of respect towards them.

The PaCs insights showed they felt dismayed when professionals including TRs did not consider whether they could understand the information being communicated to them.

“The lady that ran the chemotherapy unit had no compassion either because when I talked to her about this neutropenic sepsis that the, I had to go look it up”

PaC Site A

“Again, we are getting to this thing where people are not being, they are not having things explained to them explicitly in their situation to make them feel better or safe”

PaC Site A

The PaCs reflected on their experiences, they felt a lack of consideration had been shown when the professions had failed to consider the effect their communication would have. Examples included where diagnosis had been delivered in a technical manner, or the patient was made to feel isolated.

"That's a horrible way of telling you"

PaC Site A

"I think it was more from an infection control point of view that I need to be segregated from the other patients but as I say I had about six cycles and they just decided, oh we need you to put (participant name) on her own and I was thinking why, I've already had six cycles"

PaC Site A

Analysis showed that if the professionals failed to use lay language or had not considered their wording, it implied to the PaCs the professionals did not think this was important; therefore, appearing to convey an unprofessional and uncaring attitude. Even if unintentional, the PaCs perceived thoughtlessness to indicate the same thing. Their insights illustrating that, how a TR chooses to communicate depicts whether they have respect for you or not.

The TRs insights addressed how words could influence meaning rather than understanding. The TRs identified they tried to consider how they phrased things during their interactions. They believed with very little modification, the intent of a sentence and in-turn its ability to be interpreted as kind or compassionate could be affected.

"So, choosing the right words once again is crucial"

TR Site B1

"But it's like asking (the) patient and then 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

The participant insights illustrate to display compassion during their practice, the TR needs to present information to the patient that is appropriate, considered and is respectful of their situation, i.e. they are a patient and not a health professional. The same view was shared across the PaCs, even those who were or who had been a health professional.

Continuity of Care

Continuity of care emerged from discussions across all three participant groups, with each group believing it formed part of TR's professional practice.

Emerging from the PaCs data was their desire to see the same professionals repeatedly as continuity to them represented efficiency, where tasks would be completed and to a satisfactory level. Although mirroring signposting where tasks need to be completed by the 'best' person, there is a distinct difference between the two. Analysis showed for signposting, patients wanted a system of referral to other professionals. Patients' considered this to be compassionate through the inclusion of additional staff to ensure their needs were being appropriately met. Whereas for continuity of care, PaCs perceived having the same staff member as compassionate due to the opportunity it brings for receiving consistent care.

Discussions highlighted a desire for continuity was often based on fear. PaCs recalled numerous situations where they or others had 'slipped through the net' as a result of an inconsistency of professionals involved in their care. They noted how some of the consequences faced by this occurrence had included, referrals not being completed, delays in diagnosis and elements of care being missed. All of which held varying degrees of negative consequence for the patients. Inconsistency for them represented a lack of accountability, with no one professional taking responsibility for their care.

"The way I was treated at first with the secondary breast cancer was bad because my consultant was on maternity leave and we had a locum come in and various locums, so I never saw the same person more than once"

PaC Site A

"I only ever see Dr (name), I never see anybody else"

PaC Site A

The STRs perceived that continuity with a patient enhanced their ability to be compassionate. Their insights show this promotes the engagement in the three behavioural classifications, embodied connection, characteristic expression and indicative communication.

"The time when you're getting the patient into the changing room is invaluable"

STR Year 1

"Someone's going to have to bring the patient round anyway, like I think that's a really easy time that you can show some compassion and say, how's your daughter doing or you know, remember those things. I think just bringing the patient round is something that's got to be done and it's such an easy time to yes, to display that you do care"

STR Year 2

The concept of consistent quality care emerged from the STRs and TRs. Patients should have a TRs undivided attention no matter what the situation. This included when TRs had issues they may be facing themselves at home or when patients displayed challenging behaviour towards them.

"I think that's where it links in with patients as well it's got to be like a consistent thing, consistent sort of viewpoint that's ingrained into you. You can't just be compassionate on a good day, if you're having a good week at work, you've got to be compassionate on bad days as well which is probably the hardest part"

STR Year 1

"I think a big part of that as well, is putting-like, when you put your uniform on, when you've got like, your ID badge on, you can't do it can you. You can't, what you would normally sometimes do outside of work, if you've seen someone treat you like that outside of work, you would probaly just say, no sorry, bye, but like you can't do that"

TR Site B2

"By not reacting, again that's showing compassion isn't it? Because if you react and say well, I'm not going to sort of, I don't care about him particularly. You know I think by you sort of accepting, by turning the other cheek as it were, I think that's being compassionate"

TR Site B2

Collectively the participant groups' insights demonstrate continuity of care represents a practical display of compassion through the coherence of practice and comprehensive delivery of professional duties.

Reassurance (merged with encourage)

Emerging from the discussions of all groups was the concept of ‘normalising’. During this the circumstances or issues raised by a patient were explained to them as being normal or standard. It was considered that TRs undertook this practice to relay fears and reduce anxiety patients were facing. The PaCs acceded it brought them a sense of relief, stopping them feeing as isolated or abnormal.

“*It is like a normal side-effect of the treatment because he might just think I’m the only one. I’m the only one, but actually it’s very normal isn’t it. A lot of people experience it. So, maybe just saying we get a lot of people (going) through the same. Then maybe it might normalise it for him, make him realise he isn’t the only one*”

TR Site B2

“They should have said, that’s a really good question, that’s what a lot of people really suffer with this. Like thanks so much for bringing it up kind of thing and give the patient confidence that it wasn’t, they’re not the only person that’s dealing with this”

STR Year 2

“About asking the question, I want to be comforted in as much as I’m not the only person who’s got this problem. So the first thing I want to hear is, oh, this is very common amongst people with prostate cancer.

PaC Site B

The difference between this practice and dismissive however needs to be acknowledged. As reassurance was also thought to be paramount for making patients feel safe to approach and disclose information to TRs about different elements of their health and personal lives. Giving them the confidence and a sense of safety that they can speak up, they will be taken seriously and have no fear of repercussions.

“But make sure that they knew that like it was really okay for them to ask about that”

STR Year 2

A TR also needs to give assurances to the patients that they are taking the patients’ needs seriously and completing the appropriate professional practices required. This was thought by all participants to instil confidence in the patient about their care.

"Can reassure them that you've done something"

STR Year 1

"Who just felt so reassured and she said, well I'm a staff nurse and I've been doing it for 30 years"

PaC Site C

Reassurance was considered a compassionate practice by it instilling confidence in the TR and reducing a patient's stress when information about their situation and medical care is known and respected.

Encourage (merged with reassurance)

Emerging from all three participant groups was the theme encourage. By the TRs wanting the patient to gain the 'beneficial' outcome intended from their prescribed treatment this practice was perceived as compassionate.

"If it is trying to coach someone into getting their shell on, having their treatment today you can't rush that because that will make the situation worse"

TR Site A

Encouragement was often given by TRs to patients who were struggling to manage or showed signs of anxiety. Both participants groups identified encouragement was a practice they would undertake with the prospect to enable patients to continue with their treatment(s). Encouragement has some overlap with reassurance, where the intension was to make the patient feel comfortable to bring forward their issues and help normalise the situation for them.

"If you've got experience of your own, you can explain the problem, say that it's not just them going through this"

TR Site C2

"Like say to them, like acknowledge, you know well done for bringing it up because I know people find that difficult to talk about"

STR Year 1

Due to the similarities between reassurance and encouragement the decision was made to merge the two categories. Titled encourage, the category encapsulates those practices designed to encourage patients to have the courage to face their treatment(s) and the confidence to speak up about their issues.

Extra mile

This category emerged from the discussion across all three participant groups. The data shows the underpinning principle of extra mile is its practical application in supporting, helping or caring for a patient. This was established during the stage-one analysis where extra mile was perceived as practice for meeting needs by the TRs and STRs. Although in agreement the PaCs perceived it to be a meeting of needs on a higher level, a distinct demonstration by professionals of their intent to be compassionate.

Second-stage analysis has determined for an action by a TR to be classed as going the extra mile and not simply the meeting of needs it must go above and beyond what was required for that need to be met.

"It's just sometimes getting them that extra bit, just ringing up or just doing, just doing something which you think is nothing but to them it's a big thing that's just sort of being compassionate"

TR Site C1

Countless examples of practices displayed or observed were recalled by the participants, which they felt portrayed going the extra mile. These included examples from clinical practice where patient needs were predominantly associated with diagnosis and/or treatment. The TR and STRs however disagreed with the principle of extra mile in this context, supposing there should not be a baseline or minimum level of care in the clinical environment. TRs believed full and comprehensive care should be standard practice.

“I’ve been in uncomfortable positions where nurses would say that I’m not going to swab the guy’s penis because I think he’s got an infection and they’ve made me do it and I’m like well, whatever helps the patient that’s all I’m bothered about. So, you go and you do certain things don’t you, you go and you do certain things that are above and beyond your line of duty but obviously you’re not going to put them at risk. So even though, if I knew how to change a colostomy bag, there’s been plenty of times where I’ve been in those sorts of situations where you think this isn’t my job but I’m going to do it anyway because that patients not going to want to be sat there and you just think you’re doing everything you can to make that patient as comfortable as you can”

TR Site B1

The TR and STRs insights show how extra mile to them was something more than the comprehensive management of patients as part of a TRs role and professional duties. For these two groups the extra mile was displaying a personal touch and being person-centred

“Not long ago I was in pre-treatment and a patient had come, I remember she was talking to me about these books, about like a series of books that they were reading and they were like oh there’s only one that I missed. I can’t remember what it was anymore, but one of the radiographers I was working with had then obviously gone home, found it on Amazon, bought it and then went and found them on their first day of treatment and gave it to them”

STR Year 3

“So he said he would get a friend, he came the next day with the email address because I was going to do it online, and he said my friends on holiday and I said well if you don’t mind I will give my email address and it was just so that they send all his information, his ticket and everything and just did it and that were just sorting something out so that he could do that”

TR Site C1

“And I’d gone into the ward to have the stitches out and he wasn’t due to see me but I could see, I was waiting about, so I was waiting for the consultant to come along and when he came in he said oh, he said, he was due he said, Oh I looked on the list. He said I looked on the list to see who’s coming on and I saw your name and I thought I’d just come and see how you are and have a look at it. And he was just lovely”

PaC Site B

The participants deemed a TR to be compassionate when they put the patients’ needs in front of their own.

"But while we were chatting she picked up the phone and rang somebody because she was supposed to be going home to pick her son up from school and she actually had to get a friend to pick this son up from school so that she could spend time with me"

PaC Site A

"Well in my third year I was just there working on LA5, we had a patient with water retention and needed to go and be catheterised. So I had to go and organise it, make sure he's been catheterised so I go the nurse, she was happy to do it and that was great. She asked me if I wanted to sit in and just like watch or maybe just lend a hand and see how it happens because obviously, I'd never seen it at that point. I was like yes okay and the nurse (was) well on her way on her way doing it, she was having a difficult time, it wasn't taking it. It was just difficult, the man was becoming distressed and he turned to me, he was like have you got any music and jokingly, he asked me to sing and at this point my knees were trembling, the thought of like looking what's going (on) down there, it looked awful and I just started singing Celine Dion, like my heart will go on from Titanic to him. The nurse was just staring at me, the patient was just staring at me and I just kept on going through everything and it stopped and it was just awkward for a bit and then, I just said I've got to go now but I'll come back and check up on you in an hour or so"

TR Site B1

Extra mile was perceived by the participants to have a positive impact on the patient. Feeling it demonstrates to the PaCs that they truly care about them as a person and their attitude is person-centred.

"You don't forget that person that's done that extra bit for you"

TR Site C2

"It's like over and above isn't it, I bet you have made his day though"

TR Site C1

Give me a choice

Give me a choice emerged from the discussions in the PaCs and TRs focus groups. For the two participants groups, give me a choice addressed the patients wish to be provided with options around their cancer treatment and management. Thus, facilitating active involvement in their care.

"I want to be in the loop"

PaC Site B

"And I think asking them how they feel as well because what might be important to one person isn't to another and its very individual to that patient"

TR Site C2

Whether the situation was life-affecting or standard care, the PaCs were firm in their belief they should be involved and given a choice.

"In the literature it said that if you, you could stay on the ward until you were discharged, so she was coming in the afternoon as soon as she could after lunch and as soon as it finished at the Doctors. And the staff, one of the staff came up and said oh, we're going to send you home by transport. I said no, I've arranged my friend to be here. So he said oh well we're arranging it, we're going to take you down now to the discharge unit. So I said no I want to stay because my friend is coming. Well we'll ring her and tell her that we're sending you home and then you'll be at home. But I had nobody at home."

PaC Site C

"He said what do you want to do and she said, okay just don't treat me, I won't have the operation, but he made it all her choice"

PaC Site A

The analysis identified to the PaCs this practice signified compassion as those decisions were not being made for them by others. Even if the practice was undertaken by TRs who knew them or their wishes as an individual, it was felt the decision is still theirs to make.

"You know it should really be up to the patient at the end what happens"

PaC Site A

Make comfortable

Make comfortable emerged from the perspectives of the PaCs. Some of the discussions which formed this theme related to palliative /end of life care and the need for professionals to ensure the patient died with dignity. Although some of the attendees were in the secondary stages of cancer or had experienced bereavement, palliative care was not a dominant topic across the focus groups. It was only within make comfortable that discussions were seen to identify a differentiation between any practices which demonstrated compassionate display for palliative or radical care.

"The palliative team came that day and she was so much, Sunday night she was a lot better settled wise and I think her family members stayed with her and then they moved her to a single room on Monday morning and apparently within ten minutes of moving into a single room she passed away"

PaC Site A

"From a nursing staff point of view, was for that patient to be as comfortable as possible and to die with dignity and family around them"

PaC Site A

Discussions by the PaCs of perceived compassionate practice focused on actions and tasks completed by professionals to enhance theirs or their loved one's levels of comfort. Often positive examples were quite small and simple actions, for example extra pillows, or adjusting them into a better position. Others involved enquiring about their level of comfort or delaying discharge until they were certain they were ok (checking how I am).

"They were all very good, you know. They came up to the ward and made sure that I was comfortable and asked if there were any problems and not to hesitate to contact"

PaC Site C

"They kept me in a bit longer, make sure I was comfortable"

PaC Site C

Comparatively, the examples of non-compassionate practice recalled by the PaCs demonstrated a more significant action needed to be undertaken but instead was missed or omitted.

“They couldn’t do nothing for him there, but they shoved him on one of those trolleys and oh it was awful. They couldn’t not just put him somewhere where he would have been peaceful, they put him in the place where there were drunks and they were coming, do you know what I mean, people what had had drugs and that”

PaC Site A

“She was in a side room on her own all day, literally from about 7 o’clock in the morning and I the left the (hospital name) at 11 o’clock that night. They got her a bed at 11 o’clock that night”

PaC Site A

Although the context of the discussion was end of life care, the content focused on the care patients received as part of their experience. Participants felt by aiming to make patients comfortable when experiencing some form of adverse effect or suffering was a compassionate practice by the professional. Adverse effects can occur within both a palliative and radical context, this underpinning concept of make comfortable can be applied outside of end of life care.

Supportive

Supportive emerged from all three participant groups. The use of the term was common in all the focus group discussions, frequently used as a descriptive term denoting that it had been provided. The first year STRs use the words “be” and “just” when talking about support. This appeared to indicate support is a basic requirement of compassionate display. Whereas the second and third year STRs used words like “more” and “additional”, indicating to them that compassion requires an increased level of support to be present.

“Sometimes that might just be like support”

STR Year 1

“I think they do tend to like need thatmore emotional support”

STR Year 2

All three participant groups agreed that support is something that is needed by patients.

"Some kind of issue that they have needed your support"

TR Site A

"And I think that is, the support that I've been given is absolutely phenomenal, overwhelming in fact"

PaC Site B

The findings did not explicitly establish a consensus understanding of how support is displayed. The insights from the TRs would suggest it was achieved by being there, managing each situation experienced differently and meeting patients' needs by being person-centred.

"And we just sort of supported her all the way through and dealt with each situation differently"

TR Site B2

"Touching someone, I understand or I'm with you or I want to be supportive"

TR Site B2

Analysis identifies supportive is a collective of practices which display to the patient the TR is there for them and desires to improve their current circumstances.

Meeting needs

This theme emerged from the discussions across all groups. Meeting needs was a key and reoccurring topic throughout all eleven focus groups. The participants believed it should not be a superficial practice; instead it should be personal and consequential. It was considered an essential and paramount practice to signify compassion.

"They have to actually take an action that supports you in some way that's actually meaningful and what helps and what is appropriate to what's going on at that time"

PaC Site A

The importance of meeting needs became apparent during the first-stage analysis, where it was a distinct category across all three participant groups. Second-stage analysis has established meeting needs is the way those compassionate attitudes and behaviours which form the conceptual framework can be outwardly displayed to portray compassion. A plethora of ways the needs of patients could be met was identified, but the two stages of analysis established meeting needs did not necessarily have to equate to full achievement. Those non-compassionate examples threaded through the practice's classification section are on which this belief is based. The participants' discussions never considered practices which had failed to be meet the needs as non-compassionate. Instead what they considered as non-compassionate were those instances where professionals did not undertake any attempt, or their attempt was not based on the individuality of patients. This supports the overarching concept of intent which has been an important theme throughout the analysis.

In order to reduce repetition, the author has omitted a summary of findings and supporting quotes from the participants. The findings above have already identified the practices which can be undertaken to meet patients' needs emerging from the focus groups.

Meeting needs summary

'Meeting needs' was formed to encompass the thirteen practices that emerged from the data (Figure 5.24). The practices contained within this classification enable the TR to demonstrate a personalised approach towards the patient in attempt to meet their needs. This allows them to physically demonstrate their practices are influenced by those professional and cultural values required to display intent to be compassionate.

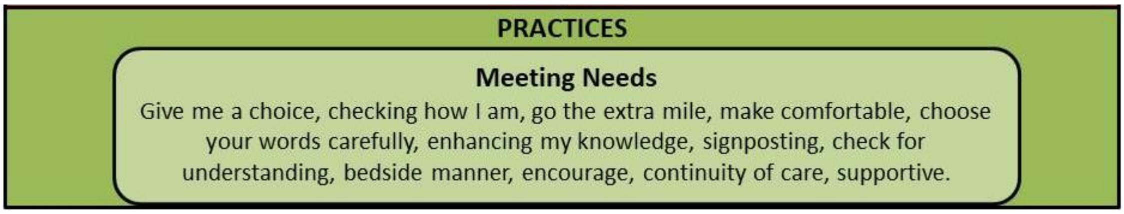


Figure 5.24: Conceptual framework- Meeting needs

Conceptual Framework summary

Attitudes

The professional and cultural values which influence a compassionate attitude form the underpinning basis of the conceptual framework and compassionate display. TRs need to uphold professional values which reflect they are respectful, non-judgemental and trustworthy whilst being committed to preserve dignity and desire to maintain privacy and confidentiality. Similarly, their own cultural values must denote they are person-centred, caring, and open and hold intent to be compassionate.

Both classifications of values are inherent to TRs as human-beings. However, they are also characteristic of the Therapeutic Radiography profession. Subsequently, they should be supported by and reflected in the environment and ethos in which TRs practice.

Analysis demonstrates both classifications of values must be possessed by the TR, if not their subsequent behaviour and corresponding practice will not be perceived as compassionate. As these attitudes dictate intent, if not possessed by a TR then compassionate practice will never be established irrespective of the behaviours or the actions they engage in.

Behaviours

Embodied connection, characteristic expression and indicative communication are the core behaviours which TRs must engage in to gain comprehension of the patient and person.

Embodied connection provides the TR with a tacit knowing of the individual patient. This intuitive togetherness enables the TR to instinctively respond. The presence of characteristic expression symbolises behaviours which are an inherently caring. Reflecting how compassion is traditionally exhibited through an awareness of the patient. Indicative communication, through conversation that is mutually understood, facilitates acquisition of knowledge and understanding that is essential in displaying compassion.

All three classifications of behaviour hold equal importance, with each being an essential component of compassionate display. Their undertaking is influenced by and symbolises that the TR possesses those professional and cultural values. Subsequently, the three classifications enable the patient to recognise and interpret the response as part of a compassionate display.

Understanding individuality and appreciation of needs

Behaviours enable TRs to establish understanding and an appreciation of the patients. Their equal partnership affords TRs comprehension through knowledge and essential insight into patient needs. Comprehension then enables the TRs to establish practices that aim to address those needs.

Practices

Meeting needs is achieved by the engagement in practices by TRs which intend to address the requirements they have identified and understood for each individual patient. The researcher acknowledges there will be a plethora of practices which have not been captured by the focus group discussions. The aim of the framework however is not to detail all those practices or in turn needs patients may have, instead it is to demonstrate what represents compassionate display. For this, it is the ability of TRs to identify the needs through the undertaking of those behaviours in conjunction with their ability to be adaptive in their practice based on the individuality of patients.

Importantly, although the final component of the framework, the practices themselves are not compassionate unless underpinned by those attitudes and based on the understanding obtained by the behaviours contained within the framework. Additionally, the analysis has demonstrated needs do not necessarily have to be met, for it is the intent to be compassionate on which those practices are based which permits them to be perceived as compassion.

Reflexive Summary

The volume of rich data although advantageous for answering the research questions has created many challenges in data management, analysis and the reporting of findings.

The Quirkos software has been a real asset throughout this process, enabling secure and effective storage of the transcripts in one place. All the focus group analysis could be done on this system meaning the data and findings were collectively located in one place when access was required for write up, workshop resource development etc.

A second stage of analysis was not originally part of the research design, but the inductive nature of the work and the findings post co-production stage necessitated its undertaking. Stage two analysis however could not be conducted using the software as the four data sources being independent, the process required comparing and contrasting across the sources which Quirkos could not facilitate. As such the process has been reliant upon print outs, word documents and Quirkos reports, going back to the original roots of qualitative analysis. Reviewing, recording and reporting has followed a slow but meticulous process in order to ensure the findings were credible and truly reflective of the patient voice. Subsequently second stage analysis has been a very laborious process, adding significant length to the PhD timeline.

Notably though, the second stage analysis and the processes involved has allowed for real immersion into the data. Writing up each category has provided meaningful insight and understanding of how compassion is displayed. This has been invaluable during the development of the conceptual framework, adding real rigour and validity to the findings. Establishing those classifications of attitude, behaviour and practice has allowed the framework to display the influence of attitudes on behavioural and practical display alongside their interconnectivity.

Some difficult decisions have needed to be made regarding mergers and exclusions of categories. The process of second stage analysis has really helped in these instances alongside the reflective diary. Overlaps between categories could be identified due to the degree of detail resulting from the analysis and write-up. Similarly, justification for those categories eliminated could be provided.

Chapter Summary

This chapter has presented the co-constructed definition of compassion and conceptual framework which demonstrates how compassion is displayed and why it is perceived as compassionate.

In summary, the findings have established:

1. Research question one: Compassion can be defined as; *the intention to help, by identifying and understanding the individual with the aim of meeting their needs. It is characterised by unique interaction that promotes connection between individuals and is reflective of a genuine desire to help.*

2. Research question two: A compassionate attitude forms the underpinning basis of a TRs compassionate display. A TR must engage in the three core behaviours, embodied connection, characteristic expression and indicative communication to gain comprehension of the patient and person. These behaviours are influenced by and symbolises that the TR possesses those professional and cultural values congruent with a compassionate attitude. The behaviours then enable TRs to establish understanding and an appreciation of the patients; this enables the TRs to establish practices that aim to address those needs. The practices themselves are not compassionate unless underpinned by those attitudes and based on the understanding obtained by the behaviours contained within the framework.

The next chapter will discuss the key findings of the thesis. The chapter will begin by outlining the co-constructed conceptual framework, followed by discussion of the central tenant of the findings, that compassion is influenced by attitude. It then considers how attitude can be defined and engages in an exploration of how attitudes are formed and how they influence a behavioural response. The discussion will then return to key components of the conceptual framework, attitude, behaviours and practices. These will be explored and discussed within the evidence based. The chapter will also consider the methodological principles and research design of the study.

Chapter 6: Discussion

Introduction

Chapter five provided the findings of the research, the co-constructed definition and conceptual framework for research questions one and two respectively. To allow the comprehensive discussion of these findings, this chapter is presented in four sections.

In the first section, the chapter will begin by introducing the co-constructed conceptual framework and provide the rationale for its development. The second section will then draw upon a key finding of the thesis and the overarching component of the conceptual framework that compassionate behaviour is influenced by attitude. This section begins by defining attitude, engaging in an exploration of how attitudes are formed and the relationships between attitudes and behaviour. The review of seminal texts and models of attitude development within this second section will explain how and why attitude(s) capacitate a TR to be compassionate. This understanding provides the foundation for the third section which discusses and explores the three classifications of behaviours within the conceptual framework that enable a TR's capacity to help promote understanding of patient individuality and meet the patients' needs. Throughout this discussion, links will be made to compassionate intent and the necessity for a TR's behaviour(s) to be motivated by a genuine desire. The importance of perception, person-centre and culture within compassionate display will also be discussed.

The final section focuses on the methodological framework, evaluating the use of focus groups and co-production as the research methods employed within this study.

Section 1: Conceptual Framework

This first section introduces the co-constructed conceptual framework developed from the findings for research question two (Figure 6.1). The development of a conceptual framework elicited understanding of how compassion is demonstrated and established the structure of the component parts essential for compassionate display.

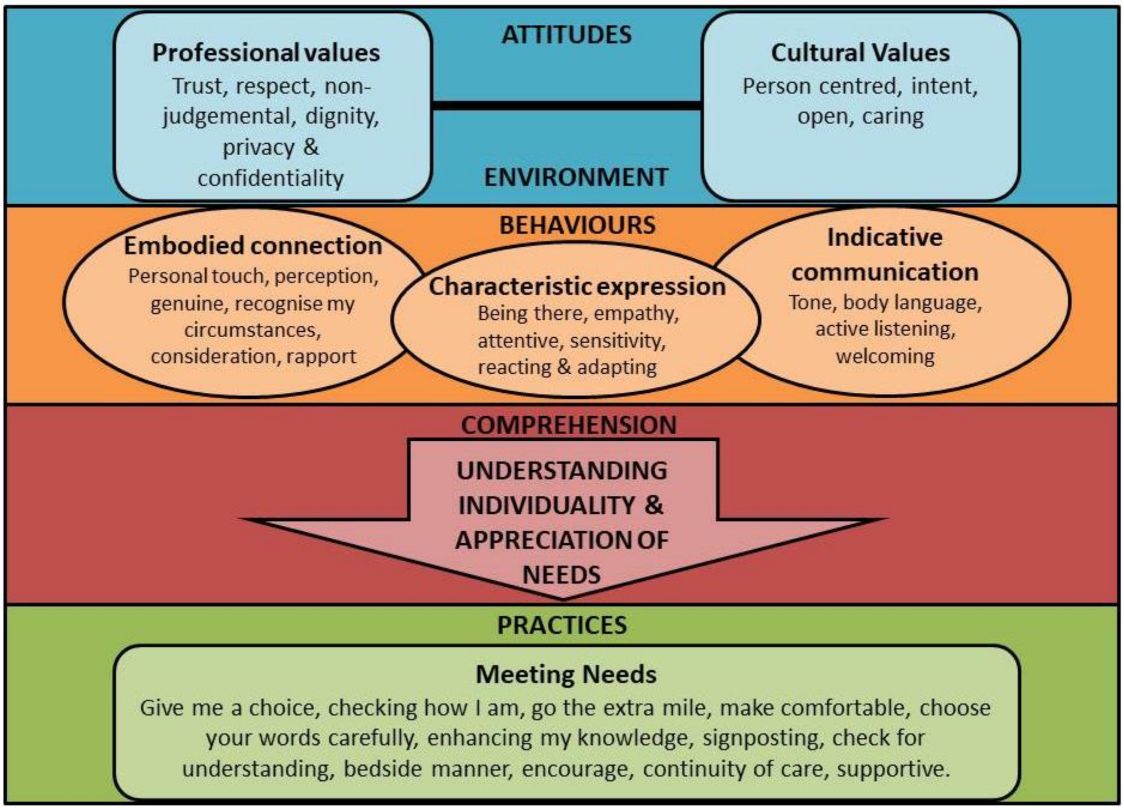


Figure 6.1: Conceptual framework

Rationale for development

The concept analysis provided the underpinning framework for guiding the research design and implementation of the research process [165,166]. To bring coherence to the findings, a conceptual framework was employed to aid interpretation and understanding of the data. A conceptual framework is a set of interlinked concepts that together provide a comprehensive understanding and explain a phenomenon [100, 167]. In respect to this study the classifications of attitudes, behaviours and practices formed these concepts.

Mintzberg believed that “*data don’t generate theory – only researchers do that*” [168, p584]. It would therefore not have been suitable to let the data speak for itself, as the findings are shaped by the philosophical position of the research (and researcher) and the radiotherapy context in which it was generated [169]. A conceptual framework needed to be developed to present the findings in a manner which would best represent and display the socially co-constructed understanding the focus group participants assigned to compassionate display.

The conceptual framework is important for illustrating the influence a TR’s attitude has on any outward compassionate display. The analysis identified the relationship between the three concepts was iterative and cyclical, rather than a linear process [100]. It was therefore best depicted diagrammatically to illustrate the position of the key concepts and their relationships [100, 169,170]. This will provide those wishing to use the framework the ability to visualise the relationships and process involved within compassionate display.

Each component part of the framework provides a summary of the key attitudes (values), behaviours and practices. The following section focuses on the attitude component, providing the thesis with the understanding of why and how attitude(s) enable TRs to be compassionate.

Section two: Theoretical Models of Attitude and Behaviour

Introduction

In this study, co-production methods provided the means to define compassion and compassionate behaviours with a certain degree of consensus. However, the data analysis identified some critical issues in relation to compassionate display. Many participants cited ‘attitude’ as a crucial component of compassion and furthermore that attitude (good or bad) preceded particular behaviour(s). In addition, it appeared that behaviour may or may not be perceived as compassionate, depending on the individual:

“There was one consultant and my wife just absolutely really hacked off by him with his attitude and it was I’m telling you this and this is what’s going to happen and then the next time we went up we had this other guy and what a difference”

PaC Site A

“The girl who did my scan was a lovely girl and afterwards she could not hide her disappointment at the result of the scan. She didn't say anything; she was very professional. But her body language told me that the actual bones were affected by the cancer, without even having to say anything at all”.

PaC Site B

Whilst chapter two provided a concept analysis of the term compassion, it was developed from literature that focused on professionals’ viewpoint. This study suggests that there are some fundamental aspects of that conceptualisation missing. Firstly, there was a strong sense amongst participants that a TR’s attitude and intention to be compassionate can influence their behaviour. Secondly, how that behaviour is perceived by the patient is unpredictable. These issues are key to understanding the complex nature of compassion and have prompted a review of the literature on the theory of attitudes and behaviour. Thus, this next section will define attitude and explore how attitudes are formed, prior to discussing the relationship between attitudes, beliefs and behaviour in section three. In this next section, theoretical models are critiqued and examples from radiotherapy practice are utilised to illustrate how attitude-behaviour theory is relevant to this study. The purpose of this section is to explain how attitudes are formed and how they can influence the compassionate practices of TRs within the clinical environment. Thus, giving comprehension to the thesis on how TRs can be compassionate and how the clinical environment in which they practice can enhance their ability to be compassionate.

To note, most empirical work and theoretical discussions focus on attitude as a means of predicting behavioural response and the development of reliable measuring techniques for the attitude-behaviour relationship. However, this research aims to identify behaviours synonymous with compassion as opposed to measuring or predicting behavioural responses. Additionally, this thesis does not seek to present an in-depth understanding of the mechanisms for attitude acquisition, merely the underpinning foundation. Therefore, only the key components of attitude formation, the links between these and their implications for compassionate practice will be considered here.

Defining attitude

Attitude is a term conceptualised in various ways by different people and as a result has become rather abstract [171,172]. There still exists some disparity around what defines an attitude. This lack of clarity made establishing its role within compassionate display complex. The discussion therefore required a review of seminal texts and theoretical models to gain explanation of what it is and to establish how it facilitates compassion.

Attitude is often described as a feeling or opinion about something or someone, or a way of behaving. Ajzen & Fishbein described two types of attitude:

1. General attitude in response to ‘objects’, for example institutions or policies.
2. Attitude that has a specific behaviour with respect to an object, known as attitude ‘towards’ behaviour [173].

They advocated how the starting point for anyone wishing to define the meaning of attitude is to distinguish between these two types. The attitudes identified within the findings of this thesis relate to both classifications. Firstly, the TR's attitude may be in response to seeing a distressed patient and their wish to help (general attitude). Secondly, they may demonstrate 'caring' behaviour as part of their professional role (attitude towards behaviour). Similarly, the patient will hold an attitude about the TR in response to their behaviour and this will influence subsequent interactions with the TR. These classifications will become integral to further discussion within this chapter.

Attitude can be described as an: approach, manner, viewpoint, stance, outlook or feeling about a person, issue or thing, suggesting it is both a thought process and a physical manifestation. It results from life experiences and has an evaluative cognitive aspect that influences both the strength of attitude and the potential to change one's views because of further experiences.

Attitude composition

Despite discrepancies many theorists agree that attitudes overall are composed of three fundamental features, 1) they are towards an object of intention; 2) they are learned; and 3) they are pre-disposing to an action, [173, 174]. Each of these will now be considered in relation to the findings of this thesis

Attitude towards an object of intention

Attitudes are related to how people perceive the situations in which they find themselves and the objects situated within them [175]. An attitude 'object' is a distinct target, such as a person, place, material object, issue, social group, the self, abstract entity or any aspect of the world that can be evaluated [176, 177]. The term "towards", as utilised in seminal texts, is representative of evaluation being the primary element of attitude [172, 178]. Fundamentally, evaluation is an opinion towards or about the object. In the context of this research, the 'object of intention' for a TR would be a patient, therefore this would be the attitude held by the TR towards a patient.

Ajzen & Fishbein, referred to the evaluation of an object along a continuum of favour or disfavour, good or bad, like or dislike [179]. There is a belief that an evaluative manner must either be consistently favourable or unfavourable towards the object(s) in question in response to its stimulus [171]. This is frequently described as ‘liking’ or having a favourable opinion of the object, conversely this can also be a dislike, or unfavourable opinion of the object [171-173, 179]. It is appropriate to note a dissonance between the principles of favourability and the position of this thesis. The attitude object relevant to this thesis is a patient who has been diagnosed with cancer and the attitude towards the patient is held by a TR, who has a professional duty and responsibility to the patient within their care. The issue of favourability hinges upon a concept of making a judgement or decision of preference towards an individual. This is not only incongruent with those professional values established within the research findings, but with professional standards deemed compulsory by the radiography professional body. However, more recent research into attitudes proposes how liking a patient is not the opposite of disliking the patient [180]. The TR may not hold or support the beliefs or values held by their patient or even ‘like’ them as a person, but that does not necessarily mean they dislike them. This is an important distinction to make in preparation for the discussion of the findings.

An attitude is learned

Although there are theorists who believe some attitudes can be inherited through a genetic component, [181] it is predominantly accepted that attitude is learned in social contexts [171, 173]. Attitude develops because of an individual’s own experiences, social encounters and observation of others’ roles and attitudes [182], which are then thought to influence behaviour [173]. Over the years there have been many learning theories applied to attitude acquirement [174, 183]. Two fundamental paradigms of behavioural theory are often used to explain this learning process: classical conditioning and operant or instrumental conditioning. Both paradigms are based on the role of stimuli, creating a stimulus-response conditioning process. Stimulus response theory accepts that behaviour manifests because of the interplay between stimulus and response. In the radiotherapy setting this could be conditioning towards professional and compassionate patient care. An attitude that is learned may then become part of an individual’s belief system. It is important to briefly explore the belief system to explain how this influences the strength of attitude.

Beliefs

Fishbein & Ajzen, identified how stimulus-response bonds that are formed are a type of ‘belief’. This is based on the premise that the object is viewed as a stimulus and the related attitude is a response [173]. A belief is something that one accepts as true or real in a firmly held opinion. There are five classifications of beliefs organised within an individual’s own belief system (Table 6.1). Fundamentally, the stronger the belief the more central its position within the system (Figure 6.2). Individuals hold beliefs to ‘make sense’ of their world [184].

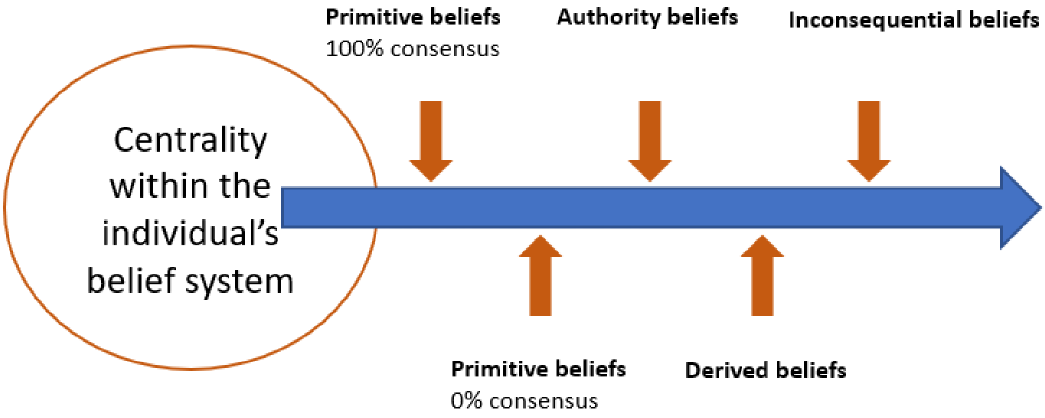


Figure 6.2: Subclassifications of beliefs and centrality.

Table 6.15: Five classifications of belief. Table adapted from Rokeach [172].

Belief type	**Description**
Primitive beliefs: 100% consensus	Most central, learned by direct observation of object and reinforced by a unanimous social consensus amongst reference persons and groups. Taken for granted beliefs. Disruption of primitive beliefs would lead to one questioning validity of many other beliefs and require major cognitive reorganisation. **Truths, physical reality, good, bad, humanity, care**
Primitive beliefs, Zero consensus	Through adverse experience some primitive beliefs may be formed in which support from external authority is abandoned altogether. Beliefs that are not shared with others are impervious to persuasion or argument by others. **Personal, prejudice**
Authority beliefs	Belief in our persons/groups of reference. These change for each of us dependant on our social structure. Disputable, as one will understand that their beliefs will be shared by some and not by others. **Organisational beliefs and values**
Derived beliefs	Belief in the credibility of an authority. If a person believes in a particular authority than you can deduce a number of their other beliefs. Institutionalised ideology - group identity. Less important dynamically than beliefs on authority and therefore a change of belief with respect to authority should lead to many other changes in beliefs deriving from authority. **Organisation, professional identity, care**
Inconsequential beliefs	Arbitrary matters of taste. Inconsequential as have no connections with other beliefs. If they change, there are no implications for other beliefs. Positive correlation between centrality and intensity. If intensity of this belief changed it would have little/no consequences on other beliefs. **Changeable, personal taste**

The above discussion suggests a clear relationship between beliefs and attitudes. More crucially, this theory explains how certain attitudes can be strongly embedded in an individual. Perhaps, in the radiotherapy setting, this is evident in some TR's having negative views about patients when their fundamental beliefs are different e.g. lifestyle choices.

Nikitina identified beliefs and attitudes as overlapping constructs due to both incorporating a degree of favourability (i.e. favour or disfavour towards the object) known also as 'pro-con' [185]. She stated that beliefs incorporate attitudes but recognises a belief may be predisposing whereas an attitude may be developed 'on sight'. Nikitina's work supports those opinions established by Eagly & Chaiken who stated:

"*attitudes do not exist at all until an individual perceives an attitude object either on a conscious or unconscious basis and responds to it on an explicit or implicit basis*" [186, p584].

It is thought like attitudes, beliefs are learned by direct observation, especially those which are most central within the belief system [172]. Based upon behaviour-theory, belief formation should follow the laws of learning through the influence of stimulus and conditioning. Fishbein & Ajzen, stated that when a belief is formed, some of the implicit evaluation associated with the response becomes conditioned to the stimulus object [173]. They emphasised this implicit evaluation associated with the response constitutes an attitude as it is formed in part because of prior conditioning. Consequently, an attitude toward an object is related to the beliefs held by the individual about the object. A tension may exist where a TR's personal beliefs must be put to one side in order to deliver good care to a patient. This was clearly demonstrated during the STRs and TRs focus group discussions and will be addressed later in this section.

Fishbein proposed five fundamental principles central to attitude formation that explains how a TR can develop a non-judgemental approach to practice [187]. An individual can hold a range of beliefs about an object and make associations between this and other objects. An evaluative response is established and through conditioning the response becomes associated with the object. A learned attitude is then established which will be displayed when exposure to a similar object occurs. This can be recognised when the TR consistently demonstrates a respectful and caring attitude towards the patient.

In addition to reinforcing the key concepts of attitude formation discussed earlier in this chapter, Fishbein's theory concluded that a person's attitude toward any object is a function of their beliefs about the object and the implicit evaluative response associated with those beliefs. Although Kretch and Crutchfield concurred with this concept, they also considered how all attitudes incorporate beliefs, but not all beliefs are necessarily part of attitudes [188]. Thus, proposing attitudes do not have to be completely composed of all beliefs held by an individual.

Attitude has an affective, a behavioural and a cognitive component (Figure 6.3), referred to as the ABC model. These are perceived to shape attitude formation and the subsequent evaluative approach [172]:

- The affective or emotional component involves the person's feelings. Beliefs held by an individual stimulate this affective component towards the object of intention, the intensity of which can vary. This results in the individual taking a positive or negative position with respect to the object belief or around the belief itself.

- The behavioural or conative component, described as the belief or response disposition, which leads to action when activated. Therefore, the action occurs as a consequence dictated by the belief. Fundamentally it represents the tendency of a person to behave in a particular manner towards an object.

- The cognitive or informational component consists of beliefs, values, ideas and other information a person has about the object. However, there is no imperative for the information to be factually correct or real; it simply represents a person's knowledge based on what they believe is true or false or what is good or bad. Thus, holding the potential for poor judgements regarding the object. Similarly, the reverse could be true, and a positive judgement made based on an ineffective or misjudged conviction.

As a person's affective feelings or cognitive beliefs cannot be seen (instead inferred), only the behavioural component can be directly observed. Whilst this notion supports the link between attitude and behaviour, it also identifies the implicit, personal nuances that may influence the perception of compassionate behaviours. Harding et al., suggested that the relationship between the three components (affect, behaviour and cognition) are interlinked and that it makes little difference which are used to rank individuals with respect to their attitudes [189]. No theory predicts how one component more strongly influences attitudes than another [190]. This would specifically be of interest when considering the concept of favourability, behavioural responses and the professional principles of the TR. In addition, research indicates the relative weighting of each of the three can vary across individuals and the attitude object [191-194].

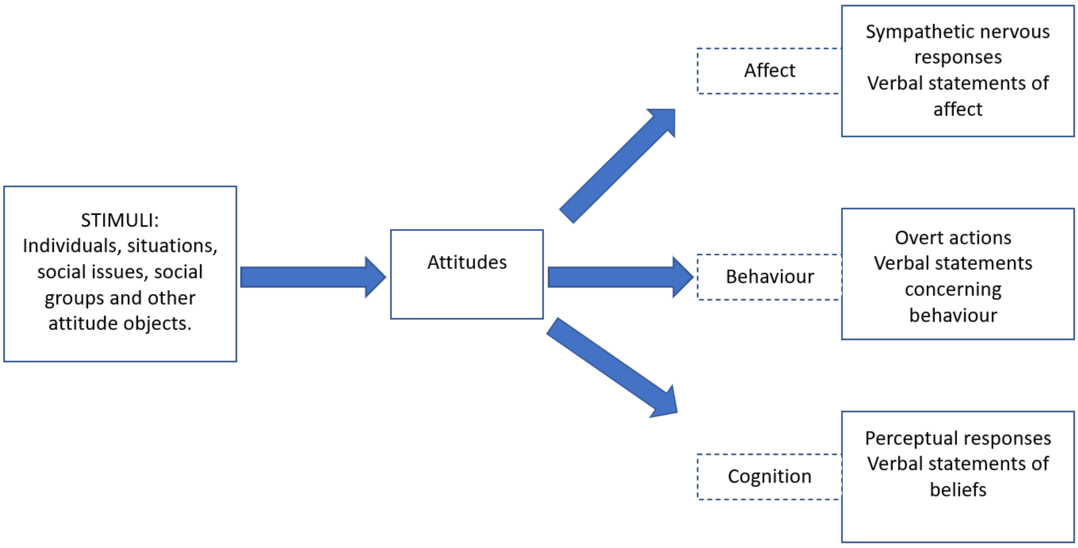


Figure 6.3: Adapted schematic conception of the three components of attitudes. Reproduced by Eiser, (1980) with permission from Hovland, & Rosenberg (1960) (Eds) Attitudes, Organisation and Change: An analysis of consistency among attitude components [195, p3].

Values

Emerging from the data was the concept of professional and cultural values situated within the collective classification of attitudes. Fundamentally, values are global abstract principles regarding issues individuals believe are important to them. Values like beliefs can be consciously or unconsciously held, but being imperceptible, they must be inferred through what the individual says or does. In Rokeach's works he stated a value is a type of belief contained within one's total belief system, specifically relating to how one ought or ought not to behave [172]. The STRs and TRs spoke frequently of the importance of professional values, placing these highly not only in relation to what is expected of them, but also of the importance they hold for them. In this respect it could be argued that the cognitive component of attitude is dominant over affect. For example, the TRs recounted times they faced ‘difficult’ or ‘challenging’ patients whose behaviour or moral codes did not align with their own, subsequently conflicting with their values and beliefs. Despite a discord, the TRs highlighted how patients still need to be treated in a respectful and non-judgemental manner and their own attitudes should demonstrate professional values. The same may also be considered for those cultural values established within the findings, where caring and person-centred values influenced attitude towards patients. An example relevant to radiotherapy practice is seen here (Figure 6.4).

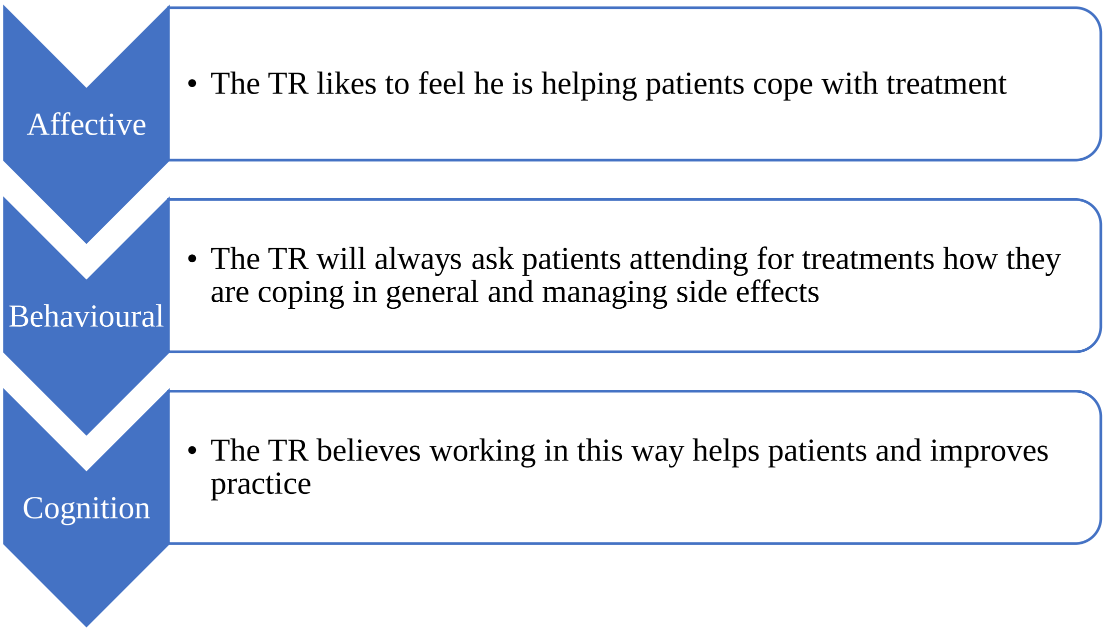


Figure 6.4: Example of the ABC components of TRs attitude to patient care

Attitude consistency

The discussion so far has developed an argument suggesting that conditioning in compassionate care is possible through a process of learning, evaluation and practice. Ostrom agreed with others that an attitude is a learned predisposition to respond in a consistent evaluative manner toward an object or class of objects [171, 196-198]. This view not only incorporates the three principles of an attitude, it identifies the need for consistency towards the patient as the object of intention. Consistency is viewed as the unidimensional continuum with a positive and negative pole and deemed important as it is felt to reflect a level of central tendency rather than a complete homogeneity of response [196]. In essence, this means that consistency in the individual's favourability or pro-con response is present, whilst accepting the degree or level of favourability demonstrated can vary. So, the TR may not always demonstrate a high level of compassionate display but may still generally have a compassionate attitude towards patients.

Attitude-behaviour consistency theory emerged in the 1930s and became the foundation for the assumption that attitudes and behaviour are not just simply linked, but attitude actually predicts behaviour [176, 181, 199]. However, Fishbein & Ajzen (1975) believed consistency is a major source of conceptual ambiguity and suggested three response consistency theories which need to be considered when the relationship between attitude and behaviour is discussed [200]:

1. Stimulus-response consistency is based on the premise that a behaviour manifests as a result of the interplay between stimulus and response. Consistency in this instance is through the same repeated behaviours or sets of behaviours towards the object.

2. Response-response consistency considers the degree of reliability between different behaviours or sets of behaviours towards the object. Although the behaviours may differ, those behaviours would still display consistency in its direction of favourability i.e. favourable or unfavourable, positive or negative.

3. Evaluative consistency is based on the premise that an individual may perform different behaviours towards an object at different points in time. However, the favourability of the behaviours remains consistent. It is assumed the favourability of the individual's attitude corresponds to the overall favourability expressed by their pro-con behavioural pattern.

Both stimulus-response and response-response do not consider the influence of other concepts, for example drive, motivation or habit which may also be influencing the behavioural response [200]. As such the theories cannot reason the behaviour and the consistency associated with it is purely attributed to the attitude held. The third theory states that although the behaviours can differ, the favourability remains consistent which eliminates those additional contributors, habit, drive, trait etc. which the other two theories fail to consider. In a radiotherapy context, this means that behavioural responses may change but compassionate or non-compassionate consistency reflects their professional and cultural attitude. Challenges to attitude-behaviour theory over the years has culminated in the view that early theorists overlooked the influence of individuality and made assumptions about perception, learning and motivation [174, 199-201].

In response to criticism many theorists readdressed their approaches to predicting behaviour. Instead of basing it upon attitude alone they became aware an individual may consider or be concerned with the wider implications of their behaviour. That is an individual will consider other factors before they decide to undertake an action, the behaviour is not purely based on their attitude alone [172]. The incorporation of moderated and mediated variables has been adopted by some to account for potential influence upon the attitudes-behaviour relationship. Baron & Kenny's overview of these variables have become accepted definitions. They defined a moderator variable as a focal independent variable that influences effectiveness in regard to a given dependent variable [202]. Whereas a mediator variable is one which represents the general mechanism through which the focal independent variable is able to influence the dependent variable of interest [202]. Fundamentally, a moderator can affect or refute the strength of the attitude whilst a mediator variable explains the relationship between the attitude and behaviour. This begins to explain why professional values in addition to their own cultural values influence the TR's behaviour within a clinical environment. This will be explored further later in the discussion when addressing the principle of intent and established theories which have examined contributing variables in the attitude-behaviour relationship.

An attitude pre-disposes an action

Fundamental to the concept of cognitive consistency is the notion individuals are an active perceiver and interpreter of events, making them predisposed to organise their attitudes and beliefs into internally consistent structures [195]. This affective or evaluative predisposition thus creates a causal influence on behaviour [203]. Collective categorisation is based upon dispositions, inherent qualities of the character. Temperament is often used as a synonym, used when referring to the complex set of attitudes and inclinations that guide behaviour. Consequently, a predisposition is those established tendencies and inclinations to hold a particular attitude, or act in a particular way. As previously identified, stimulus-response theory infers that behaviour manifests as a result of the interplay between stimulus and response. Consistency stimulus-response theory is interested in understanding how, why, and when human beliefs and attitudes are influenced by a desire for consistency. The three consistency theories presented by Fishbein & Ajzen each considers predisposition [173]. Within stimulus-response theory there is an assumption an individual is predisposed to undertaking a particular response or set of response towards the object. This concept is frequently used with empirical works to predict behaviours based upon attitude. However, response-response theory implies a more general predisposition as the individual is predisposed to undertaking a class of behaviours, all of which will hold the same pro-con response of favourability towards the object. Therefore, if holding a favourable attitude, it would be expected their behaviours would be favourable or not unfavourable towards the object and vice versa. The predisposition of evaluative-response is thought to be more general than that of the other two consistency theories. The individual is seen to be predisposed to a certain degree of favourability in their behaviour towards the object, but the behaviour can manifest in several differing ways. The predisposition therefore refers to the favourability of their behaviour pattern rather than the behaviour or class of behaviour. Knowledge of the individual's attitude would therefore not aid the prediction of their behaviour(s). This assumes that behaviours can physically differ, but favourability or intent is consistent.

Although generally accepted, the concept of predispositions still holds concerns for some theorists. Horowitz for example, does not agree that attitudes are predispositions to respond, arguing an attitude is a response rather than a set to respond [204]. Similarly, concerns have been raised regarding the way social cognitive theory is viewed as a linear model, where the human mind works like a computer. Information is simply fed-in, through to a central system which processes the information to a set of preordained rules [205]. The failure to consider other variables or influencers is a continuing criticism of the attitude-behaviour relationship.

Despite disparities, Rokeach supported Fishbein & Ajzen believing that an attitude constitutes a predisposition to respond, evaluate, and be motivated to act [172, 173]. He suggested there are several points theorists must consider when assumptions regarding predispositions are made. Although these arguments are submitted in the context of measuring or predicting behaviours, they raise some important implications for the research findings. Firstly, because an attitude is a set of interrelated predispositions focused on an attitude, object or situation rather a single predisposition, one cannot simply attribute the behaviour or action to a single causal disposition. The observer, in this instance the patient, is therefore unable to separate it from others. If predispositions and their corresponding attitudes are intertwined across the belief system, elements could be taken from multiple predispositions. For example, an affective evaluation may be made by the TR about the individual as a 'challenging patient', whilst simultaneously a cognitive evaluation is made about the individual as a 'cancer patient'. Interconnectivity across the dispositions may create an accord between their professional and cultural values, potentially causing their predispositions regarding professional care to supersede their personal ones. This is additionally influenced by the type of belief and its centrality in their belief system exerting a dominance (Table 6.1). A second consideration is that not all predispositions will be activated by the attitude object or situation. Based on the findings it is proposed the TR may display strong professional and caring values as part of their role but only their predispositions regarding the cognitive components are triggered, consequently leaving those predispositions relating to the affective component untouched. When one again considers the distinction between beliefs and attitudes, it can be considered how beliefs were originally thought to only have a cognitive component while attitudes have both cognitive and affective, i.e. attitudes can be pro-con, whereas a belief is neutral [188]. It appears this is now widely disputed, demonstrated by the move towards the integration of both a cognitive and evaluative component in empirical works. Based on the premise that a belief represents a predisposition to respond in a preferential way to the object, it will have an affective as well as a cognitive component, so even though it may not be activated it must be assumed to be there [172]. Similarly, an observer cannot assume the pro-con affect is towards the object (patent), affect may instead be directed towards other objects, individuals or groups which oppose our beliefs. This concept will be explored when models specific to attitude-behaviour relationship are considered. Thirdly, Rokeach considered the strength or length of a predisposition to influence its role in attitude formation. He believed if a predisposition is momentary, it (they) should not even be called an attitude, as for this classification to be given the predisposition should be enduring or a persistent set of organisations of predispositions [172]. On consideration those fleeting moments may just then be an opinion of the object as opposed to an attitude. This may squash those concerns raised earlier regarding the unacceptability of a TR's favourability towards a patient within a healthcare environment.

What is agreed however, is that any predispositions an individual has to respond to in a consistently favourable or unfavourable way is a direct result of their past experiences [174]. Those experiences are summed, stored and organised in the individual as he approaches a new situation [206]. How a TR approaches a clinical situation with a patient will therefore be based on their previous experiences within a similar situation or patient. The impact of this on compassionate care will be addressed further later in this section.

Attitude definition

The definition constructed by Rockeach proposed an attitude to be "*a relatively enduring organisation of beliefs around an object or situation predisposing one to respond in some preferential manner*" [172, p112]. Thus, attitude is directed towards an object, person or situation. It is learned through experiences and based on personal and professional beliefs and values. The strength of attitude is influenced by feelings and thoughts about the focal object and generally is in response to stimuli. Individuals generally demonstrate consistency in their attitude, although the more evaluative approach is demonstrated in health care. Dissonance between personal and professional predispositions may result in the professional attitude having dominance. Therefore, it is generally accepted that attitude pre-disposes action/behaviour that can be observed.

Alongside incorporating the three agreed principles of attitude composition, this definition subsumes both the concepts of favourability and consistency in addition to the relationship between belief and attitude. It is on this definition, future discussion of attitude and the relationship between these and behaviours will be based.

The relationship between attitudes and behaviours

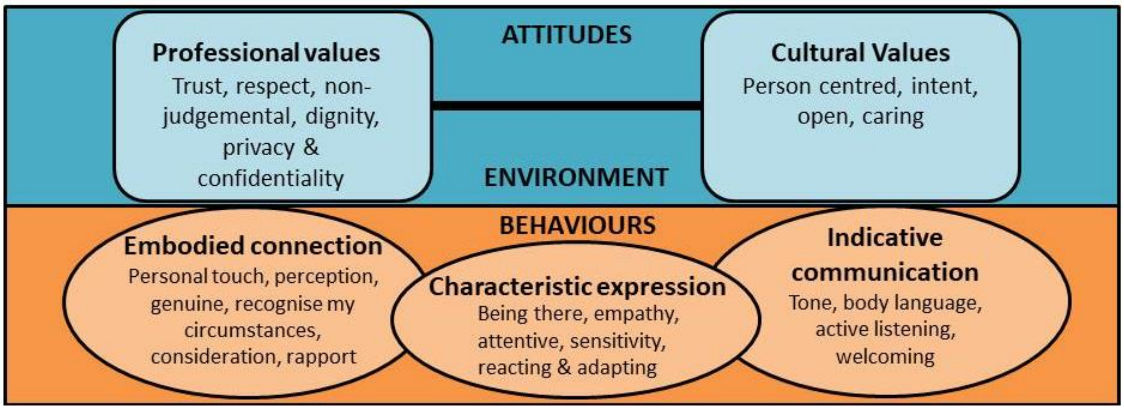


Figure 6.5: Conceptual framework - attitudes and behaviours of compassionate display

Whilst defining attitude, the previous section identified an attitude cannot be seen, therefore it must be inferred through the behaviours demonstrated by the individual. It is on this premise the behavioural classifications which emerged from the data; embodied connection, characteristic expression and indicative communication when displayed, demonstrated the attitude held by the TR (Figure 6.5). The three classifications were identified as distinct, albeit interconnected aspects of the TR-patient interaction which enabled the patient to recognise and interpret the behaviour synonymous with compassionate display.

Behaviour

If behaviour is the physical manifestation of an attitude, it is important to explore what the term means. As a general principle, behaviour can be perceived to be the manner of conducting oneself in the external relations of life, demonstrated through one's demeanour, posture, and manners. Behaviour would therefore be the way an individual acts in front of others, or when alone. However, this interpretation of behaviour simply describes its components but does not provide any depth of understanding of the purpose of behaviour. It does not consider some fundamental questions about what behaviour may represent, its motive and why has it manifested in such a way. These issues require consideration to explain the key findings of the thesis regarding the relationship between attitude and behaviour.

Ajzen & Fishbein stated that behaviour involves an action directed at a target performed in a given context at a certain point in time [173, 207, 208]. Their definition builds on the principle of an individual taking action, but proposes the action has a direction or purpose. In his work to define behaviour Ossorio considered it to be

"an attempt on the part of an individual to affect a change from one state of affairs to another or to maintain the currently existing one" [209 p49].

Having an intention to change or manage a current state resonates with the findings of this thesis. Analysis demonstrated three classifications of behaviours that enable the TR to establish understanding and appreciation of the patient's situation and provide essential insight into what the patient needs are. This comprehension enables the TR to establish practices that aim to address those needs and result in a change, or at least intent to change the patient's current state. However, understanding the function of behaviour does not explain how the behaviour is influenced by attitudes. This needs to be considered further with respect to theory.

Behavioural influences

Behaviours are complex and shaped through physical, verbal and/or non-verbal actions, which culminate in externalised displays. Bergner's eight-parameter formula provides a model that explains behavioural processes:

$Behaviour = (I, W, K, K\text{-}H, P, A, PC, S)$ [210]

The formula identifies the influences and contributors of behavioural displays (Table 6.2). It provides a framework for those studying behaviour to ask the rudimental questions; who it is being undertaken by, what motivates it, what individual characteristics do they bring to the behaviour and what outcome do they aim for?

Table 6.16: Scientific behaviour calculation. Adapted from Bergner) [210]

	Parameter	**Description**	**Radiotherapy example**
I	Identity	The identity of the person who displays the behaviour	TR working clinically
W	Want	The motivational parameter. The state of affairs the person wants to bring about.	Meeting the need(s) of the patient
K	Know	The cognitive parameter. The knowledge that is being acted upon	The patient is showing signs of distress
K-H	Know-How	Skill or competency parameter The exercise of broader or general competencies	The TR identifies the distress, seeking to take the patient to a private room to talk with the aim of understanding their needs.
P	Performance	Process or procedural aspect. Includes all bodily postures, movements and processes involved in behaviour.	TR makes eye contact, leans forward and may touch their arm, then guides the patient to a private area. The TR demonstrates listening skills
A	Achievement	Outcome parameter. The bringing about of an outcome	The patient is able to sit in a private room and talk to the TR explaining their needs, potential for TR to act upon this
PC	Personal Characteristics	Individual difference parameter. Personal characteristics are expressed. Can include: Dispositions (traits, attitudes, values) Powers (Abilities, knowledge) Derivatives	Caring attitude of the TR. Knowledge that being in a private place and given chance to talk often relieves a patient's distress.

		(Capacities, embodiments, states)	
S	Significance	Consequence of the behaviour.	By moving the patient into a side room to talk in private the TR is demonstrating to the patient they care and are concerned for their well-being.

Bergner's formula and its component parameters prompt this discussion to consider how behaviour is not simply determined by attitudes, but reliant on motivation and intent. Subsequently this section will address how attitudes translate into compassionate care. Several attitude-behaviour models will be discussed here in order to develop an understanding of how attitude influences behaviour and to illustrate the findings of this study.

Attitude-behaviour process model

For decades theorists have examined the relationship between attitude and behaviour, agreeing that knowledge of the attitude(s) held by an individual enables one to predict their behavioural response [173, 179, 207, 208]. The theoretical basis on which they ground the attitude-behaviour relationship will be utilised in the following discussion to provide understanding of the findings.

The method by which attitudes influence behaviour is perceived to follow a linear process. Known as the attitude-behaviour process model it establishes how an attitude held by an individual is activated "towards" the attitude object (Figure 6.6) [211]. An attitude is retrieved from memory, composed from previous experiences. In respect to the research, the attitude of a TR would be activated towards a patient, stimulated from situations/patients the TR has previously encountered. These may be TRs prior experiences with that patient or another in a similar situation.

Fazio et al., stressed that attitude activation is essential and if not activated any behavioural display will not be guided by attitude and considered purposeless [211].

Upon activation the attitude will then influence the TRs immediate perception of the patient, either favourable or unfavourable towards them. This selective perception shapes the TRs pro-con definition of the patient and it is this definition which determines the direction and nature of behaviour. Where a positive or favourable perception/definition is formed ‘approach’ behaviour will be displayed. Whereas, if a negative or unfavourable perception/definition is formed avoidance behaviours will be displayed. Within this context, approach behaviours would be those by a TR that intend to achieve a positive change for the patient as part of a compassionate response. Conversely, avoidance behaviours would be those by a TR that hold no intent to achieve a positive change for the patient and therefore not compassionate.

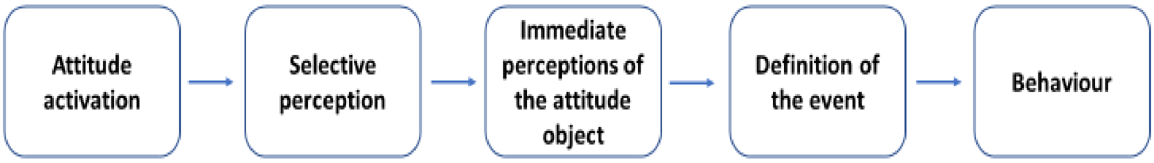


Figure 6.6: Diagrammatic model of Attitude-behaviour process model [211].

To consider the identity of the individual undertaking the behaviour, Bergner acknowledged each person will bring to that situation other attitude(s) and subsequent bias/perceptions that may also influence their behaviour [210]. A distinct example captured in the research findings was the expectation of TRs to be non-judgemental of a patient despite potential conflicts between their own personal values and beliefs and those perceived as intrinsic to TRs as healthcare professionals. In one example, the TR referred to a patient continuing to smoke and drink despite this behaviour contributing to their head and neck cancer diagnosis. Although bemused with how this patient could continue with negative habits despite this being the cause of their cancer, the TR and the group addressed how they would treat this patient as they would any other. In this situation, it appears two sets of values were stimulated, those of the TR as an individual and those of the TR as healthcare professional. In Fazio et als., model, those personal values would have stimulated a negative perception/bias of the patient and their behaviour would have been one of avoidance [211]. But in this example the TR’s professional and caring values underpinned their attitude, stimulating a positive perception/bias and associated behavioural display of approach. Despite a disconnect between their own values and those of the patient, the TR's caring, and professional attitudes stimulated behaviours which intended to improve the situation for the patient. Bergner described this as 'want'; the motivational element of the behaviour or the intent underpinning the behaviour [210].

Fundamentally, the model assumes that general attitude(s) can influence or bias the TR's perception and judgments of information relevant to the patient. The strength of the attitude is then congruent with the direction of bias. At the heart of this assumption is the only influencer of behaviour is the attitude(s) held by the TR. Yet, every situation is unique, and the manifestation of behaviour is diverse and complex. This was evident throughout the focus groups where each participant group spoke about their range of experiences with patients, TRs or other STRs. It would be imprudent to simply consider the attitude-behaviour relationship on this model and fail to consider additional stimuli or factors that may influence a behavioural display.

Motivation and Observation: MODE Model

Attitudes should be considered on a continuum, varying in strength [212, 213]. Attitude strength is a prominent example of a moderator variable [199]. At one end are those weak non-attitudes, where no prior experience of the attitude object has occurred or is available in memory, potentially reflecting that it was not worth remembering. At this end of the spectrum, if asked for an attitude the individual would struggle, having to create one on the spot by recalling other experiences. Moving along the continuum are well-learned, strong association attitudes based on personal experiences. Their strength enables automatic activation from memory on observation or mention of the object [172, 214]. As strong, long-standing attitudes are prominent in the mind they are more accessible and easier to activate, thus follow a process of automatic activation. Whereas weaker, short-lived attitudes follow a deliberate activation process, taking time to reflect, consider and construct (Figure 6.7). Due to their instant accessibility, automatically activated or strong attitudes are more likely to guide behaviour [199, 213].

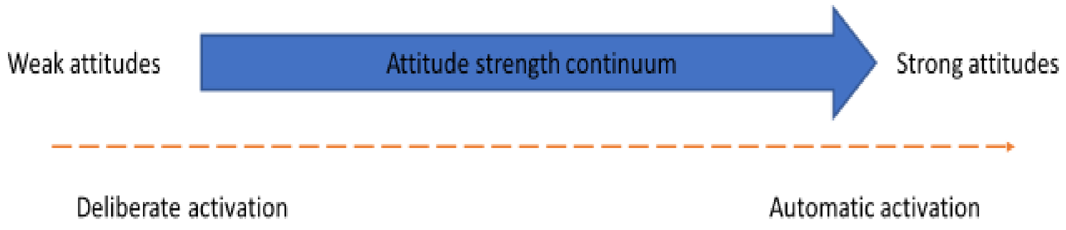


Figure 6.7: Diagrammatic representation of attitude strength continuum and activation process

Behavioural responses are provoked by the social situation in which they arise and any prior attitudes held about that situation [172]. Essentially then, any social behaviour by a TR would be mediated by two attitudes, one activated by the patient and the other by the situation. If only the attitude towards the patient is the focus, inconsistencies will be observed between attitude and behaviour. When considering this within the context of a TR's role, it could be the attitude activated may not be one they had desired within that situation. Thus, creating a potential dissonance between what behaviour, the individual 'wants' or 'feels' they should undertake rather than the one automatically activated.

Emerging within the TRs discussions was an acceptance that whilst 'wearing the uniform' the TRs were healthcare professionals, so should treat and care for all patients equally regardless of the patient's behaviour or attitudes towards them. The TRs discussed their experiences of abusive or aggressive behaviour but continued to display compassionate practice because of their professional duty. When faced with similar experiences outside of work, the TRs indicated they did not demonstrate the same behavioural display. The TRs discussions indicated they were intolerant of people who were disrespectful to them, holding a strong negative attitude of this behaviour in a social setting. However, when experienced in the clinical setting, this attitude was suppressed in favour of a positive attitude towards the patient. To address how and why the professional attitude becomes dominant within a clinical context some assumptions need to be made.

It is proposed that a TR's personal attitude towards anti-social behaviour is strong and their professional attitude to be non-judgemental and is weak(er). Therefore, a deliberate action to stimulate weaker attitudes becomes a motivating force and influences an individual (TR) to engage in reasoning to activate the attitude in the clinical setting [214]. The consequence of behaviour or its importance is considered a motivating force [214]. Fazio developed the MODE model that builds on the attitude-behaviour process model, establishing **m**otivation and **o**pportunity as **de**terminants of a spontaneous versus deliberate attitude-behaviour process [214]. MODE accepts and uses the process of attitude activation within his attitude-behaviour process model, (Figure 6.8) but proposes that motivation and opportunity can influence which form of processing is undertaken. Fundamentally if the individual is sufficiently motivated and has cognitive capacity to do so, they can retrieve or construct attitudes towards an object purposefully. Therefore, modifying which attitude is automatically activated and stimulating a behaviour which is congruent with the favourability of the attitude. Motivation refers to the desire to behave in a certain way or reach a certain conclusion. Opportunity refers to the time, energy, and ability required to override the influence of attitude. Fazio, stressed that both motivation and opportunity must be present to overrule the automatic activation process [214].

Emerging from the findings was the belief by the TRs and STRs that they held a strong motivational desire to meet the needs of patients and display compassionate behaviours and practice. With respect to 'opportunity', an emergent theme was one of barriers to compassionate practice, such as time and work pressure. This was perceived by all participants to affect the ability of the TR's to behave in a compassionate manner. In clinical environments where the collective ethos was compassionate and the physical environment conducive, this acted as an enabler for opportunity. When present, motivation and opportunity enable individuals to follow the deliberate process route to attitude activation (Figure 6.8). It is this deliberate, controlled process which overrides those stronger attitudes, which normally follow an automatic activation process. Thus, in the case of TRs, the motivation to improve the situation of the patient coupled with appropriate opportunity, overruled the automatic activation of their personal attitude regarding anti-social behaviour. This meaning their behaviour reflected the positive perceptions of the patient rather than a negative viewpoint of their behaviour.

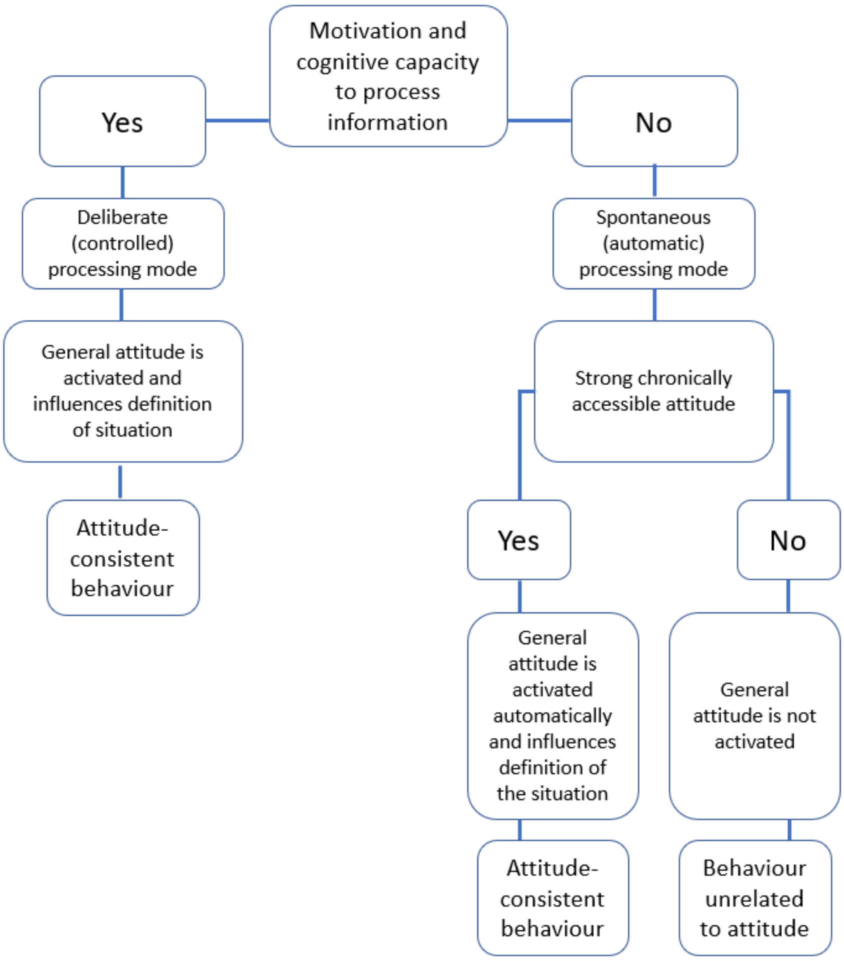


Figure 6.8: MODE Model Motivation and Opportunity as DEterminants of spontaneous versus deliberate attitude to behaviour process [214].

Although this clinical example contains several assumptions, the concept of motivation aligns with the key findings of the research. Intent as a component of motivation to undertake and achieve a desired outcome was prominent in the findings. In contrast, one may consider the MODE model to explain those experiences encountered or observed by the participants where non-compassionate practice occurred. A TR may not be motivated and behaviour displayed does not reflect professional values (attitude is weaker). Furthermore, it could it also signify they do not hold cultural values which motivate their desire to care for the patient. Or perhaps, they do not feel confident in their abilities or are not working in an environment which promotes these attitudes and behaviours (removing opportunity).

Both the attitude-behaviour process and MODE models demonstrate attitude-behaviour relationship to be an internal process, shaped by the TR’s attitude and personal motivation. As established, behaviours are not determined by a single attitude, but by several influencers including external social situations [172, 215, 216], whichever is strongest will dictate response. Although MODE does begin to indicate that the attitude activated is also influenced by opportunity, it fails to consider the importance of or the extent to which those other attitudes especially any external factors will influence behaviour.

Several theorists have proposed that the intention to perform behaviour rather than the attitude is the closest cognitive antecedent of actual behaviour [173, 217, 218]. This implies it is the actual intention to engage with the behaviour that shapes behaviour rather than the attitude held. Intention expressed by Fazio as 'motivation' [214] and by Bergner as 'want' [210] is evident in the findings and represented in the conceptual framework. Both the definition of compassion and the behaviours synonymous with its display are underpinned by the intent of the TR to be compassionate. Analysis demonstrated TRs could undertake behaviours and practices, which one would traditionally typify as compassionate, but if these were undertaken without intent the TRs behaviours were perceived by patients to be superficial or ingenuine. The view of many of the patient participants was that they could discern when a TR wanted to help them, rather than 'doing what they ought to do'. The conceptual framework identifies within the behaviour theme, embodied connection which represents the personal inter-relationship between the TR and the patient. This was a tacit sense of 'knowing' the patient and the ability to compassionately respond to their needs. In turn, those behaviours were then recognised by the patient as a compassionate display. To further reinforce the notion of intention, the theory of reasoned action will now be discussed.

Theory of reasoned action

Ajzen & Fishbein's theory of reasoned action placed intention at the centre of attitude-behaviour relationship. The model provides an assumption that people's behaviour follows reasonably from their attitudes and intentions [219]. Notably however, it recognised that attitude and intent are not the only contributory factors to behaviour as normative beliefs are also incorporated into the relationship (Figure 6.9).

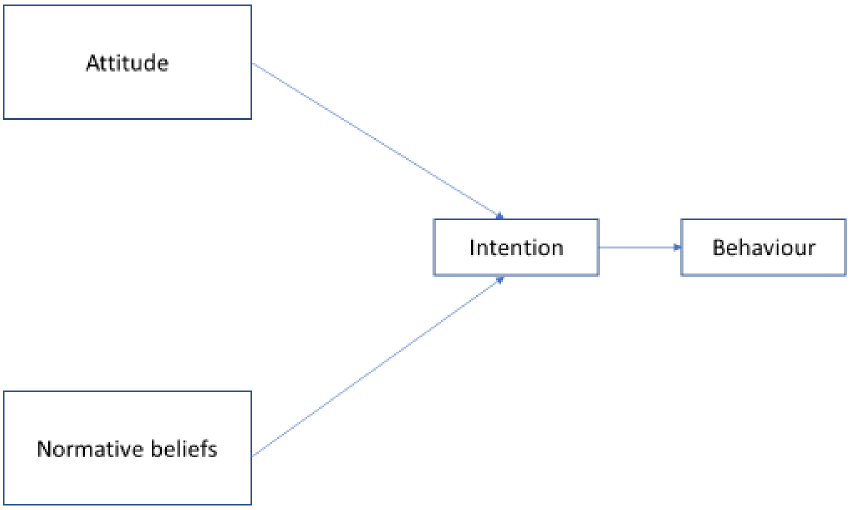


Figure 6.9: Theory of reasoned action, Ajzen & Fishbein [208]

Normative beliefs are the perceived behavioural expectations of individuals or groups [208]. When establishing intent an individual will consider the acceptability of their attitude as displayed by their behaviour from the perspective of the collective group of which they are part or hold as important. The individual will consider what the group thinks about whether they should or should not display particular behaviours. The perceived social pressure will then influence their decision to engage or not to engage in the behaviour [173,208] (Figure 6.10). Convergence with others is stronger when an individual's belief system holds congruence with those others [172], or with an individual who is similar to one's self or are respected by others [220-222].

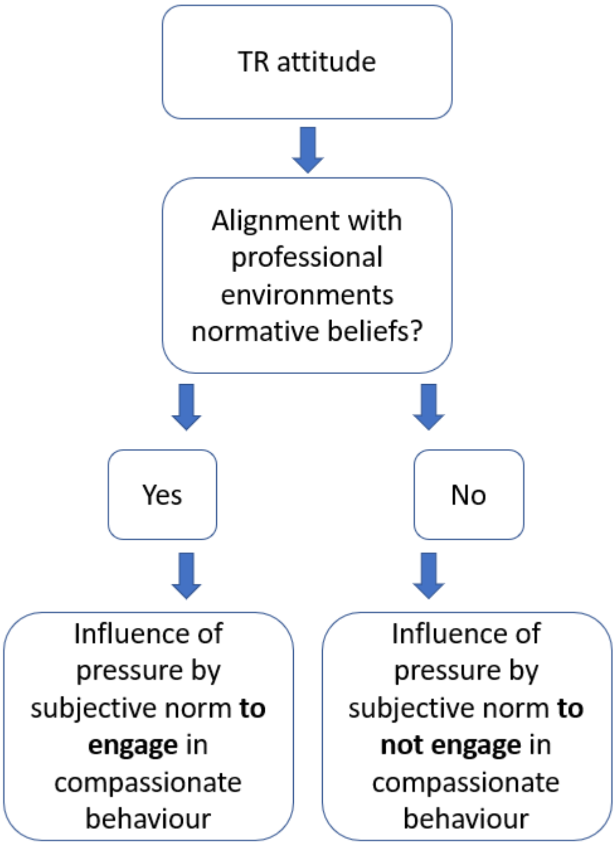


Figure 6.10: Process of social pressure

In the focus groups there was strong sense of pride by the TRs and STRs in their profession, their colleagues and departments. However, what was also evident was the influence of social pressure on views about compassion. This was especially demonstrated during the TRs focus group at site B1. As detailed within the findings, one TR expressed his personal struggle to display compassion. The responses from the other participants who were his colleagues and peers were anger and a rejection of his values [223]. They expressed disappointment at his inability to deliver compassionate care which did not meet the standards set by the collective ethos in department. Belonging to a profession necessitates conformance and upholding the shared attitudes and behaviours of the collective.

Although appearing to fail to be compassionate, the TR demonstrated he held the professional and cultural attitudes established as essential for compassionate practice identified in the conceptual framework. These attitudes underpinned his intent to aid patients by responding to their needs. His actions and behaviours were not however perceived as compassionate by either his peers or the patients in his care, causing his failings (and personal struggle). In this instance, internal motivation and opportunity existed, but the external pressure exerted by the subjective norm was lacking (weaker) (Figure 6.11).

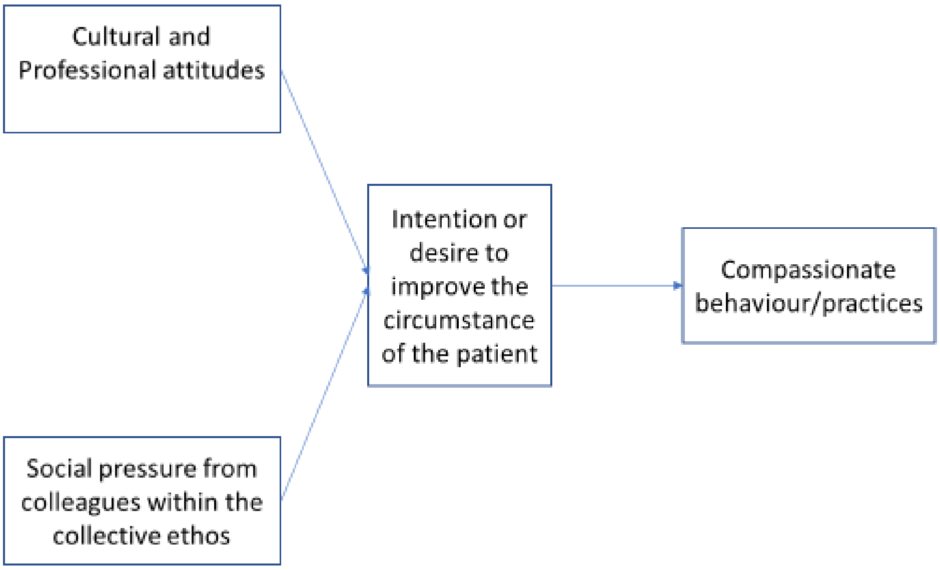


Figure 6.11: Intention

The social pressure exerted by his peers manifested. The TR recognised his failings, consciously working to change and develop his behaviour by learning the ‘accepted’ behaviours from his colleagues. Subsequently, he was trying to modify his behaviour, to align it with the collective ethos of the department.

Undeniably, the theory of reasoned action enables comprehension of the external factors or subjective norms which influence compassionate behaviour, but there are limitations to its application within these findings. Although non-compassionate practice was not the focus of this thesis, it became apparent throughout data collection that compassion could not be explored without its opposite being discussed by participants. Numerous accounts were recalled; many negative examples included the behaviours and practices of TRs. Leading to the question of why some TRs behave non-compassionately. Assuming they do not possess the professional and cultural attitudes deemed essential for compassion, Ajzen & Fishbein accentuated that the social pressure from the clinical environment could overrule the TR’s own attitude and subsequent behaviour [208]. The findings do indicate that social pressure was evident within clinical settings and departments had a sense of professional pride in the care they delivered.

Potentially then, can some TRs override or ignore the social pressure from the collective? As Fazio’s MODE model indicated, with the right conditions, a TR can consciously construct an attitude resulting in it overriding a strong(er) attitude [214]. If a parallel version of this process is considered, where the TR already holds a negative attitude or consciously constructs one. Within this scenario the negative perspective becomes stronger than the subjective pressure exerted by the environment (positive). This would firstly imply the TR decides (motivated by intent and opportunity) to behave non-compassionately towards a patient. This would not only conflict with the established concept of a TRs professional identify and responsibility [224, 225] but rejects the belief that individuals seek consensual validation about their attitudes and values from their important social groups [208, 226]. Typically, when a discrepancy of behaviour arises, it provides motivation for an individual to change as part of a self-awareness process. Therefore, a disconnect between the collective accepted behaviour and the TR's actual behaviour occurs, resulting in an expectation the TR would learn and modify behaviour. Unfortunately, as the behaviours of specific TRs disclosed by participants as displaying non-compassionate practices cannot be tracked, the researcher cannot verify if a change in compassionate practice occurred. Many participants however indicated there are individuals who are 'well-known' in departments for not delivering compassionate care. Social pressure appears to bear no weight in their attitude-behaviour relationship.

"*I think innately they are compassionate on the whole. I think I can count maybe count on two or three fingers certainly across the radiotherapy department*"

TR Site B2

Predicting behaviour

Trafimow discussed the ability to predict behaviour and relies on beta regression analysis to determine whether the behavioural beliefs (attitude) or normative beliefs (social pressure) are the dominant power [227]. Critics believed the theory failed to correctly weight the two factors of behaviour formation creating difficulties when identifying which belief holds dominance. This failure is attributed to the lack of clear conceptual separation between the factors, leading some to consider behavioural beliefs and normative beliefs to be different names for the same construct [227,228]. A relevant clinical example of this would be:

"I demonstrate compassion towards patients as it improves their care" (behavioural belief)

and

"*Patients like to be treated in a compassionate way"* (normative belief)

Miniard & Cohen argued that whilst structurally different, both beliefs reflect an underlying concern of the TR behaving compassionately [228]. Thus, arguing there is no clear distinction between them. Although the thesis is not concerned with the predictability of the theory, the semantics of the two belief types may skew understanding of those components that contribute to the attitude-behaviour relationship. A limited variance between the two components may result in the effect not being exerted or indeed apparent to the TR due to a confusion within their own belief system. Additionally, Trafimow's argument is based upon the principle that these two beliefs do not hold equal weight [227]. Therefore, suggesting the proposed scenario of a TR having a negative attitude towards the patient being stronger than the social pressure from their peers could be correct.

As established, the emotional element within the ABC model of attitudes considers affect, with a specific focus on need for affect. The need for affect is understood as a "*general motivation of people to approach or avoid situations or activities that are emotion driven activities*" [229 p15]. This need incorporates the desire to experience and understand the emotions of the self and others, which suggests that emotions are useful for shaping judgements and behaviour [230]. Like any human-being, TR are individuals driven by a variety of factors, each influencing their motivation to engage in or avoid compassionate behaviours. It was highlighted by Haddock & Maio, that some individuals may experience high levels of positive affect, potentially having a strong sense of psychological security that enables them to pursue emotions [229]. Conversely, some individuals may experience high levels of negative affect due to reasons of low-coping ability, experience or multiple high-stress life events. Research on compassion fatigue indicates a system of self-preservation is often employed to reduce health professionals suffering burnout [231-233]. Those TRs perceived as non-compassionate may therefore be consciously protecting themselves from the emotional negative affect in order to be able to continue working in an emotionally demanding role.

The affective element of the ABC model not only provides a potential explanation of non-compassionate behaviours, it also provides understanding of how the attitude-behaviour relationship is relevant to the context of this thesis. The findings established that embodied connection promotes an intuitive togetherness between the patient and the TR. Its six component behaviours are each affective, enabling both the perception and portrayal of emotion (Figure 6.12). Evaluation is fundamental to emotion [234] and affective reaction development requires information-processing [235], thus contributing to the development of attitude formation and a pro-con response. If this results in a negative affective evaluation, any resultant actions undertaken by a TR to facilitate self-preservation will create a barrier to embodied connection, thus generating a barrier to compassionate practice. In contrast a positive affective evaluation will promote a TR to engage in those behaviours encouraging embodied connection, aiding compassionate practice.

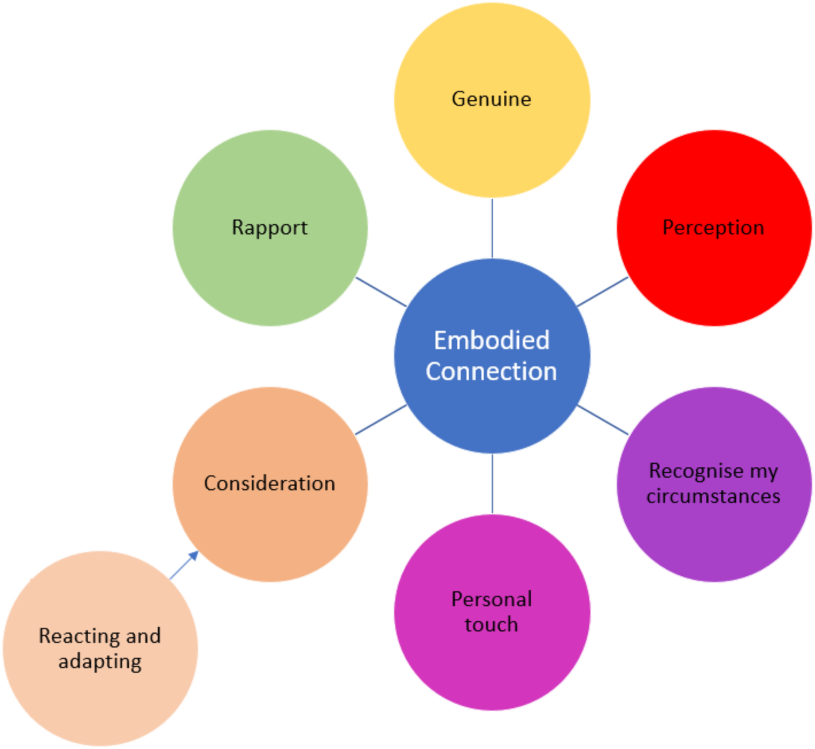


Figure 6.12: Embodied Connection

In summary, the theory of reasoned action places intent at its heart. Although intent is imperative, the findings established this is not enough on its own, TRs also need the know-how [210] to engage in the behaviours required for embodied connection or indeed indicative communication and characteristic expression. The discussion will now consider the theory of planned behaviour and the influence a TR's perceived behavioural control has on their ability to be compassionate.

Theory of planned behaviour

The theory of planned behaviour [236,237] builds upon the theory of reasoned action. Whilst maintaining the fundamental components of attitude and normative beliefs, the theory also incorporated perceived behavioural control as an additional determinant of both behavioural intention and behaviour (Figure 6.13). To note, behavioural control is not a novel concept, considered in MODE to form part of opportunity.

Prior to discussing the inclusion of perceived behavioural control, it is worth addressing that in Ajzen's theory of planned behaviour, he wished to reemphases the importance of behavioural belief within attitude-behaviour relationship. The power of a TR's attitude towards a patient and the apparent benefit to the patient is conceded throughout all the theories discussed in this chapter as determinant of behaviour. There are some considerations within the context of this thesis which should be included at this point. The perceived outcome benefit correlates with the TR's intent to meet the needs of patients and Osorio's definition which addresses behaviour to achieve a change in state of affairs [209]. Whether achievement is reached or not, the outcome would need to be recognised by the TR. In many of the examples discussed throughout the focus groups, achievement or failure would be have been clearly observed by the reactions of the patients or carers or another TR involved. There were however instances where the outcome may have not been portrayed or received. It is therefore required at this stage for a discussion on perception and its role in compassion to be included.

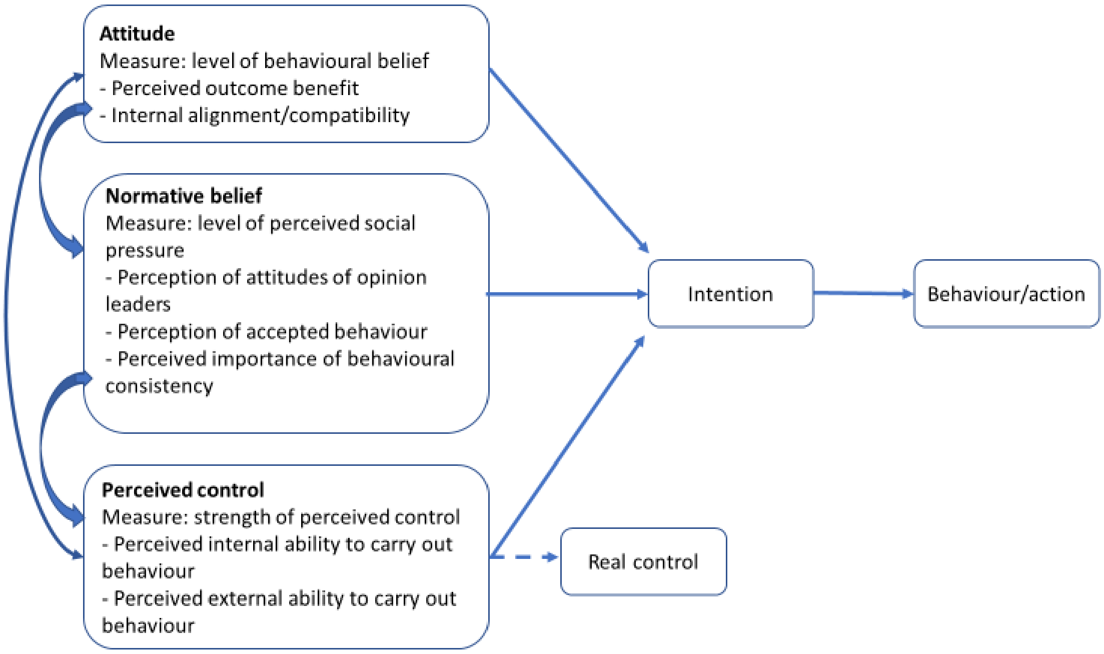


Figure 6.13: Ajzen's (1991) Theory of planned behaviour [237]

Perception

Perception is one of the six behaviours identified within embodied connection. Emerging as a concept from the PaCs and the STRs focus groups, it firstly addresses the TRs' need to have an awareness of their own style of indicative communication. Termed self-perception, it represents how genuine intent may be present, but the professional may not know how to display it. Secondly, it acknowledges how the professional must also have an awareness of the individual patient with whom they are engaging with. Termed perception of others, this enables the patient to recognise the display is person-centred. Centrally, it demonstrates that perception relates to the ability of a TR to understand and appreciate what behaviour is required as a compassionate response from two perspectives, their own and the individual patient. The two must occur harmoniously, for when a dichotomy exists intent can be lost.

Outcomes: social learning

Social learning theory advocates individuals learn from performing actions or behaviour and then reflecting upon the effects they produced [205]. In instances where achievement or failure to accomplish an outcome is not observed, the TR could potentially be unable to identify whether their behaviour was correct in that situation with that patient. This may be through an inability of the TR to perceive or insufficient response being provided. In either case, if unaware of the consequences of their behaviour, the TR would not be able to learn from or enhance their behaviours. If the TR perceived their behaviour to be compassionate, but the patient did not, they would not be able to learn from and change subsequent behaviour patterns. This reduces their potential for change by observing the positive and negative effects of their behaviour [205]. This type of learning infers that responses are shaped both automatically and unconsciously by their consequences. The TR learns whilst performing activities and subsequently forms ideas about the consequences, acting upon those ideas or predicting occurrence from them. As a result, they can judge the adequacy of their behaviours and change them accordingly [205]. The principle of learned behaviour appears to oppose the views established by participants regarding non-compassionate practice. The findings demonstrated the participants felt in general TR's who had been in the profession a long time were more likely to be non-compassionate than those who were more recently employed. It would therefore be reasonable to assume the longer the length of time working in clinical practice should equate to more interactions with patients and opportunities for observation of accomplishment and reflective learning. This meaning the TR should be 'more' compassionate and not 'less', contradicting the perspectives of the STRs and TRs participants.

Bergner equated behavioural outcome to 'significance' of the behaviour [210]. The analysis highlighted the necessity to appreciate the vulnerability patients diagnosed with cancer as part of a characteristic behavioural expression. Subsequently there is an advanced need for compassionate behaviour due to the circumstances the patients face. Many theorists believe individuals are more likely to maintain attitude behavioural belief in situations that elicit high need for closure than low need [238, 239]. Thus, denoting there is a high chance of compliance to undertaking the behaviour due to it being towards a patient diagnosed with cancer. This reaffirms the importance of intent within the attitude-behaviour relationship.

Perceived behavioural control

Perceived behavioural control relates to a person's perception of the ease or difficulty of performing the intended behaviour. The rationale that having a greater perceived control will hold intention constant, subsequently increases the likelihood that the undertaking of the behaviour will be successful [172]. If perceived control reflects the actual level of control, then perceived behavioural control will directly influence behaviour. In its use as a method of predicting behaviour, perceived behavioural control acts as both a proxy measure of actual control and a measure of confidence in one's ability. Fundamentally, the easier a behaviour is, and the individual realises they are capable of performing, the more likely the intent to perform it. The theory however is limited by its assumption each individual has acquired the opportunities and resources to be successful in performing the desired behaviour, regardless of the intention.

One example emerging from the findings relates to the category of ‘signposting’. For all the focus group participants, the act of signposting to another person or service indicated a desire to ensure that the patients' needs were met or at least an attempt was made. Failure to signpost was deemed unacceptable and inappropriate signposting was classed as ‘passing the buck’ unless it was due to an acceptance of their own skills and abilities being insufficient for the task. This however is a very practical example, focussing on the outcome of the behaviour, thus aligning more with the principles of behavioural belief.

There were however facets of signposting which held a more distinct alignment with the principles of perceived behavioural control. As outlined in the findings, one STR spoke about the changes she had noticed in the patient’s behaviour and the frustrations she felt when no action was being taken to help him. Analysis demonstrated in this context, signposting demonstrated a deeper understanding and knowing of the patient through the ability to interpret and comprehend without verbal ques. As established during the discussion of MODE, a caveat of opportunity lies within the TR’s individual skillsets, abilities and know-how [210]. These skill sets are not simply related to the practical tasks associated with meeting the needs of patients. They are also required to undertake those three behavioural classifications which afford the TR with an understanding of individuality and appreciation of needs (Figure 6.14). In this example, the STR had both the ability and capacity for perception, recognising the patient's circumstances enabling her to achieve a connection. There were others working within her team that did not develop a connection, potentially indicating engagement was due to a perceived lack of the skills required to facilitate connection.

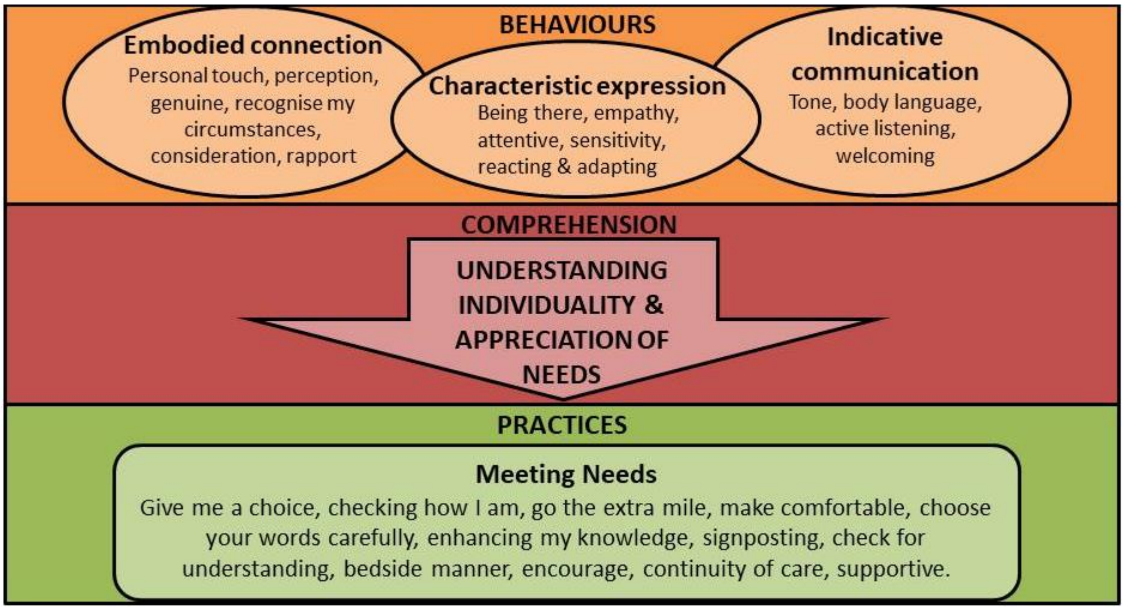


Figure 6.14: Conceptual framework – influence of behaviours on the practices of compassionate display

An important consideration is that every individual is different, similarly every situation is different. Perceived behavioural control can therefore vary, which can result in an individual having varying perceptions of behavioural control depending on the situation they face [172]. Consequently, even if competent to engage with or undertake those behaviours essential for compassionate care in one situation or with one patient, it may mean this know-how does not translate to all situations or all patients.

Critics of perceived behavioural control highlight its failure to consider other variables which may influence behavioural response [172]. In relation to behavioural intention and motivation, it is felt fear, threat, mood, and prior experience should be considered. Whereas for normative influences, it should consider environmental and economic factors that may influence a person's intention to perform behaviours. Although appreciative of the issues raised by the theory's critics, the position of the thesis indicates there are several counterarguments which support the theory's validity in application and verification of the conceptual framework.

Firstly, it would be implausible for any theory to account for all, due to the vast array of variables any individual may face. Secondly, as established the purpose of this and other attitude-behaviour theories and models are for the predictability of behaviours. Research into their application in healthcare predominantly focuses upon two areas: the behaviours of the patient or the behaviours of healthcare professionals. The former focuses upon the theories ability to predict the uptake of a change in patients' behaviour in matters of public health [240-242], for example smoking cessation or a reduction in alcohol intake. In this area theories would need to consider variables such as habit and threat, similarly social and economic factors as these would be detrimental in the decision-making process as to whether to adopt a personal behavioural change. In relation to the latter, this research investigates the probability of health professionals implementing changes in clinical practice [243, 244]. Equally habit and threat, alongside environmental factors would need to be considered as potential barriers to professional change. The thesis however is not utilising this or other theories to predict behaviours of TRs. Instead their employment is for explanation of how the attitude of the TR results in and influences a compassionate behavioural display. Thus, providing understanding of how those behaviours and practices when undertaken by TRs represent compassion.

The dominant finding emerging from the research was the importance of the TR's intent to be compassionate. The foundations of intent are situated within the professional and cultural values of the individual, generating influence on their engagement in the three behavioural components of compassion. Similarly, engagement in those behaviours enable the TR to denote their intent, permitting it be perceived by patients as a compassionate display. The concept of intent is situated within a professional clinical environment. The environment motivates intent through promotion of professional expectations along with the exertion of social pressure for others to comply with expectations. Additionally, environment can facilitate opportunity for compliance through the removal of barriers and by realising the importance of, subsequently equipping its staff with skills to facilitate the know-how.

A further criticism of the theory of planned behaviour is it assumes behaviour is the result of a linear decision-making process, therefore does not consider it can change over time [172]. To establish the validity of this criticism, behaviour must be considered within the context of radiotherapy. Despite potential variations in the practical display based on the changing needs of the patient demographic or through advancements in treatment, the attitude-behaviour process of compassionate display would remain the same. The practices are simply undertaken to attain achievement of outcome or significance. These are not fixed instead being interchangeable. The influencers of behaviour within the context of radiotherapy are however fixed (Figure 6.15) and therefore in most instances TRs will follow a linear decision-making process.

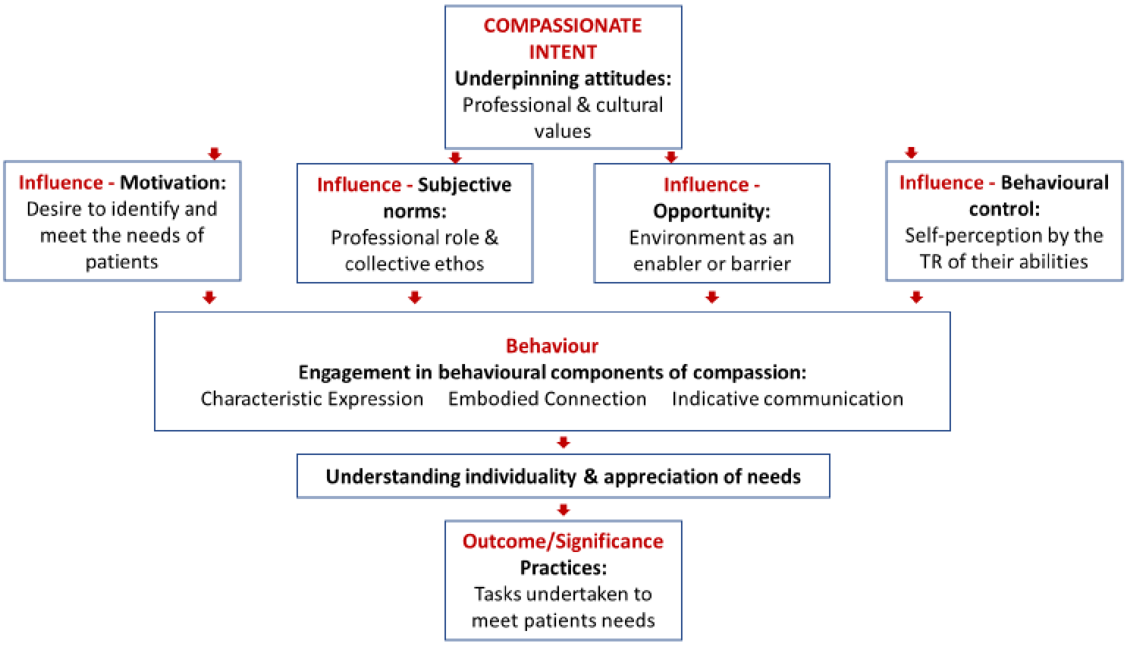


Figure 6.15: Compassionate attitude-behaviour model.

Summary

The second part of the chapter has identified how compassionate attitudes are learnt within the context of a clinical environment, shaped by individual TR’s own experiences, belief systems and values in addition to the observation of others. Those internal attitudes forming the basis of a behavioural response towards the patient as an object of intension.

Intent and the desire (internal) to improve the circumstances or outcomes for the patient are a key motivator for the TR to respond in a behavioural manner which is indicative of compassion. Behavioural responses are also shaped by an external pressure to conform exerted by peers, alongside the individual TR’s own perception of their ability (internal) and any potential barriers (external) to engage.

When the internal and external factors are in accordance, it culminates in a behavioural response which represents to both the individual TR and their patient a display of compassionate practice.

The next section of this chapter considers the three behavioural classifications of the conceptual framework: characteristic expression, embodied connection and indicative communication. It details the dual roles each classification holds in both enabling and portraying compassionate display. Discussion is situated in and supported by appropriate literature and reference is made to the findings of the concept analysis presented in Chapter 2. The influence of each behaviour on a TR's ability to understand individuality and the needs of the patient will become the basis for discussing those practices established as reflecting compassionate display.

Section three: Compassionate behaviour and practice

The previous section focused on attitude as a central component of compassion and has drawn on theory to explain how attitude influences behaviour. This section takes that discussion further by exploring the behavioural components of the conceptual framework: embodied connection, characteristic expression and indicative communication. Further exploration of how compassionate behaviours are incorporated into the everyday practice of TRs follows.

The discussion in this section will refer to and draw upon the defining attributes and empirical referents which emerged from the concept analysis, as the practical and presentable elements of compassion within healthcare presented in chapter two. In a move away from tradition, this chapter will not directly return to the concept analysis to provide a comparable to the findings as this was not its purpose. Rather the concept analyses' aim was to establish what was known and understood on the topic of compassion providing justification for the research and shape the design of the project.

This third section of the discussion instead examines the current literature base around the key components and themes of which the conceptual framework is comprised. To note some of these will however have been part of the original concept analysis. This method allows the discussion to explain how the behavioural components of the conceptual framework enable the TR to be compassionate and why these behaviours are perceived as compassionate by the patient. Thus, aligning with the principles and purpose of a conceptual framework to provide meaning and comprehension to a phenomenon [100,167].

Compassionate behaviours

Embodied Connection

Embodied connection reflects an implicit knowing of the individual patient, a dominant concept in the findings, reflected in the desire of the patients to be known and its centrality in a TRs' ability to be person-centred.

Knowing the patient

Previous research in oncology has established individualised care, where health professionals display flexibility in their practice and understanding individuality. This establishes strong human connections and shows that personal interest is paramount for the display of connection [82,245]. In their work with teenage and young adults Jacobsen et al., established that to be considered as “not a number” was paramount in displaying individualised care [253]. To the research participants in their study, this behaviour represented being treated like a unique individual whilst classified as a patient and recognised as a person separate from the disease. In congruence, the work of Thorne et al., identified that being known gives a distinct sense of connection separate from the physical disease that helps to define a patient as a unique human-being [82]. Evident in the findings was the patient’s desire for individuality. Within compassionate display, tailored personalisation portrays to patients they are not simply another patient diagnosed with cancer; they are a human-being with individual compassionate needs. Perception of behaviours which convey this message by the patients provides reassurances they are known to the healthcare professional [246].

John et al., advocated how knowing the patient is “*essential for establishing rapport, understanding the needs of the patient and planning effectively for meeting these needs*” [247, p51]. The conceptual framework established each of these three factors were consequential elements achieved through knowing the patient. Empirical works indicate how knowing the patient promotes effective decision-making, aiding health professionals to address the individual clinical needs of the patient [248 -250]. Within the context of this thesis ‘knowing the patient’ promotes effective decision-making aiding the TR to identify and meet the individual compassionate needs of the patient.

The findings are congruent with those of the concept analysis, where a personal connection between the patient and the healthcare professional was identified as a defining attribute of compassion. This connection is based on shared experience, knowledge or understanding of the patient’s current situation [55,82,87,95].

Within compassionate display, embodied connection also actualises cherished values [251], demonstrating to the patient the TR’s congruency with collective professional and cultural values [250,252,253].

The process of knowing

In Swanson’s theory of caring, ‘knowing’ is one of five essential processors for caring, describing it as “*striving to understand an event as it has meaning in the life of another*” [254, p163]. In order to know, she believed the health professional should centre on the patient being cared for, seek cues from their behaviour and engage the self to perceive the patient [254]. Perception of the self and of the patient was demonstrated in the findings as supporting the TR's capacity to engage in compassionate display. As a result, enabling the patient to perceive the TR's intent to know them and modify their compassionate practice in accordance with their needs. Perhaps then, the patient may perceive the TR's practice as compassionate.

It is thought that through repeated experience with patients, healthcare professionals can begin to perceive their specific rather than their typical needs, causing elements of their interactions with patients to stand out as salient [248,255]. Within nursing literature, repeated interactions are believed to provide professionals with recognition of relevant changes and potential warning signs of complications. This knowledge results in better-informed clinical decision-making [256]. This concept of repeated interactions was mirrored within the findings, as the STRs discussions demonstrated that to enable compassionate practice, recurring interactions enhanced their knowing of the patient:

"when I went to tell the staff about him they were all like is he complaining, he never does that why is he complaining, they didn't even bother talking to him but he was really showing that he needed someone to talk to so I just felt.."

STR Year 1

Consequently, their perception of that patient became more intuitive and their ability to behave compassionately was more instinctive by knowing the patient.

Participants in both phases of the research perceived 'time' as a barrier to TRs being able to 'know' the patient [247]. TRs commented further that it was difficult to really know each individual patient within their care. Although organisational barriers are valid concerns [251], the findings indicate that knowing is not about obtaining information about each element of the patient's life, rather the specific facets that may bear influence on their needs at that time. Previous research has established that connecting with patients is forged by helping and working together [257] to create shared understanding and meaning to their goals and expectations [247,258]. The thesis' findings highlight how primarily the desire of the patients was to be recognised as a person first and a patient second. Knowing the patient on a personal level could in this context then be the simple acknowledgement of individuality through their interactions [253].

Consequences of not knowing the patient

When connection is not established, healthcare professionals report an inability to help patients [257]. Similarly, the findings establish that when no connection is present the TR is unable to display genuine compassion, or for their behaviour to be perceived as genuine by the patient. ‘Knowing’ demonstrates that the TR is making a commitment to the patient [254], whereas a lack of commitment denotes a lack of genuine compassionate intent. This difference between knowing and not knowing the patient is equivalent to the difference of being compassionate and performing obligatory actions as part of a TR’s clinical duties [259].

In summary the establishment of embodied connection permits the TR to know and appreciate the individuality of the patient. Behaviours which both facilitate and signify embodied connection are not simply undertaken in isolation and are implicit in nature. The capacity to ‘know’ a patient is only achieved when accompanied by behaviours which symbolise characteristic expression and indicative communication, which will be discussed further in this section.

Characteristic Expression

Characteristic expression reflects the natural and automatic caring approach being adopted. The particular behaviours utilised enable the patient to perceive the TR is ‘there for them’, shares an understanding of what they are experiencing and holds intent to engage in compassionate display.

As established, embodied connection facilitates the TR to express knowledge of the patient and in turn the patient to perceive they are known to the TR. However, a deeper understanding of the patient needs to be attained. The findings established how general knowledge of the patient and their situation is not sufficient for compassionate display. Understanding also needs to recognise the individual, the impact of their situation and its consequences for them, what they are thinking and how they are feeling [260]. A TR needs to be able to see the experience through the patient’s eyes, to possess a personal understanding of the patient’s world [261] and be sensitive to their way of thinking [262]. In order for this to happen, particular skills were identified during the analysis.

Empathy

The role empathy plays in compassion emerged throughout the analysis with the STR holding strong beliefs that the two were interdependent.

"I think it'd be very hard to have compassion if you didn't have empathy .. I think you have to have empathy in order to be compassionate"

STR Year 1

"I feel that empathy and compassion are kind of interchangeable in some ways"

STR Year 1

In the context of compassionate practice, empathy is not just having capacity to understand, it is also the display of the understanding of other another person's emotional situation [263]. This concept is key to characteristic expression as compassion requires the patient to perceive the TR has empathetic understanding, portraying to the patient how the TR not only cares for them but is caring about their needs. The findings demonstrate empathy can be both established and its existence recognised as a result of the TR having presence with the patient.

Presence

Presence is a concept traditionally associated within nursing; with the perception that the term 'to nurse' represents an ability to present oneself in a way that acknowledges shared humanity between the healthcare professional and the patient [264].

Osterman, & Schwartz-Barcott, indicated there are four ways to have presence, ranging from simply being in the same room (presence) to spiritual alignment with a patient (transcendent presence) [265]. The findings illustrate to simply 'be there' does not denote or enable compassionate display, the act must present the TR to the patient as an individual who is committed to understanding and engaging in their experience. Their third stage, full presence however sees the nurse (or healthcare professional) using "*the self*" to evaluate patient outcomes [266, p198]. Consequently, the professional is focused on the whole patient, open to them, their problems, issues, or needs and can perform intentional acts of caregiving [265,266].

In the context of this thesis, a TR's presence evidences their commitment to the patient, to know them and their compassionate needs. A TR uses "the self" to focus on the whole patient permitting them to understand and perform individual acts of compassionate practice based on what is known. Their presence embodies empathy and caring, the cognitive and behavioural elements of compassionate care [267]. The TRs are not just simply appreciative of the patient's situation, they understand, are committed and hold intent to help the patient through their practice [266,267].

Display of characteristic expression

The quality of connection between the patient and the TR is determined by the level of presence displayed by the TR [268]. In the research by Harris & Templeton on the communication preferences of patients diagnosed with breast cancer, active listening was ranked as creating the most positive experience [269]. One participant reported how her oncologist "*gave me the impression that he had unlimited time to spend with me in appointments, listened and waited for me to think things through*" [269, p445]. Engagement in active listening (one of the specific elements of indicative communication), demonstrated the TR's presence and focus on the patient.

Interestingly, the participants in Harris & Templeton's research also ranked the 'use of touch to communicate' high in their preferred behavioural display by professionals [269]. They believed that touching, holding hands and hugging reflected presence. Conversely, presence was not evident where health workers kept a professional distance. Scientific research on the topic of interpersonal touch and communicating presence is limited [270]. Often any empirical work focuses on an empathetic ability to reduce pain [271,272] or stress [273] through therapeutic touch. Touch however is a well-established channel for communicating [270,274] and a means for forging relationship [275] which as suggested in the findings are indicative of both connection and expression. But although initially considered to reflect compassionate practice, physical touch was eliminated during the co-production workshops. Its exclusion was based on the concerns of the participants of it being difficult to ascertain how receptive and accepting patients are to be being touched and whether it was a professional behaviour. These concerns were also acknowledged by the participants in Harris & Templeton’s research. These apprehensions perhaps suggesting its role in compassionate display is contraindicated due to the potential blurring of boundaries associated with a TR’s professional role.

The thesis’ findings established that empathy is also displayed through body language; by the TR portraying they are present and fully engaged. In addition, participants regarded that congruence in the spoken word, verbal tone and the message communicated demonstrated empathetic display. This mirrors Kupetz’s research who found that empathy was displayed primarily through body language, supplemented by verbal communication [263].

The concept of ‘affiliative communication’ describes the healthcare professional who is open, honest, encouraging, empathetic and actively listening and was shown to be highly desirable and increased patient satisfaction [276]. Equally, many empirical works have found interaction styles which denote the professionals are committed and engaged increase patient satisfaction [277-284]. Importantly, participants within all these studies believed these interaction styles reflected that the professional cared and portrayed care-giving behaviours.

Presence, supported by behavioural responses portray understanding and reflect that the TR has recognised the patient’s emotional and personal issues they need to address [78,79,254,].

In every clinical situation there are those patients with whom a TR cannot connect with.

“I think some patients are just more responsive to you”

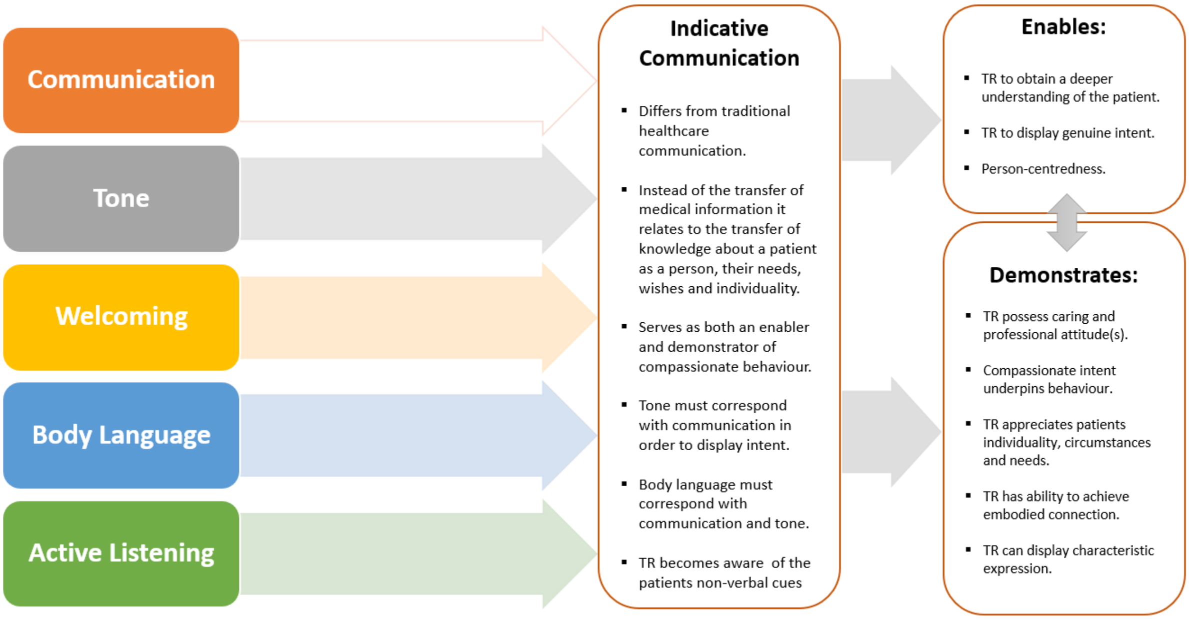
STR Year 1

As empathy requires the patient to permit the TR to enter their private world [260], it must be considered that some patients will not want others to gain access, thus creating a barrier to connection and compassion. This is an important issue to recognise as it demonstrates that attempts to show compassion can be futile.

In summary, characteristic expression discloses to the patient that the TR is understanding of and cares about them and their situation. These behaviours help to form an embodied connection between the TR and the patient. Success however is dependent on the TR’s effective engagement in indicative communication.

Indicative Communication

Communication within a clinical setting considers the interactions between healthcare professionals, most frequently consultants/physicians and the patient. This relationship is often the focus of both commentaries and empirical work which address communication’s fundamental role in patient care and management. Most commonly authors report the importance of; effective communication [285,286], knowing a patient’s communication needs [287,299] and the consequence of getting it wrong [281, 289,290]. Although it must be acknowledged communication is a component of patient care and therefore on some level influences compassionate care, the finding indicative communication does not relate to the traditional concept of relaying medical information to a patient [287]. Instead, it considers the principles of communication as both an indicatory sign of compassionate behaviour and a mechanism for obtaining knowledge, permitting understanding of patient’s individuality (Figure 6.16).



Indicative Communication

- Differs from traditional healthcare communication.
- Instead of the transfer of medical information it relates to the transfer of knowledge about a patient as a person, their needs, wishes and individuality.
- Serves as both an enabler and demonstrator of compassionate behaviour.
- Tone must correspond with communication in order to display intent.
- Body language must correspond with communication and tone.
- TR becomes aware of the patients non-verbal cues

Enables:

- TR to obtain a deeper understanding of the patient.
- TR to display genuine intent.
- Person-centredness.

Demonstrates:

- TR possess caring and professional attitude(s).
- Compassionate intent underpins behaviour.
- TR appreciates patients individuality, circumstances and needs.
- TR has ability to achieve embodied connection.
- TR can display characteristic expression.

Figure 6.16: Compassion through indicative communication

A relationship of understanding

The findings demonstrated that indicative communication ‘brought together’ the patient and the TR. Communication is viewed as an aid in the development of a relationship between healthcare professionals and patients [288,290-292], and an essential component for TRs to foster relations built on trust and empathy [114,261,286,292-296].

The relationship permits a TR to accompany the patient through their radiotherapy experience [290]. However, it is important there is interconnectivity, with both parties contributing to create a shared partnership and understanding [267,269,279,281,286,289,292]. Dual engagement shapes the dynamic [297,299], creating an encounter which enables those individuals to relate to one another and share experiences [292] supporting the formation of embodied connection.

The way a TR portrays themselves can affect relationship formation. Pollard, et al’s., research established patients felt a gentle manner, comprised of body language and tone of voice formed part of effective communication for diagnostic radiographers [294]. Patients judged the overall impression of the radiographer based on the way they had interacted with them. Negative experiences led to patients desiring to no longer engage with radiographers who did not possess this gentle manner. Without the formation of a relationship, embodied connection cannot be formed thus creating a barrier to compassionate practice. This was demonstrated throughout the focus groups, with each participant group believing the TR’s poor behavioural display towards ‘Frank’ would lead him to disconnect and disengage with that professional (and potentially others).

Effective communication is shown to inspire confidence in patients that medical procedure(s) will be undertaken effectively [294,299]. Whereas in the context of compassion, the research findings have demonstrated that effective indicative communication inspires confidence that the TR possesses genuine compassionate intent.

Communication skills

The theories of reasoned action and planned behaviour identified how perceived behavioural control holds influence in the attitude-behaviour relationship. This is through the TR considering the strength of their skills and abilities required for the behavioural response.

There is much debate across the literature regarding whether communication is a skill. Those who oppose do so on the premise that skills in healthcare are measurable and reproducible [292,296]. Communication cannot be standardised, for example, when extracting blood or undertaking an examination there is a correct process established from an evidence base. Whereas, as an example, there is no evidence to indicate how long is the correct length of time to hold eye contact with a patient [292,300]. Indicative communication is not based on skills required to communicate, therefore, those criticisms would therefore not apply [301]. Instead they are concerned with how the TR communicates their compassionate intent and displaying presence with the patient in their care.

Ishikawa et al., perceived communication as a process of reflection upon the words of patients [279]. It is thought how a curiosity in the patient and their individuality creates an ability to perceive and understand their narrative and their individual lives [288,292]. Although each of the five behaviours of which indicative communication comprises will aid information gathering, active listening particularly enables a TR to have a deeper awareness of the person. Research with cancer patients highlights that positive experiences with healthcare professionals are characterised by communication based on active listening [269,302]. Although these studies investigate what patients want in order to maximise the transfer of knowledge to aid them through their cancer journey, the key principles and benefits of active listening can be transferred. Primarily, active listening enables professionals to pick up non-verbal cues which often are in discord with the patients verbal communication [303]. This enables them to hear the hidden meaning behind a patient’s words often depicted through their tone and body-language.

“but this patient was laughing like everything she said to you she would laugh at the end, but it was tough…but I got to realise that she was not really laughing, it's like a way maybe to deal”

STR Year 1

The findings correlate with previous research, establishing that to know and understand the patient and their perspective is paramount when tailoring interactions [297]. Active listening provides the TR with the opportunity and method to achieve this comprehension of the patient enabling them, should they wish, to reflect on what the patients have communicated to them. Those TRs that do reflect are able to obtain a heightened understanding of the patient and are perceived as attentive, friendly, understanding, and responsive [304]. Therefore, it may be assumed that those who choose not to reflect are unable to demonstrate genuine compassionate display.

Informative Communication

The findings notably demonstrate that indicative communication holds an informative intension [305]. By utilising the relational bond created through embodied connection and characteristic expression, the TR has an understanding and awareness of the patient [82,295,306] and perceives themselves to understand what communicative display the patient requires [307]. Through their indicative communication, the TR provides a patient with cues to illustrate what their behaviour intends to display. The patient is then required to give meaning to their cues; to interpret what their behaviour denotes [305]. There are several levels of perception required for this process to achieve success. In addition to the TR effectively perceiving what the patient's communicative needs are, they also must have a perception of that patient's ability to recognise and interpret their cues through characteristic expression. This is not just simply based on cognitive capacity, although this will need to be taken in to account. The TR will need to consider the level of embodied connection between the two of them, reflecting on whether their bond facilitates this process [288,290,292].

In summary, indicative communication displays presence to a patient, permitting the development of a relationship built on trust and mutual understanding of the patient and their needs. Indicative communication not only enables an embodied connection to be formed, it also displays through characteristic expression to the patient that the TR is caring, and how they are known to them. When the three behavioural classifications are evident, patients can perceive that a TR's behaviours and resultant practices hold a genuine intent to be compassionate.

Understanding Individuality and Appreciation of needs

Compassionate behaviours allow TRs to understand the individual and appreciate their unique needs. Dewar's research explored and developed strategies to enhance compassionate relationship centred care [308]. Patients reported that 'when things had gone well' this had happened because healthcare professionals had known information about what mattered to them. The professionals had then used this information to inform their practice(s). When considered in the context of this thesis, the conceptual framework demonstrates if the TR effectively uses behaviours in interactions with the patient, they are more likely to be perceived as compassionate.

However, this will not always be the case as compassionate practices are complicated as perceptions of care and caring maybe context dependent. Bassett's literature review found patients who are in pain or acutely ill may be more focused on tasks and having their immediate needs met compared to times when their condition was more stable or managed [309]. The findings demonstrate compassionate care however differs from traditional practical care as the focus is on meeting needs which signify individuality rather than management of the patient's treatment needs. As the TR knows the patient, their needs will be known within the context of their current situation. If professional and cultural values are present and the three behavioural classifications are undertaken, any change in patients' circumstances should result in the TR knowing there is a change in their compassionate needs and adapting their practice accordingly.

Meeting needs

The goal of health care is to meet the needs of the patient and compassion focuses on meeting those holistic needs. The findings demonstrate that what was important to participants was that there was evidence of an obvious attempt or intent to meet needs. The meeting of needs is achieved by the engagement in practices by TRs which hold intent to address those needs identified and understood for each individual patient.

Practices

Overview

Compassionate display is the ability of a TR to identify the needs through the undertaking of behaviours classified as compassionate in conjunction with their ability to be adaptive in their practice based on the individuality of patients.

The conceptual framework identifies a group of thirteen practices which had emerged from the focus groups and were collectively selected to represent compassionate display in the co-production phase. Acknowledgement is given to the plethora of practices not captured by the data, but the purpose of the conceptual framework was to provide a representation of compassionate display, not to collate all potential practices associated with the concept.

Although the final component of the conceptual framework, the practices themselves are not compassionate unless underpinned by those attitudes identified and based on the understanding of individuality facilitated through the behaviours defined within the framework.

The concept analysis detailed in chapter two ascertained professional practice alongside non-verbal and verbal communication were empirical referents of compassionate display. Similarities between the study findings and those professional practices determined within the concept analysis were established. Both identified that patients want health professionals to understand and appreciate the impact of illness on the physical, emotional and social rudiments of their life [44,46,47,77,94]. The findings however demonstrate this understanding is not achieved through practices. Undertaking the three distinct but inter-related aspects of behaviour creates understanding, allowing the TR to connect with the patient, to gain this understanding, whist simultaneously displaying it to the patient. Practices instead are specific tasks or approaches taken by the TR in an attempt to help the patient based upon how they are known to them. These may be physical care, supporting choices, informing, listening and encouraging throughout their treatment experience.

There is a congruence between the findings, and the literature which demonstrates verbal and non-verbal communication is a means of conveying compassion. Those non-verbal [47,73-77] and verbal behaviours [43,77,78,80-87] established within the literature base were reported to have been experienced by TRs, PaCs and STRs within the clinical setting.

As engagement by a TR in the behavioural classifications identified in this study not only enables compassionate display, it also displays compassionate intent, thus enabling the patient to perceive their behaviour as compassionate. Consequently, the practices which aim to meet the needs of the patient closely mirror what the behaviour is achieving with and / or displaying to the patient. To consider two examples of practices; supportive was achieved through presence (being there) for the patient, whilst give me a choice was realised by involvement of the patient into their own individual care (person-centred).

Although underpinned and influenced by the attitudes and behaviours from which the conceptual framework is formed, practices do differ as they are a physical manifestation, the undertaking of a task or exercise. The term practice is linked in many ways to the concept of compassion. Empirical work however fails to define or describe what these practices are or where relevant what their undertaking depicts.

In their research to develop recommendations for medical students' clinical education Murinson et al., established the need to develop programmes which enable pre-registration healthcare professionals to demonstrate knowledge of and promote compassionate care practices [310]. Their research however fails to identify what these practices are or how they can be delivered. Within nursing, Apker et al., established compassion as one of four distinct communicative skills sets exemplified by the nursing profession [311]. Although mirroring the behavioural elements of indicative communication by displaying consideration and caring through their use of body language, their research focuses on professional communication with colleagues, not with patients. However, what can be considered is the 'skills' required for indicative communication will need to be possessed and utilised when undertaking practices to meet patients' compassionate needs. It is beyond the scope of this thesis to consider the skill sets required for each behaviour and practice within the conceptual framework. Chapter seven will however be briefly addressing these considerations when making recommendations for practice and future research.

The thesis also articulates how patients' needs do not necessarily have to be met by the undertaking / completion of the practice. The underpinning intent and a genuine desire to help meet their needs, whilst tailoring to the individual is what permits them to be perceived by patients as compassionate.

In summary, practices which aim to meet the needs of patients must be underpinned by those values and informed by the understanding obtained by the three behavioural classifications contained within the framework. If not, these will be perceived by patients as standard tasks as part of their treatment or care, and not a display of compassionate practice.

Key principles of compassion in radiotherapy cancer care

In addition to intent, the conceptual framework illustrates the importance of three key principles: person-centred, perception and culture. These will be briefly considered below and their role within compassionate display discussed.

Person-centred compassionate care

The findings mirror some of the key principles of patient and person-centred models [312-314] where the TR and healthcare professional utilise interactions to gather information about each individual patient. The models advocate that patients' narrative and experiences need to be heard by the professional [315-318], shaping the interaction and communicative response based on patient cues [307]. In contrast, instead of information relating to tailoring treatment and management of the care, the three behavioural classifications enable the perception of the patient and vice versa [307].

Engel's biopsychosocial model saw a shift from the biomedical approach towards patients to one that recognised the importance of holistic care [319]. The model addressed the importance of considering psychological and social alongside biomedical factors and is hailed to mark the beginning of patient-centred and person-centred care [319]. Patient-centred and person-centred terms are however used interchangeably throughout the literature. Although both reflect the concept of consideration and involvement of patients within their own care, the two differ in their attention to who the 'patient' is. In their research Zhao, et al., defined a patient as someone who is sick or being treated for an illness or injury, whilst a person is a human being, an individual [319].

The distinction between patient and person appears to be significant when considering the three classifications of behaviour demonstrated as integral to compassionate display. Emerging from the focus group data were the categories patient-centredness and person-centred. Patient-centredness was eliminated during the co-production workshops, whilst person-centred was selected for inclusion. During second stage analysis, a connection between the categories; not a blanket approach, not another number and awareness of the person, firmly illustrated the desire of patients to be considered as individuals. They placed high importance on TRs continuing to treat them as a human-being despite their diagnosis. Desiring the TR to demonstrate an attitude that denotes they value the importance of being person-centred. Alongside this, the focus group participants placed ‘treating patients holistically’ central to a person-centred attitude. The four categories were subsequently merged with and became part of the umbrella term person-centred.

Person-centred aligns with the findings that patients wanted to be recognised, respected and treated as an individual human-being. Despite the term patient-centredness also putting them at the centre of care it labels them as a patient. Even if a tailoring of care and compassionate display occurs through a patient-centred approach, it inevitably removes individuality through stereotypical categorisation.

The desire for individually and recognition of patients as a human being are recognised throughout patient and person-centred literature [320,321] and central to compassionate practice is understanding of the patient and the individuality of their needs [41]. Researchers have addressed the specifics of centredness across a spectrum of patient demographics and diagnoses and comparisons between the two concepts have been made. However, the focus of previous research has been to identify specific preferences to ensure practice and procedures are patient or person centred. Research has subsequently failed to consider that a patient and a person are two different objects of attention. The findings of this research indicate they may each stimulate a different evaluative response from a TR. Indicating that whether the individual in front of them is perceived as a patient or a person may influence a TR’s attitude and subsequent behavioural response.

Furthermore, person-centred was a principle concept within each of the behavioural classifications established within the conceptual framework. To achieve an embodied connection with a patient and display characteristic expression through indicative communication, recognition of individuality must be presented to and be perceived by the patient. As already established, the TR must possess those professional and caring values, forming a compassionate attitude towards the individual patient in their care. Furthermore, the three behavioural classifications demonstrate that the patient is considered an individual human-being and not simply another patient.

Perception

As outlined earlier, the findings illustrate that not only do the behaviours and practices undertaken by the TR have to hold intent be compassionate, but they also need to be interpreted as such by the patient.

Social perception

Social perception is the ability to create an impression or form a judgment about another individual or group. Like attitudes, perceptions are based on previous experiences, beliefs and of the attributes the other individual displays including physical appearance, verbal and non-verbal communication. These factors will help patients to form their judgements, which they will then use to try and make sense of the TR's behaviour in order to help guide our own actions and interactions [322]. As attitudes can only be inferred, patients are reliant upon the external cues displayed within a TR's behaviour to be able to know professional and cultural values are influencing their intent to be compassionate [323].

Compassionate behaviours as a process of social perception

As the patient must interpret all three classifications of behavioural cues to denote compassion, they must perceive them to be compassionate. Patients will hold dispositions regarding the anticipated and experienced behaviour of the TR [305]. These will be based on the traditional expectations of TRs who are professional, caring, and compassionate [30]. When their perception of these behaviours aligns with anticipated behaviours there is congruence, distinguishable as a compassionate. Where there is a conflict in perception, the patient will deem their behaviour to be non-compliant with expected compassionate display (Figure 6.17).

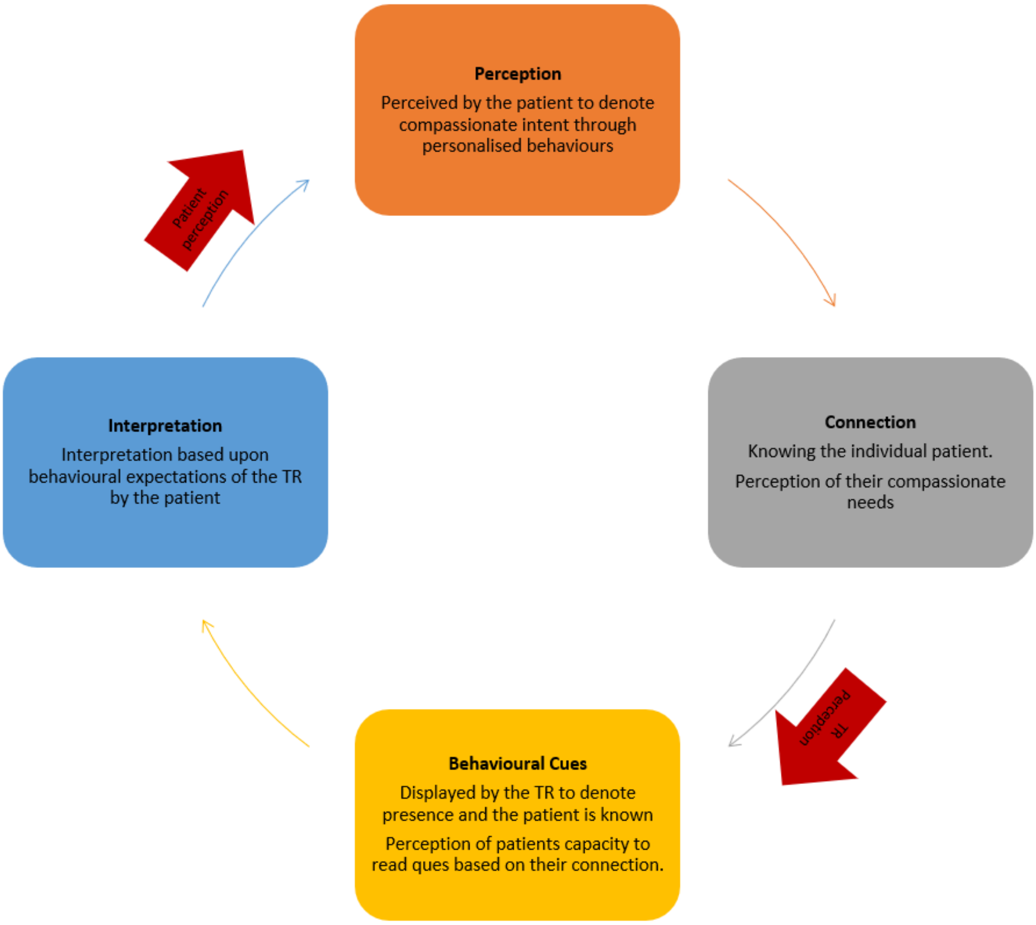


Figure 6.17: Social perception of compassion

Perception of compassion by the patient is based on their satisfaction with the personalised care that shows to them they are known to the TR. As a social interaction, both the patient and TR understand the compassionate attempt that is occurring [263]. The findings of this study established that patients instantly recognise generic behaviours, which they interpret as lacking a genuine desire to connect and a failure to understand their individual needs. This could then influence subsequent interactions as the patient constructs their own attitude or opinion of the TR, or indeed other TRs. Consequently, the patient potentially develops a negative view and perceives a collective culture of a radiotherapy department which is not compassionate.

Culture

Although without a consensus in definition [324], culture is considered as shared basic assumptions, norms, values and repeated behaviours of a particular group [325]. Ajzen & Fishbein’s theory of reasoned action established normative beliefs, as forms of perceived pressure from TRs are a contributory factor in the attitude-behaviour relationship [208]. The strength of the professional and cultural values within the clinical environment results in socialisation of TRs to align with the collective. Culture subsequently then dictates ‘the way things are done here’ [325], creating a disparity between those departments who collectively share and cultivate compassionate values and those that do not. As established the patient may however form an opinion of that culture based on other TRs within it, thus creating a disconnect between how the culture is perceived by patients versus the actual culture developed by a collective.

Part three summary

This section has established how in order to be compassionate the TR must possess attitudes which are congruent with cultural and professional values. These attitudes determine whether the TR will concurrently engage in those behaviours required for achieving an embodied connection, displaying characteristic expression and utilising indicative communication. If successfully undertaken these behaviours provide TRs with an appreciation and understanding of the individual patient and their compassionate needs, to which they can tailor their practices in an attempt to help meet their needs.

Four fundamental principles have been established, intent, perception, person-centred and culture. Intent by the TR to be compassionate, influenced by their underpinning attitude(s) is key, this shaping the perception of the patient when deeming (or not) those practices helping to meet their needs represent a compassionate display. Within all three components of the conceptual framework; attitudes, behaviours and practices, a person-centred approach is paramount. By engaging in behaviours which allow the TR to know, appreciate and recognise the patient as a person results in personalised practices which distinguishes each patient as an individual. Consequently, the practice is perceived by the patient as compassionate, rather than a generic task undertaken as part of a TR professional role.

Section four: Research method

This final section will discuss and reflect on the research process. It will consider the appropriateness of the focus group and co-production methods employed and address the limitations of the research. This will be followed by a discussion on the importance of engaging patients and carers in research and the benefits granted to the research by the inclusion of a strong patient and public involvement strategy.

Focus groups

The benefits of focus groups, as a method to explore the meaning and understanding assigned by participants to a concept are well documented [126,131]. This study was no exception and there are several aspects which are of note.

By using focus groups, a concentrated volume of data directly related to compassion, the topic under investigation was generated [126]. This enabled the findings to answer the research questions.

Compassion in radiotherapy could be considered a sensitive topic due to the emotive nature of the context in which it has (or has not) occurred. The focus groups provided a comfortable and safe platform for participants to confidently share both their positive and negative experiences of compassionate practice [103]. This was demonstrated by the openness of participants to disclose and discuss their examples.

The method enabled the perspectives of the three participants groups (as a data source) to be collected and explored independently. This allowed the thematic analysis to develop themes reflective of each participant group in preparation for co-production.

Supplementary observational data was also generated from the focus groups. This rich secondary data highlighted any salient features of group dynamics and impressions of key points which engaged participants [102,143]. For example, at site B1 it captured where the mood of the group changed in response to the participant's comments. This supplementary data was used to support the emergence of the concept of culture and its role within compassionate display.

Importance of facilitation

The importance of effective facilitation was established within chapters three and four. The employment of a range of skills can be required to ensure fluidity of discussion and equality across the participants. In relation to this study there are several instances to note:

Student therapeutic radiographers

The year one STRs were quiet at the beginning of the session so the pre-designed prompts were utilised alongside impromptu questions [126]. These included *"Is that similar to everyone, did you all have the same?"* These aiming to invite participants to confirm or agree with the student who had initiated some brief discussion to increase it further.

Therapeutic Radiographers

At site B1 on hearing one of their colleagues express their personal struggle to display compassion, the remaining TRs united to question their reasons for this. Appropriate facilitation in that situation was to remain quiet, as by delving deep the collective TRs were stimulating the individual to explore his own beliefs and understanding of compassion. These tensions and challenging approaches held analytical promise [102,126,143] and the exploration of interactions between the different participants contributed rich data to the findings. If the situation had become confrontational or the TR had shown signs of distress an intervention would have occurred.

Patients and carers

One of the PaCs at site C spoke for much of the focus group duration. This could have been considered as domineering, reducing the opportunity for the others to speak. Upon invitation to contribute, the other participants indicated they were comfortable with the other participant speaking and what they were saying, so they were left to continue [143]. The only times the other participants spoke was to build-upon what she had said, thus using her experiences as a platform for their own [326]. On review of the transcript, if this participant had not spoken so frequently the dataset would have been limited.

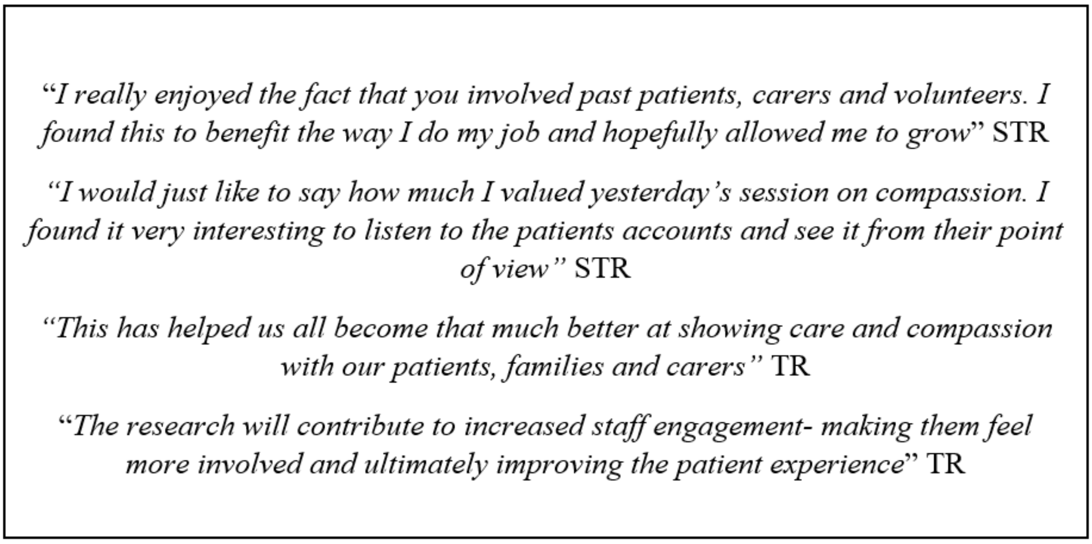
Co-production

Co-production as a concept is already accepted in healthcare practice but is debated as a research methodology. As a novel approach to research, using this methodology could have been a risk. Being a trailblazer means there is limited guidance or lessons that can be learnt from previous research.

The inductive nature of co-production created the opportunity for fluidity in the research process. Having the flexibility and ability to explore different ways to integrate the data meant the most effective method to co-construct the findings could be utilised. The methodology and method of co-production was a key strength of the research's rigour.

The employment of co-production is invaluable where researchers are aiming to generate findings which explore and reflect shared knowledge and understanding. Enabling the effective integration of data and the voices of multiple groups to be represented.

When considering the links between co-production and participatory inquiry in chapter three, it was indicated how participatory action research aims to produce understanding that is useful for the group that are being worked with. The co-production workshops supported the provision of knowledge. In the feedback of the STRs and TRs who attended, they commented how involvement had enhanced their understanding of compassion. They believed they could transfer this knowledge to create improvements in their own compassionate practice (Textbox 6.1). This also holds some important implications for how compassionate care can be enhanced in the Therapeutic Radiography profession. These will be considered in the recommendations section in chapter seven.



"I really enjoyed the fact that you involved past patients, carers and volunteers. I found this to benefit the way I do my job and hopefully allowed me to grow" STR

"I would just like to say how much I valued yesterday's session on compassion. I found it very interesting to listen to the patients accounts and see it from their point of view" STR

"This has helped us all become that much better at showing care and compassion with our patients, families and carers" TR

"The research will contribute to increased staff engagement- making them feel more involved and ultimately improving the patient experience" TR

Textbox 6.1: STRs and TRs feedback on their involvement in the co-production workshops.

Limitations

Sample size

Acknowledgement is given to the sample size included within the research. Across the eleven focus groups a total of sixty-seven participants were recruited, STRs (n=24), TRs (n=27) and PaCs (n=16). For the three co-production workshops, recruitment totalled thirty-nine with STRs (n=9), TRs (n=20) and PaCs (n=10). Seven group members attended the North Trent event. When compared to the number of TRs working in the UK, STRs training in higher education institutions and patients receiving treatment and those classed as a carer for a cancer patient, the numbers are limited. Consequently, the definition and conceptual framework may be considered as having limited representative validity. The recurrence and strength of conviction of the themes during analysis, across all participants and participants groups would however dispute this. Commonality could indicate the perspectives were shared and would represent the perspective of a wider sample. The employment of co-production and the agreement of themes across the participants groups strengthens its representative validity further. The mutual agreement of the themes selected during the co-construction of findings is suggestive of congruence amongst a wider participant population.

Regional variations

The recruitment of participants from across the North of England only, may be considered as a limitation of the research. It could be the case that the interpretation of compassionate and non-compassionate behaviour(s) may be influenced by local variations in preference and experience. Subsequently the definition and conceptual framework maybe considered to only reflect the population of those living within the North of the UK.

Importantly however, a consensually agreed central tenant of compassionate display is that patients desire to be known and understood. The conceptual framework essentially informs TRs that their behaviour(s) can achieve and display to a patient they are known and that their actions are personalised towards them. To present to the patient that they are known, then enables the TRs to display compassion and for the patients to perceive the display as compassionate. The nuances around this behaviour, for example using local dialect or relating behaviours to local preference may differ throughout the UK. But what is important is that translation of the concept into practice by TRs will naturally incorporate local preference based on the TRs knowing of any regional variation and their individual patients.

In addition, natural geographical mobility, the transfer of TRs employment to different departments across the UK, alongside national and international recruitment to the higher education institution will have occurred. Subsequently, this will result in a participant population that is more geographically diverse than one singular region in the North.

Joint patient and carer focus groups

The benefits granted to the research through the inclusion of patients and carers have been well documented throughout the thesis. The study's process of inquiry was designed so that both participant cohorts' patients and carers, would be invited and eligible to take part in the focus groups and the co-production workshops. This adding a further richness to the data by incorporating a dual perspective of those meant to be in 'receipt' of compassion. In contrast with previous literature on the topic which have failed to consider the opinion of carers, purely exploring the perceptions of patients.

It may be argued that patients are the 'focus' of the TRs behaviour as the one in receipt of radiotherapy treatment and care and therefore are the ones TRs are compassionate towards. Radiography's professional codes of conduct however specify a TR's relationship is with both patients and carers [29]. Compassion should therefore form part of their interactions with carers as well as patients.

The decision to combine the two groups within one cohort however may be questioned due to the differences between their experiences, leading to a disconnect between expectations and perceptions of compassion. In defence of this point, the value of this dual perspective was clearly demonstrated throughout the research, a prime example occurring at the focus groups at Site B. During this a patient diagnosed with metastatic prostate cancer attended with his wife. They both shared their experiences of compassion and non-compassionate care during his cancer treatments. In some instances, their interpretation of the actions and behaviours of health care professionals varied. They expressed differing accounts of how that individual professional had made them feel and had disparate perceptions on whether they had been shown compassion.

Their shared, yet differing experiences supporting the importance and role of perception in the behavioural display of compassion.

Power imbalances

The method was designed so each focus group would be conducted with one participant demographic, i.e. there would be no mixing of participants groups. This was firstly to ensure the analysis could present the findings of each group independently so similarities and disparities could be identified in preparation for co-production. It was also to reduce the potential for power-imbalances, to promote the participants to feel comfortable to disclose amongst others. Even though no TRs or STRs were present at the PaCs focus groups, one participant at site C, appeared to feel uncomfortable talking negatively about TRs and health professionals. After providing a negative example, this patient remarked *"they were all very good, it was just a slip of the tongue in her compassion"* appearing to provide an excuse for the healthcare professionals behaviour. This patient appeared to be displaying guilt for talking negatively about her care despite it being what she had experienced. Even with the guilt the patient still shared her experience with the group, this indicates she felt safe within the environment to disclose. This situation did not occur with any other participant across the eleven focus groups. This includes the mixed patient and carer focus groups, where it might be argued that those attending as a carer could potentially feel like their experience or opinion is not as important as those attending as a patient, as the emphasis of care is often placed on the one diagnosed.

The recordings and transcripts of the focus groups contradict this argument as they identify respectful discussion across both groups of participants without hesitation, indicating the participants did not have any concerns about speaking out. On the contrary, the patients in attendance supported the discussion that carers are just as important when it comes to compassion. This is supported within the findings as both groups were ardent that compassionate care should extend to carers as well as patients. The findings demonstrate the TR needs to consider caring for carers as important, this enables their behaviours to be inclusive where appropriate of carer needs. By recognising a patient's wider needs, i.e. the needs of their carer, this displays the TR's caring attitude and subsequently enables them to be and be perceived as being compassionate.

Site C co-production workshop

Failure to include any PaCs and the dominance of one individual at Site C's co-production workshop may lead to questioning whether the research truly adhered to the principles of co-production. The four data sources included in the second stage analysis were however examined collectively from across the three co-production workshops. PaCs (n=10) had been present in the other two, contributing to the co-constructed findings during each of the tasks. In these two, the mixed groups had worked together to collectively decide their answers. This ensures the findings are reflective of all three participant groups. In addition, the primary source of data was the findings from the focus groups where the opinions of PaCs were explored (n=16). The method and analytical processes ensuring the voice of all participants were reflected in the collective findings.

To further strengthen the qualitative validity of the findings, a process of member checking was employed during the co-production workshops. The benefits of this approach were evident during research question one where the participants agreed that connection, listening and communication to be defining components of compassion. Whereas these three had originally been considered part of behavioural display, so were included only in the findings prior to the workshops in research question two. This process enabling the participants to validate the themes were a true interpretation and representation of their perceptions of the phenomenon.

Engaging patients and carers in research

Benefits to the participants

Building upon the reflexive account included in chapter four, the involvement of the PaCs in the focus groups and co-production design did not just simply benefit the research. The feedback provided by the PaCs following the co-production workshops portrayed the participants felt it had enhanced their knowledge and personal understanding of individuality.

"It was good to mix with people from different disciplines in life and to share each other's experiences, traumas! expectations etc. it made you view each other's emotions, and create more respect for people's uniqueness, and individuality! which unfortunately is often not recognised"

(Patient)

"I found both sessions you gave us very useful and informative"

(Patient)

Involvement and engagement in research are believed to make an important contribution to people's physical and mental health [120]. It can create the feeling of empowerment by being able to contribute in a meaningful way [161]. The topic of compassion was considered by the participants as significant. The participants had all experienced first-hand compassion in both its positive and negative forms and knew the impact they or their loved ones had faced. As such, they were invested in its importance within radiotherapy cancer care.

"Compassion in caring for people is a subject very close to me and feel very passionate about it"

(Patient)

The value of involvement and the need to incorporate PaCs into research is a key take home message of this thesis and has been included within the dissemination strategy detailed in chapter seven.

Patient and public involvement strategy

The importance of patient and public involvement in research is well recognised in this thesis. In the researcher's previous role as a senior lecturer, the position of patient and public involvement champion for the allied health professional departments was held.

This carried the responsibility for organising and incorporating patient and carer input into the faculty's recruitment strategies, research proposals, course development and evaluation and academic delivery across the programmes. The necessity to ensure the voice of both patients and carers was heard and incorporated into the design of university services, strategy, teaching and recruitment was paramount. The principles and the passion for patient involvement have been transferred into the research arena. Subsequently a strong involvement strategy has been implemented throughout.

Patients and carers as user representatives were at the centre of the design and data collection method utilised in this research and it was therefore essential to ensure this was developed in unison to ensure the methods were deemed appropriate and were something they were supportive of being involved with.

At the initial development stages, the project was established in conjunction with members of the partners in learning group at the host higher education institution, with consultations occurring at key stages of its design including preliminary idea generation and proposal development. As indicated in chapter four, alongside these consultations the feedback obtained during the pilot focus group was built into the research design.

The researcher has worked closely with the North Trent Patient and Public Involvement group. Prior to Health Research Authority and local research and development / innovation submissions, the proposal and all participant information were reviewed by the panel and amended as required. The focus group guide and scenario used during the data collection were also were reviewed prior to implementation.

The involvement strategy provided the study with unique and invaluable insights from individuals who have direct experience of a diagnosis of cancer or caring for an individual who has [161].

One aspect of the groups involvement where value can be clearly shown is the North Trent's feedback on the use of 'Frank's' scenario. The group were in favour of its use, feeling it would be a "*good way to promote discussion*". The group however advised that it would be good to ask the participants if they felt the situation would have been different if the TR involved in Franks care had been male rather than female. This question was asked when the discussion appeared to be coming to a natural close. The inclusion of this question provoked further discussion and generated additional rich data.

Chapter summary

This chapter presented the relationship between attitude, behaviour and the intent to be compassionate. It established the influence of motivation, opportunity and behavioural control (internal) and subjective norms (external) on a TR’s compassionate behaviour and practice. It has presented four key concepts within compassionate practice, intent, perception, person-centred and culture and the role each place in displaying compassion and its interpretation as such. These form the basis of recommendations to aid the enhancement of compassionate practice in radiotherapy in the next chapter.

The final chapter will conclude with a summary of the key findings and the implications of the research within radiotherapy. It will outline the original contribution to knowledge made by the thesis and the potential transferability of the conceptual framework to other health professionals.

Chapter 7: Conclusions and recommendations

Introduction

This thesis is an exploration of the socially constructed perceptions of compassion by TRs, PaCs and STRs, examining how it is defined and displayed within radiotherapy. The key outcomes of this study were to generate a context specific co-constructed definition of compassion and the development of a conceptual framework that describes compassionate display.

The findings have established a TR’s attitude is what drives them to be compassionate, directly influencing their behaviour and practices towards the patient. Parallel to these findings, the thesis demonstrates that: intent, perception, person-centred and culture are central to compassion and the ability to be displayed by a TR and interpreted as such by the patient. On review of the attitude-behaviour relationship models, it has been recognised that four factors influence whether the TR will engage in compassionate behaviour: motivation, subjective norms, opportunity and perceived behavioural control.

This chapter will return to the research questions outlined in chapter two, to consider how the findings can aid understanding and translate compassionate policy into practice. Recommendations will be made based on the four factors that influence the attitude-behaviour relationship to address how compassion can be enhanced across the therapeutic radiography workforce. The role of values-based recruitment will also be considered in this chapter and how the findings align with the professional standards of the radiography profession.

The chapter will also consider dissemination plans and the future directions of work. It will culminate in detailing the original contribution to knowledge made by the thesis, provide a conclusion and incorporate a reflexive summary of the research process.

Returning to the research questions

Within chapter one, high importance was placed on the need to enhance understanding of compassion within a healthcare context. Omission of a clear, consensual and context specific definition was attributed to be the cause of many of the NHS's failings in patient care. Notably, this has been due to an inability to interpret and implement policy mandating implementation of compassionate care into clinical practice.

The concept analysis, although not purely focused upon radiotherapy, rather healthcare in general, identified a gap in the evidence base. Published empirical work which sought to define compassion previously had explored only a singular cohort perspective. Understanding of the concept had never been co-constructed from both those in its receipt and those responsible for its delivery collectively.

In respect of radiotherapy, the necessity to co-construct a shared definition and understanding of its professional display became a key tenet of the thesis. Co-

construction using a co-production approach became central to the methodology and procedural design of the method utilised. TRs and STRs became the healthcare professionals under the lens of investigation due to the interest and professional registration held by the researcher. These provided the perspectives of those who it is expected will be responsible for the delivery of compassionate care. Exploration of cancer patients and those individuals classed as carers (including, friends and family) provided the perspective of those who expect to receive compassionate care.

Their socially constructed perspectives of compassion were explored to address two research questions:

1. How is compassion understood by patients and carers, student therapeutic radiographers and therapeutic radiographers?

2. How do patients and carers, student therapeutic radiographers and therapeutic radiographers believe compassionate behaviours are demonstrated?

Research question one

Exploration of the participants understanding of compassion provided the thesis with a co-constructed definition of compassion:

Compassion can be defined as, *the intention to help, by identifying and understanding the individual with the aim of meeting their needs. It is characterised by unique interaction that promotes connection between individuals and is reflective of a genuine desire to help.*

The co-constructed definition provides clarity to the concept, distinguishing it from other similar concepts, for example, empathy and sympathy. It conveys how compassion can be recognised by the intention to help, achieved through recognition of individuality and a tailored approach to meet the person’s individual needs. The unique interaction encompasses the four internal components; empathy, connection, communication and listening. These are what enable the TR to understand, connect and appreciate the patient’s individuality, whilst portraying their behaviour as genuine and holds intent to be compassionate.

Although defined within a radiotherapy context, the definition itself does not specify compassion delivered by a TR, nor does it identify the object of intention as a patient. The definition reflects how compassion is determined; this has applications beyond radiotherapy and TRs and will be addressed later in this chapter. In addition, as the concept of individuality and person-centred was predominant throughout the findings, to make a patient the object of intention would oppose the key principle of compassion. In many respects, compassion should be regarded as a cultural phenomenon that organisations should strive to follow.

Research question two

The process of enquiry has established that although important, the definition is not what conveys meaning or permits understanding of the concept. Instead, understanding of compassion is illustrated by the conceptual framework. By obtaining an understanding of how compassionate behaviours are demonstrated, the conceptual framework establishes the structure of the component parts essential for compassionate display. These reflect what TRs need to do for their interactions to represent and be interpreted as compassionate based on the perceptions of the patient.

What has been particularly highlighted in this study is the complexity that surrounds compassion. Numerous distinct behaviours and three classifications were identified that could aid the improvement of compassionate care. However, what is more illuminating and will be useful in supporting service developments is the realisation that attitude is at the heart of compassionate display. The health professional’s attitude not only influences behaviour but is outwardly apparent to patients through their presence. A further layer of complexity emanates from the intention / perception paradox. Intention on the part of the TR / STR to help was seen as compassionate by patients and a motivation by professionals. However, a tension exists where behaviours could be perceived positively or negatively depending on each individual.

Fundamentally, the attitude-behaviour relationship is essential when establishing why compassion does or does not occur within clinical practice. This knowledge is what will aid NHS Trusts, service delivery managers and individual employees (TR) to understand, interpret and implement policy recommendations regarding compassionate practice at a local level.

Values based recruitment

Central to the conceptual framework is the necessity for the individual TR to possess a compassionate attitude, underpinned by professional and cultural values. The impetus for Trusts to recruit the “right staff” [17,20] and higher education institutions to enrol the ‘right students’ to provide compassionate care validates the emphasis placed on values-based recruitment [9]. Consequently, it is important that current and future professionals are recruited into clinical positions and onto academic programmes based as much on their values as on their qualifications, abilities and experience.

Throughout the research, the question posed by many on hearing about the topic of the PhD is *“can compassion be taught?”* although a question beyond this thesis, the answer holds important implications which need to be briefly considered.

As attitudes are inherent to an individual formed through life experiences, endeavours to reframe their experiences would be a huge task and one which perhaps would be beyond the scope of academic programmes. Furthermore, as higher education institutions should already be enrolling individuals whose values align with those associated with compassion and the six Cs’ as standard; in theory there should not be a necessity to address this.

However, the findings indicate that ‘compassion ability’ is not what needs to be taught. Rather, teaching needs to generate comprehension of the importance of connecting, understanding and responding to the individuality of patients. Pedagogy addressing the behavioural components of compassionate display would promote learners, both pre and post registration to understand the centrality and importance of individuality and person-centredness within compassion. Thus, in terms of this study’s contribution to knowledge, we have a clearer understanding that to deliver compassionate practice the individual must be aware of their own values and attitudes. Only when these concepts are understood and they are able to reflect on how they can best meet the needs of every individual in their care, can students begin to learn how best to deliver compassionate care.

Recommendations of the thesis

In chapter six, the review of the attitude-behaviour theories established four key factors which can stimulate a TR's attitude to more effectively engage in compassionate behaviours (Figure 7.1). The thesis identifies that: motivation, subjective norms, opportunity and perceived behavioural control perform as both enablers and barriers to compassionate care. This next section discusses those four factors and will form the basis of the recommendations.

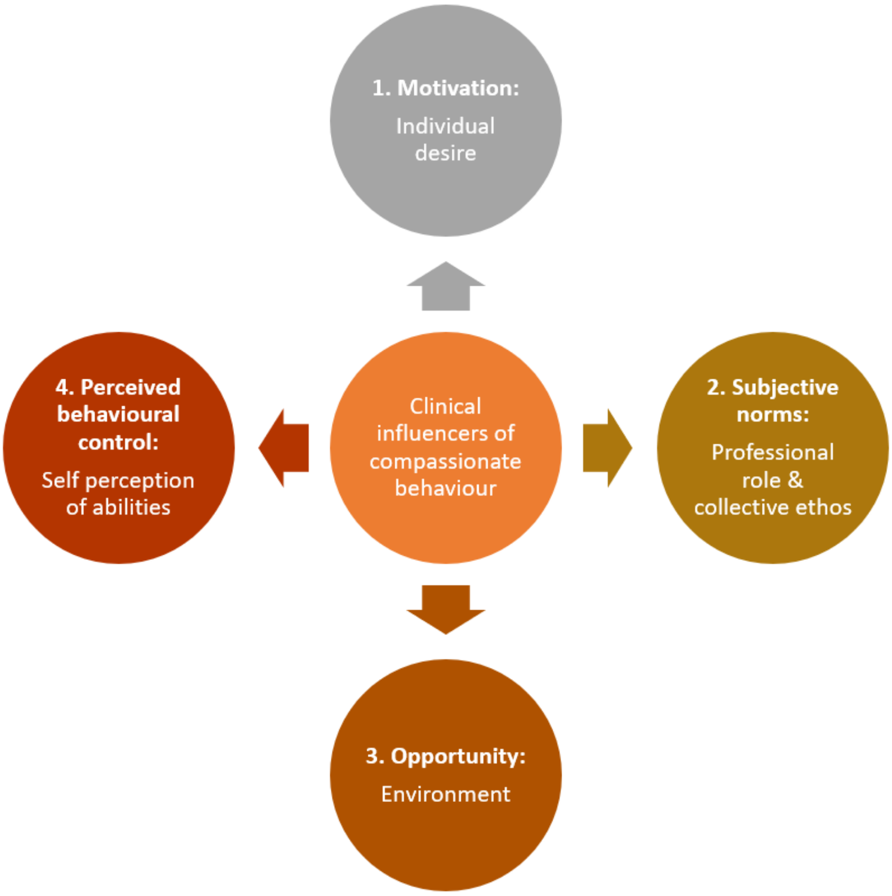


Figure 7.1: Clinical influencers of compassionate behaviour.

Motivation

There are several implications regarding a TR's motivation to be compassionate. Motivation by its nature links to the TR's intent to be compassionate and their desire to embark upon those components of behaviour to help the patient.

As a registered TR they should practice in compliance with the Society and College of Radiographers (SCoR) code of professional conduct and the Health and Care Professions Councils Standards of Proficiency. Section one of the SCoR document considers a TR's relationship with patients and carers, it instructs radiography professionals to; "*provide the best compassionate care for patients based on up-to-date evidence*" [29]. Whilst the Council's standards mandate radiographers need to "*understand the need to act in the best interests of service users at all times*" [30] any failure in motivation to aid the patient through a display of compassionate care indicates they are not practicing in accordance with the standards required for professional registration. TRs need to consider how failure to practice in accordance with these standards could deem them not 'fit to practice' and removing their eligibility to work clinically within the UK. Failures need to be recorded and reported, then used as examples to denote its unacceptability within clinical practice and the culture of that department. This will be addressed further within the next section.

To support the culture of a workforce which is motivated, Trusts need to review their recruitment strategies to ensure they align with the government advocated values-based recruitment. Ensuring their clinical teams are composed of TRs who are motivated to be compassionate towards the object of intention, a person diagnosed with cancer.

Subjective norms

Pressure for the TR to align their behaviour to those behaviours endorsed by their peers and colleagues, demonstrates the importance of culture within clinical environments. Thus, compassion becomes the norm when promoted by a collective of TRs who are motivated to engage in compassionate behaviours. This viewpoint affirms the necessity to employ the 'right staff' to generate this collective culture. The assumption would be that because TRs are engaged in patient-facing work, any shortcomings in compassionate care are a reflection on their own personal failings. However, in many cases this is not true as TRs are one link in the compassionate chain; their behaviours represent the culture of that department, hospital or Trust.

Creating a culture of compassion requires the establishment of a shared vision that is collectively co-produced by engaging staff from across a trust from high-level management right through to supportive services. A vision for compassion cannot be a superficial paper or a ‘tick box’ exercise, it must be embedded and supported at every level of an organisation, not just by those who are patient-facing. High levels of patient satisfaction in the quality of care and services they receive has been observed in Trusts that have a clear vision and one that is shown to be supported by goals and a strategy for achievement [325].

High-level management, service-level delivery managers and TRs all play an essential role in ensuring compassion becomes the norm and not just an added extra. High-level management are essential in supporting the vision, by embedding it into Trust strategy and advocating its importance demonstrates commitment and governs engagement.

Service-level management are responsible for embedding the vision into local services and conveyance of the vision through their operations. It is essential managers create environments and systems for nurturing caring cultures by ensuring that staff feel valued, respected and engaged. Compassion must not only extend to patients and carers, but staff too. Equally important, is the role of service-level managers in embedding a compassionate culture, they must also be responsible for adherence to the vision, by developing supportive schemes for those who are struggling to provide person-centred compassionate care.

Furthermore, during the focus groups, TRs and STRs indicated how there were individuals who were consistently recognisable for not engaging in compassionate behaviours despite it being the ethos of other TRs in their department to do so.

“*I think some staff may think it’s another person’s job to be compassionate*”

STR Year 2

“And I think sometimes you sense that some people don't have that, even working within health”

TR Site B1

Challenging those TRs who repeatedly fail to engage in compassionate behaviours is also essential. It reinforces the commitment by the managers to the shared vision, signifying that non-compliance is not accepted. As social learning theory promotes the use of feedback to understand the significance of their own behaviour, TRs can learn and make modifications to future behaviour based on this understanding.

Clinical departments need to have an open and supportive system in place where concerns can be raised if alignment to the vision is not being displayed. Any dissonance weakens the strength of the culture, reducing the influence held by the subjective norm and the levels of compassionate care received by its patients.

TRs not only have a responsibility directed by their professional body and mandated by professional registration to deliver compassionate care, but their contractual employment necessitates TRs to conduct themselves and undertake their role in accordance with Trust directives. Mandated compassion should not be the driver behind TRs behaviour. To be perceived as genuine, it must be based on intent, the natural desire arising from their underpinning attitude. This again reinforces the need for values-based recruitment and employment of the “right staff”. Engendering responsibility for patients, colleagues and for themselves is created through a collective culture, the TR desiring compassion for the benefit of all.

Culture however cannot be mandated, it develops over time portrayed through successful adaptation to conditions, bringing desired results and defining desired norms and values [327]. However, the findings highlight there is a consensus amongst TRs regarding the importance of compassion and its congruence to their professional role. A big shift in the vision shared by the culture in those departments where failings have been reported would not be required, rather a realignment and refresh of their values.

Culture was also demonstrated to be portrayed by the environment in which it is being delivered. Facilities also need to promote the values of compassion, for example they must not fail to maintain dignity or the preservation of privacy and confidentiality. When these measures are not present, this indicates to patients that compassion is not inherent in that environment or those TRs who work within it. Service-delivery managers, supported by high-level management must ensure facilities not only meet the treatment and care needs of the patients, but also their compassionate needs.

To ensure a person-centred, compassionate culture is developed it is vital that patients and carers are also involved in the vision and strategy of departments, to ensure that professionals listen and are open to their ideas.

Opportunity

Time constraints and work pressures were perceived as barriers to compassion, subsequently removing the opportunity for TRs to engage. A clear recommendation would therefore be to reduce/remove the effect of these barriers to aid the delivery of compassionate care. If the UK Government seeks an increase in compassionate care and coupled with a reduction in patient complaints and official inquiries into NHS Trusts who are failing its patients, then the services need to be supported to promote opportunity. Although it is appreciated that this recommendation has an impact on NHS funding and services, attainment of this would not simply have to be reliant on increasing the number of TRs employed or reducing the percentage of patients treated daily. Capacity in many radiotherapy departments is severely stretched and increased staffing would improve the ability for compassionate care. There is an imperative to increase training numbers and retain experienced staff as TR staffing levels has already been established as a priority to cope with the predicted future demand on services [328]. Without increasing student and registered professional numbers, a further reduction in opportunity has the potential to increase failings in compassionate care.

On a local level, service-level managers need to address the roles and responsibilities of their workforce, promote diversification and expansion of roles and responsibilities. Similarly reviewing the supportive and administrative tasks associated with radiotherapy and their potential devolvement to non-professionals.

At this point it is important to consider the Francis report and the failings linked to opportunities which were the driver for this research.

Reflections on the Francis report

In 2013 Lord Francis attributed failings and appalling suffering to be caused by overemphasis on "*a culture focused on doing the system's business – not that of the patients*" [2, p4]. The transcriptions highlighted that despite recommendations, there is still pressure placed upon departments and those TRs practicing within them to meet the 'systems' needs.

"There's more than just delivering the treatment, isn't it, it's making them feel like they're a person. I think we can lose sight of it with all the targets and things"

STR Year 2

It is recognised that challenges are faced by those aiming to create a unified vision for the quality of care received by its patients. All levels of an organisation face a range of diverse and complex internal and external expectations and requirements [325].

Although important and essential within the NHS to promote safety and standards of care, there are additional pressures created through meeting targets, and overlapping demands for information can often waste time. This takes time away from important operational business, development of the vision, goal setting and implementation and supportive strategies for the healthcare workforce. On a patient facing level, it can result in a reduced time to focus on the patient, their treatment experience often appearing like a conveyor belt system, and this fails to create the capacity for compassion [32,239]. Within Trusts, the operational roles of TRs need to be examined to ensure they have capacity to practice compassion rather than being task or 'system' focused.

The traditional view is that to be compassionate requires time. Although the recommendations suggest an increase in time for patients will aid compassionate ability, it does not centre on the notion that TR cannot be compassionate because they do not have time. Within chapter six it was established that obtaining an understanding of a patient, knowing about them as an individual and appreciating them and their needs as such portrayed compassion. Small and straightforward practices (e.g. asking about their life outside of radiotherapy) and behavioural displays (e.g. tailoring their display based on knowledge about them) can demonstrate the TR recognises them as a person. These practices often take no additional time and can be undertaken during standard treatment and care delivery. The recommendation for increasing opportunity therefore addresses the need for time in general with the patient to undertake routine practice, not the need for time to allow TRs to be compassionate.

Perceived behavioural control

As the interpretation of the ease of undertaking the behaviour based on the TR's own abilities influences the attitude-behaviours relationship, it must be ensured that TRs have the “right skills” to engage in compassionate behaviours [20]. Giving them confidence in both their abilities to undertake the behaviours and form an evaluative response. A criticism of Ajzen’s theory of planned behaviour is that it assumes each TR has acquired the resources to be successful in performing the desired behaviour [237]. Standardisation would therefore be required to ensure equality of resources across the profession. It is recommended for the design and inclusion into the curriculum of all UK radiotherapy and oncology courses a pedagogy addressing skills that promote and develop person-centredness. Thus, ensuring all newly registered TRs entering the profession will have a consistent understanding as a resource to perform compassionate behaviours. The responsibility would then fall upon service-delivery managers to ensure systems are in place to support the maintenance and enhancement of these skills whilst in clinical employment. TRs and STRs believed repeated exposure and experiences enables them to enhance their own compassionate skills.

“*I think that helps if everyone’s kind of practising that and I learnt that watching in first year, watching all the radiographers*”

STR Year 3

Ways to enhance compassionate ability

Development of the preceptorship model employed already by some clinical centres would facilitate the observation and shadowing of TRs in different clinical settings. This not only increases their range of experiences but provides them with the benefits of personal motivation and development attained through the observation of role models [330,331]. Shadowing those who are exemplars in compassion could inspire other TRs to engage in similar behaviours. This can be achieved by illustrating an ideal, highlighting possible achievements in compassionate care they can strive for, and demonstrating the behaviours in which they need to engage for their interactions to be perceived by patients as compassionate [332,333].

As motivation also includes the perceived outcome of the behaviour, observing the positive impact experienced by patients as a result of compassionate behaviours can strengthen intent. This can reinforce the importance of compassion within their professional role.

"…one of the radiographers I was working with had then obviously gone home, found it on Amazon, bought it and then went and found them on their first day of treatment and gave it to them…..they burst out crying, they were so happy."

STR Year 3

Negative role models can also have a positive impact in some instances. Observing the adverse effects on a patient when another TR has been dispassionate, enables the TR to visualise a non-compassionate version of themselves; acting as a deterrent as they do not want to become like that [331,334,335]. Although the recommendations are not advocating the purposeful inclusion of non-compassionate negative role models into clinical practice, their use would have a role within higher education institutions person-centred pedagogy.

Furthermore, the participants who attended the co-production workshops provided feedback on their session. The insights of the STRs and TRs demonstrate they had reflected on their own behaviour as a result of the workshop, identifying ways they felt they could make improvements to their own compassionate practices.

It was really nice to get feedback from patients who have had treatment here, and to hear how they feel we demonstrate compassion to them during their treatment. I will definitely use their feedback in the future. I feel like we all learnt a lot in the session"

STR

"the whole experience made me think about compassion more and what we do as a radiographer to show compassion to patients each day was really interesting. It made me think about it more and if any of my body language or actions could have been misconstrued to the patient in any other way"

STR

"I really enjoyed being able to talk frankly and openly with service users. It really made me think about how I am perceived by service users, staff and students". It also made me consider about what is important to them and how I could be more aware of that in my daily practice"

TR

"After being qualified for a long time you can sometimes bring the barriers down a bit- it's not that you don't care but you have seen so many upsetting things and have dealt with so much stress that it can be a defence mechanism. Attending these groups has developed my awareness of how I come across and what I could do differently"

TR

Hearing the positive and negative accounts provided by the PaCs and how it had made them feel, engaged the TRs and STRs in a process of experiential learning. This phenomenon has implications for higher education institutions regarding how they can incorporate teaching which enhances compassionate practice into their pedagogy.

Recommendations summary

Collectively the recommendations address the:

- Responsibility of higher education institutions and service delivery managers / clinical departments to ensure a robust, values-based recruitment strategy is implemented. Ensuring the 'right TRs' are working in the profession (motivation).
- Unified development and reinforcement of a culture which promotes compassion is embedded and supported at every level (subjective norms).
- Need for service-level managers to consider ways opportunity can be increased through the reduction of pressure and time constraints on TRs (opportunity).
- Necessity for skill development, providing TRs with the resources to engage in compassionate display (perceived behavioural control).

These recommendations aim to equip the profession with TRs that not only hold intent to be compassionate, but they are motivated, have the confidence and opportunity to be compassionate and are doing so in a supported culture which shares the vision for person-centred compassionate care.

Beyond therapeutic radiographers

TRs were the professionals investigated in this research, their display of compassion being directly under the lens. This decision based on the researchers own professional registration and the desire to understand and enhance compassionate care for the benefit of patients.

The conceptual framework establishes that although some practices may be specific to radiotherapy, compassion within cancer healthcare is not defined nor demonstrated by what practices the TR or health professional undertakes. The TR's own underpinning attitude, in alignment with professional and cultural values determines intent, prompting behavioural responses which facilitates compassionate display and how it is perceived. The practices are the end-product, the act which holds intention to meet the patient's needs.

The conceptual framework would therefore translate across healthcare settings as compassionate display will always be influenced by attitudes. Compassion can be achieved and demonstrated through the behavioural classifications in every healthcare professional. The practices will be shaped by an evaluative response appropriate to the context of care.

In addition, the definition and conceptual framework were not developed solely within a radiotherapy context focusing purely on TRs. Those experiences relayed by PaCs, STRs and TRs did not simply focus on TRs. Examples of compassionate and non-compassionate accounts recalled a whole spectrum of health professionals including, nurses, consultants, general practitioners and allied health professionals. Thus, the formulation of the conceptual framework spans across cancer healthcare and beyond radiotherapy.

Alignment to radiography's professional standards

The professional and cultural values presented in the conceptual framework are in direct alignment of those professional standards which guide a TRs clinical practice (Figure 7.2).

The SCoR highlight how TRs should "*respect patient confidentiality at all times*" and *"practise in an anti-discriminatory manner, giving compassionate care that takes account of socio-cultural differences"* (Professional values). Alongside "*promote and* *protect the best interests of your patients at all times, giving due recognition to the views of carers where appropriate*" and "*empower them* (patients) *to make decisions about their care and treatment"* (Cultural values) [29].

Similarly, the Health and Social Care Professions Councils mandate TRs must, "*understand the need to respect and uphold the rights, dignity, values, and autonomy of service users"* (Professional values). As well as to *"adapt practice to meet the needs of different groups and individual's"* and "*understand the need to provide service users or people acting on their behalf with the information necessary to enable them to make informed decisions"* (Cultural values) [30].

The findings provide TRs professional and regulatory bodies with the evidence base that depicts the importance of the values contained within their professional standards and the impact they have on patients within clinical practice. The findings also reinforce the necessity of those values within a TRs professional role.

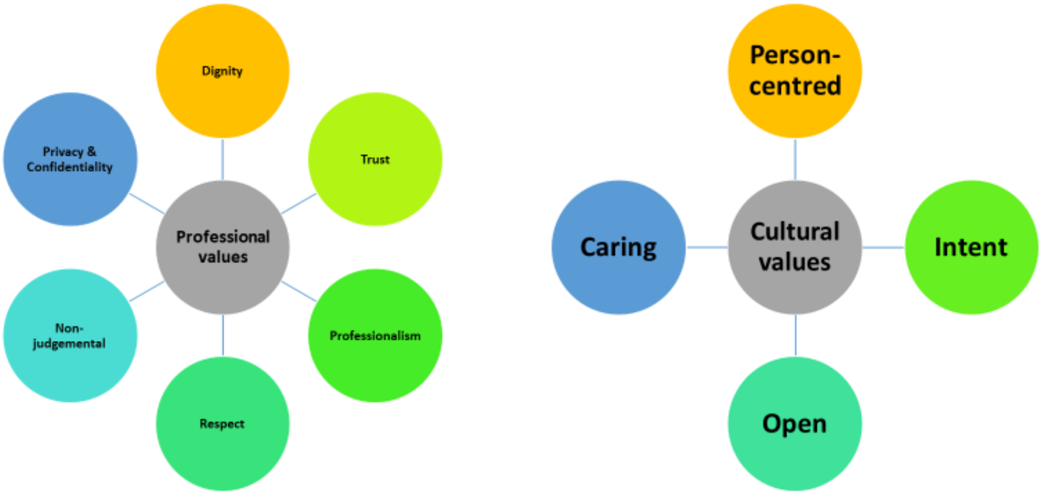


Figure 7.2: Professional and cultural vales

The behaviours established within the findings; embodied connection, characteristic expression and indicative communication provide the ways these values can be displayed by a TR to patients within clinical practice (Figure 7.3). The values and behaviours established within the findings could be used in conjunction with the values-based practice training models advocated by the SCoR [336].

Figure 7.3: Compassionate behaviours; embodied connection, characteristic expression and indicative communication.

Throughout the findings, all participant groups perceived compassion to be part of a TRs professional role and responsibility. This indicates the work done by the professional bodies and the pedagogy used by higher education institutions is effective in instilling the importance of compassionate within STRs and TRs beliefs. The failures at present appear to be attributed to STRs and TR having a limited understanding of how those behaviours can be used within clinical practice to develop a connection and communicate their person-centred compassionate intent. Improving awareness of the values synonymous compassion amongst professionals may help stimulate learning.

Dissemination of findings

The research has produced a definition of compassion and a conceptual framework, aiding understanding of its application into clinical practice. Dissemination of the research is essential to ensure the key messages are shared so NHS Trusts, clinical departments and higher education institutions can implement the key recommendations. Utilising the three platforms, dissemination for awareness, dissemination for understanding and dissemination for action will create a comprehensive plan, targeting a wide audience [337].

'Dissemination for Awareness' will be at a local level at the host higher education institution and NHS Trust. As established, the topic is important to the wider healthcare professionals, with the values connected to compassion being inherent for all higher education institution medical and health and social care courses. Discussions with faculty leads and presentation at the faculty led learning teaching and assessment annual conference would be a valuable forum.

'Dissemination for understanding' and 'for action' will include presentation at radiotherapy specific conferences including, SCoR’s annual radiotherapy conference, European Society for Radiation Oncology (ESTRO), American Society for Radiation Oncology (ASTRO). In March 2019, the work on co-production was presented at the Australian Society for Medical Imaging and Radiation Therapy Conference (ASMIRT). The presentation was received very well with delegates being keen to hear the findings specific to compassion. Based on the thesis and the findings, a publication plan has been devised. The topics of compassion, healthcare professionals and co-production create an audience wider than radiotherapy. Therefore, in addition to publication in Radiography journal, articles will be submitted to Nurse Education Today and other professions journals and this will provide an opportune platform for each facet of the study.

There is also the opportunity to work with the UK Parliament's Knowledge Exchange Unit. This will provide a platform to engage with parliamentary groups and policy makers, to make recommendations based on the findings of this thesis for the inclusion of the co-constructed definition and conceptual framework in future healthcare policy.

Co-production as a methodology and research method is novel and in its infancy. There is a pertinent opportunity to share and educate others regarding its value in research, particularly where the topic / concept under investigated is experienced from a variety of demographical perspectives. Publication in a qualitative methods journal will contribute to the knowledge base and facilitate others to utilise this method in their own studies. The benefits of co-production for the participants will also publicised. The experiential learning experienced by the TRs and STRs will be of interest to those working within an academic arena. The sense of personal enhancement and empowerment experienced by the PaCs will be of relevance to patient and public organisations, for example INVOLVE and the Scottish Co-production Network. Similarly, at a local level these benefits will be shared within the local trust and any affiliated support services to support the implementation of ‘service user groups’ for the engagement of patients and carers into services and research design and delivery.

Further work

As established in chapter one, the original ambition of the research was to address any ‘effect’ the utilisation of the partners in learning group had on the compassionate skills of STRs. Although the research focus changed and became more refined, the motivation behind the research has not changed. Overwhelmingly, the desire has been to improve the compassionate care received by patients undergoing radiotherapy. By providing an understanding of what compassion is and how it is displayed, provides the foundation to begin to address how compassion can be enhanced and embedded in pre and post-registration TRs. The translation of these findings in to academic and clinical practice is essential to ensure PaCs are receiving compassionate care.

Social learning theory would be a key topic for further research due to the influence of positive and negative feedback on enhancing motivation to engage in compassionate display. A further area of research would be to explore the use of role models in behavioural development.

The immediate future will see the establishment of collaborative working partnerships with the two local higher education institutions who are responsible for the training of a wide range of health professionals, including allied health, nursing and medicine. The ambition is to develop resources to promote and enhance compassion in pre and post registration professionals.

Final reflexive piece

Despite the traditional challenges faced during the undertaking of my PhD, the process has not only been enjoyable but there are so many positives that I can take from it. I have been able to work with some great people. The principal investigators have become key people within my network. We call upon each other to offer help and advice when needed, becoming friends over the years. Within our profession, it is important to have a strong network, to work together to help and support each other.

Personal and research skills

Undertaking eleven focus groups and the first two co-production workshops had built upon my foundation of knowledge and skills, giving me an opportunity to develop my skillset further. Site C's co-production workshop certainly tested these skills. I had to exert control over the dominant TR whilst promoting the STRs to speak in a situation where they felt their opinions were restricted. This needed a careful balance, so discussion was not stifled or overly controlled by me, leaving the participants feeling like their opinions were not welcomed or valid. In addition, although dominant, their opinion was still valid as it was their opinion, so I needed to ensure this message was also portrayed to them. All this was occurring whilst the standard tasks required for the effective facilitation were being undertaken. This included the provision of instructions for participants, note taking to record the discussion and all while keeping a friendly, approachable but neutral stance.

This thesis is not the end of my research career, so the enhanced and new skills acquired will be invaluable in my future projects. It has been clear throughout that the skills I was developing and acquiring would be ones that I could use to enhance the quality and qualitative validity of future research. What I had not anticipated was the number of skills that I would be able to apply to my work and personal life. For example, undertaking the research has changed the way I engage in meetings with other professionals, especially those in 'higher' positions than myself. It has shown me the importance of sitting back, listening, and then having the confidence to take my time and formulate a response. I am naturally quite a shy person, sometimes I find being in meetings is daunting and am quite happy to let others take the lead. Engagement with people in the focus groups, co-production workshops, and during the registration and development of the research, (the list could go on) has given me the confidence to take my time, engage in or lead the conversation. Similarly, disseminating my work through presentation has enhanced my presentation skills and given me the confidence in my expertise, to take my time and communicate my message clearly.

In addition to the experience and skills gained by undertaking the research, I was able to complete several qualitative MSc methods courses which helped during this thesis and will be a skill set that I can apply throughout my professional research career.

Using co-production

The co-production workshops took a lot of organising but although hard work, they were thoroughly enjoyable. There was a real buzz throughout (except as indicated at site C) and it was just so great to see people working together to achieve a common goal. There was something quite special about it all and I was honoured that I was part of it.

Why compassion is important

Working with the patients and carers has been incredible. It goes without saying that everyone's contribution has been invaluable and valued, but there is something about working with this group that is really inspiring. Of course, they talked about their negative experiences, but they were never moaning. They had tackled whatever they had faced in life, and many were continuing to face due to the impact their cancer diagnosis (or that of their loved one) had brought. Their insights showed how important it is not only to be compassionate but how important our role as TRs is during their treatment.

Their insights clearly demonstrated that patients need compassion. There were some experiences that were difficult to hear, at times during the focus group I wanted to apologise to the participants for the care they had received. I was upset to think that a health professional, or one of my radiographer colleagues or maybe even a friend had failed to be compassionate to these people.

At one point, one of the participants recalled an example that I had been present at during my clinical years. As soon as she said it, I remembered it so well and could even recall the consultant who had been involved in the incident she was referring to. I had not recognised the patient, nor had she indicated that she recognised me or that she remembered that it was me who was treating her at that time. It made me reflect on my own actions, should I have challenged the consultant for his behaviour, could I have done anything differently to help this patient and have stopped the situation from happening. The data analysis was very difficult to undertake and at times I would sit with tears in my eyes listening to the negative examples experienced by these patients and carers. The positive accounts could also be just as emotive. Why compassion is important I feel is evident because of this, more than ten years had passed, and she still remembered the event and the negative way it had made her feel. Likewise, those patients and carers who recalled compassionate experiences had remembered how positive it had made them feel. If it had not been a significant experience in their lives or not held any consequence, then potentially they may not have remembered the details. But they had and this to me showed the impact both compassionate and non-compassionate practice can have on patients. These are the lasting memories of their treatment and care that patients take away with them.

My personal learning

Alongside all the other changes which have arisen through the undertaking of my PhD (skillsets, confidence, knowledge and abilities etc.), the findings have really made me reflect on my own behaviour, my body language in particular and how this can be interpreted by others around me. The research has made me more understanding and more appreciative of the individuality of others. Not just in respect of being compassionate, but across life in general. I always considered myself to be a caring and compassionate person, but it has made me reflect that it is not what I think about how I should be displaying compassion, it is the person who I am directing compassion towards whose opinion is important.

Although I no longer work clinically, my role within research means I still interact with patients and carers and a whole spectrum of health care professionals. I have worked to try and apply my enhanced level of understanding to my interactions with everyone I meet and engage with.

It has also made me reflect upon my own values and beliefs, making me realise how I have naturally aligned myself at work and at home with people who I share those values with. Undertaking the research has made me realise who I am and what I stand for.

Original contribution to knowledge

Co-produced findings

As established, previous research investigating compassion in radiotherapy has failed to consider the perspectives of multiple groups. In respect to defining and understanding compassion in general healthcare, although some consideration has been given to multiple perspectives, the insights of patients on compassion has been identified as a significant gap in knowledge [45]. The methods employed by those investigating multiple perspectives have also relied upon the traditional role of the researcher as the singular constructor of findings.

Within this thesis the definition of compassion and the conceptual framework were co-constructed between the researcher and over seventy participants. Importantly this means the findings benefited from a wealth of socially constructed understanding of the concept. The inclusion of the perspectives of those delivering and in receipt of compassion, has provided multi-dimensional insights into the concept.

This not only affords strength and originality to the research but will aid interpretation and implementation of the findings into working practices, as co-construction has provided 'real life' meaning to the concept.

Co-produced definition

With respect to the definition specifically, this provides clarity to the concept within radiotherapy whilst distinguishing it from other similar concepts. The previous inclusion of concepts like sympathy, empathy and pity were felt to make the existing definitions ambiguous and limit their translation into practice. This will make the definition 'user friendly' as it is devoid of jargon and vague terms.

Co-produced conceptual framework

The conceptual framework provides further clarity to the concept of compassion. By providing an understanding of how compassionate behaviours are instigated and demonstrated, the conceptual framework establishes the structure of the component parts essential for compassionate display. Each component part provides a summary of the key attitudes (values), behaviours and practices. The diagrammatic models can be used within academic delivery to aid understanding of the component parts of compassion and their role within compassionate display.

Some empirical frameworks on compassion have been produced but have not been co-constructed from the perspectives of multiple demographical groups [45,338]. Subsequently these fail to capture the complexity and issues of perception and the ability of a TR to display genuine intent to be compassionate. These two components are vital to its delivery and interpretation by the patient as compassionate. Thus, the inclusion of intent and perception in the conceptual framework is essential for it to be translated into clinical practice.

Co-production methodology

As reported, the methodology and method of co-production was the main strength of the research rigour. The thesis has detailed the philosophical underpinnings of co-construction in alignment with qualitative inquiry and social constructivism which has not been detailed prior. Furthermore, it has created a process model that provides a structure for researchers wishing to employ the methodology and the method in future studies.

In summary, this thesis makes several original contributions to knowledge:

1. The findings provide a context specific co-constructed definition of compassion. Although the definition is generalisable, at present there are no other published definitions of compassion specific to radiotherapy. Nor is there any definition of compassion within healthcare that has been co-constructed.

2. The findings provide a conceptual framework for understanding compassionate display. At present there is no framework which identifies the component parts or

identifies the importance of the attitude-behaviour relationship within compassionate display.

3. The thesis provides a process model for the use of co-construction in research and has demonstrated the alignment of co-production with the key principles of qualitative enquiry and social constructivism.

Conclusions

The findings have demonstrated how professional and cultural values both underpin an attitude that is congruent with compassion. It is these values that are fundamental for establishing intent, an innate desire within the TR to be a compassionate professional. Intention is integral to the ability to display compassion, enabling the patient to perceive person-centred behavioural interactions as a genuine display of compassion.

Engagement in the three behavioural classifications required for compassion, embodied connection, characteristic expression and indicative communication are essential for TRs to connect with and establish an awareness of the patient. Compassion then becomes an evaluative response to the patient's current needs and an attempt to meet them.

"that's not being compassionate because you're not reading them as a person, you're just automatically going into that mode, because that's what you consider to be compassionate"

STR Year 2

"I'm well aware that because everybody's uniquely different they have a different perspective of what their own kind of what they consider to be compassion and of course, that influences what they interpret compassion to be at the moment in time"

TR Site B1

Developing a shared vision for compassion will help to ensure compassion is promoted and practiced as standard by the collective and becomes the foundation of radiotherapy practice.

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Appendices

Appendix 1:

Concept analysis: Twitter Review 19th June - 3rd July 2016

A Twitter search was conducted utilising the #compassion to capture current discussion around the topic.
This provided a broader meaning to the term outside the published healthcare context as the twitter hashtag collates accounts and posts from a wide range of individuals, newspapers, charities and organisations.

Searching using the #Compassion identified 108 accounts, of these 25 were included within the concept analysis. 15 tweets were also included in the review. The review was conducted over an 11-day period, with twitter being accessed on different days and different times of those days to capture the array of pertinent issues within the news and popular culture which may have dominated social media at that point in time.

Searching on Twitter using #Compassion also amassed tweets and accounts which used the hashtag #compass. All but one of these were excluded from the analysis as their focus was on geographical location, orienteering, marketing and recruitment. Patchwork Compass's account biography however described its purpose as to *"weave global experiences & inspirational resources to help travellers navigate life's journeys"* which indicated a more personal supportive compass rather than a geographical one as it aimed to prepare its followers for what lay ahead in life.

Table one is an example of the Excel document used to record the author, content of the tweet or profile, hashtags used and a summary of key points.

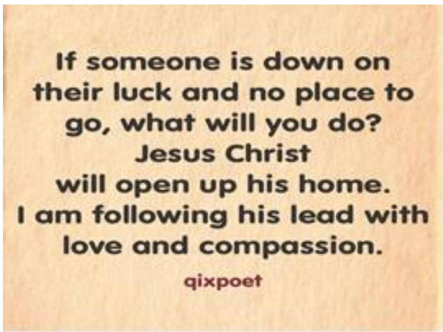
Theme	Author	Content/Description of account	Hashtags	Key points
Animal Welfare	Individual	Vegan, because nothing tastes better than compassion	#Compassion	- Meat free diet - Not killing animals for consumption
Religion	Individual	 If someone is down on their luck and no place to go, what will you do? Jesus Christ will open up his home. I am following his lead with love and compassion. qixpoet	#Jesus #god #heaven #love #compassion	- Teachings of the bible. - Promotion of behaviours

Table 1: Extract from Excel Twitter review.

By reviewing the content of the tweets and the profile statements of the accounts a number of reoccurring topics and themes were identified. The author placed each of these within one of six categorises; animal welfare, religion, spirituality, humanitarian, self-care and healthcare. Not all could be taken in isolation with a number post tweets cross-cutting over a number of themes, this was especially apparent with spirituality, self-care and humanitarian. Once the content of the tweets and the accounts generated no new themes, the author concluded saturation had been reached.

The six concepts can be summarised as:

Animal Welfare

These users and tweets followed the theme of saving or protecting the animal from over farming, inhumane conditions and nature of their slaughter. Each of which identified animals are subject to some form of suffering or inequality and called for an intervention in order to reduce it, most frequently suggesting opting for a vegetarian or vegan diet.

Healthcare

Healthcare could be divided into two main threads, supportive care (towards others) and end of life care. Supportive care offered services for those diagnosed with a medical condition whereas end of life care called for improved services, options and the right of choice for those facing death. Both however aimed to promote best practice through providing patients with information, support and autonomy within their area of healthcare.

Religion

Tweets and accounts in this category often promoted the activities of faiths and religious groups, advertised meetings and events. The content would often highlight the teachings of the bible, how Jesus would respond to those in need, promoting moral actions and behaviours and advocating how others should follow to improve the lives of others.

Humanitarian

The focus of these was to promote equality across society on local, national and international levels. Often these tweets were designed to raise awareness of injustices across the world or to urge people to unite to help areas which had faced natural disasters, poverty or suffered from the effects of war. On a more basic level they intended to promote good will to all by allowing us to understand the variance of our daily lives and the acceptance we should have of others and ourselves for being different. Resultantly the meaning of compassion within this theme had two strands, firstly as a means to accept and appreciate fellow humans for all our differences. Secondly as way to act upon the sufferings and misfortune of others and aid their transition out of the period of suffering.

Spirituality

As with humanitarianism, spiritually tweets and profiles frequently discussed good will and peace across the human world. These tweets however warranted the classification of spirituality as they discussed qualities of being concerned with the human spirit or soul, speaking of inner-peace and the healing powers of the universe. These tweets frequently discussed compassion as meditation and inner qualities in order to enhance one’s own life.

Self-care

This was closely linked to spirituality by the promotion of the inner-dimension. These however encouraged the follower to take action in their own lives, promote a strong mind and character wanting them to have the ability to believe in themselves and protect themselves from the psychological hazards of the world rather than a focus on the inner spirit or soul. Compassion therefore had an external focus rather than an internal.

Limitations

It must be considered that the review only spans an 11-day period and therefore only represents tweets at that point in time and therefore may not represent a broad range of ideas around the concept. The saturation of themes however denotes that tweets discussing other topics popular within the media or climate would have still fallen into one of the six classifications.

An additional limitation is that not everyone will engage with this form of social media, therefore possibly alienating topics which may be discussed by different social or geographical groups.

Summary of points

- Six classifications
- Promotion of actions or behaviours to improve or enhance the life of oneself or of another (human or animal).
- Equality for all.
- Self-care

Appendix 2:

Host higher education institution research approval

Sheffield Hallam University | Centre for Health and Social Care Research

20 July 2016

Amy Taylor
Sheffield Hallam University
Centre for Health and Social Care Research

Research proposal number: 2015-16/HWB/HSC/36

Dear Amy

This letter relates to your research proposal:

Exploring compassion and compassionate behaviours in cancer care: A mixed methods study

This proposal was submitted to the Faculty Research Ethics Committee with a standard SHUREC1 form. This indicates that your project does not require formal ethics and scientific review. As such, it has been added to the register of projects and given a reference number. You do not need any further review from the Ethics Committee. You will need to ensure you have all other necessary permission in place before proceeding, for example, from the Research Governance office of any sites outside the University where your research will take place. This letter can be used as evidence that the proposal has been registered within Sheffield Hallam University.

The documents reviewed were:

March2016 Binder1

Good luck with your project.

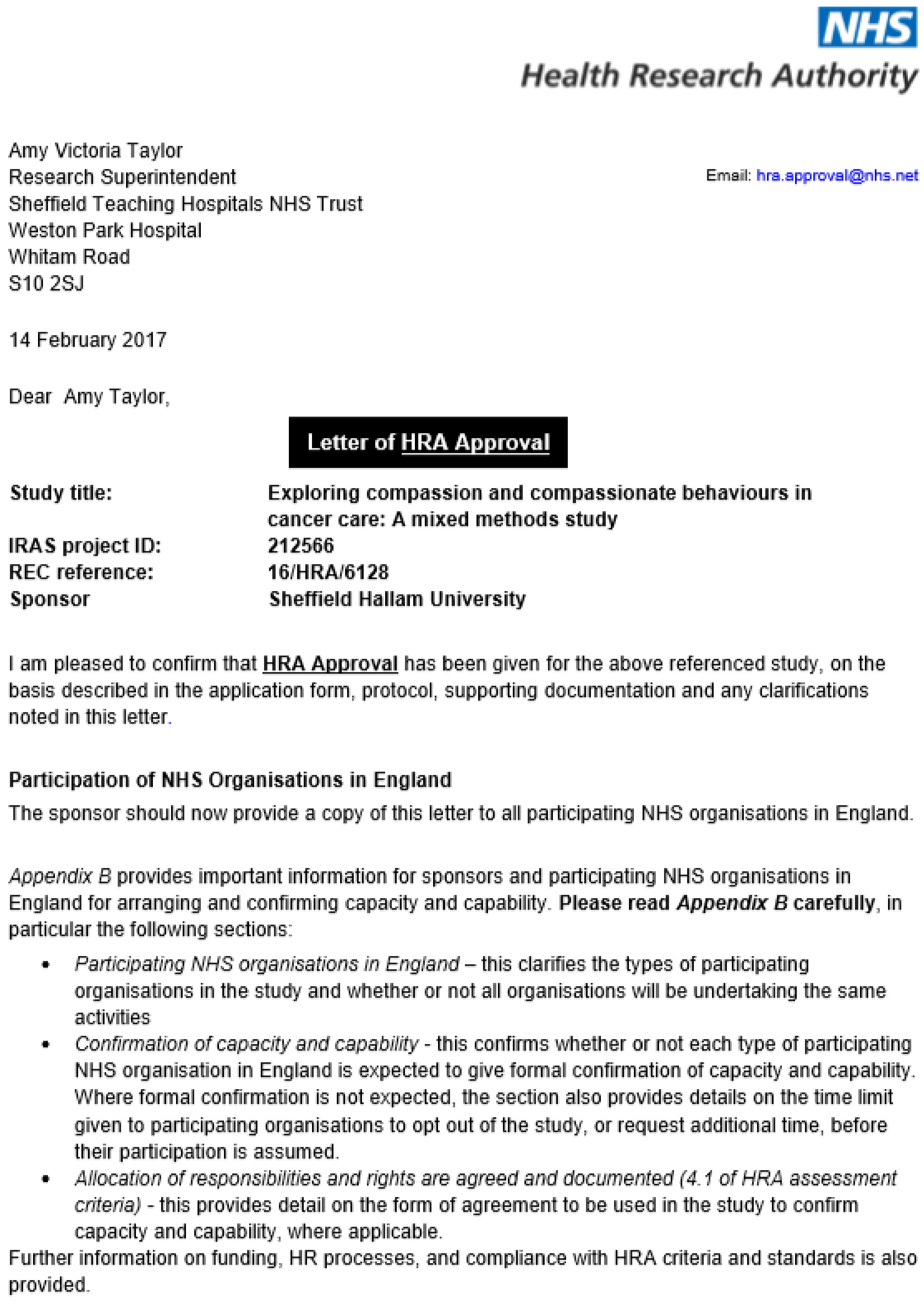
Yours sincerely

Peter Allmark

Peter Allmark
Chair Faculty Research Ethics Committee
Faculty of Health and Wellbeing
Sheffield Hallam University
32 Collegiate Crescent
Sheffield
S10 2BP
0114 224 5727
p.allmark@shu.ac.uk

Appendix 3:

Health Research Authority approval



NHS
Health Research Authority

Amy Victoria Taylor
Research Superintendent
Sheffield Teaching Hospitals NHS Trust
Weston Park Hospital
Whitam Road
S10 2SJ

Email: hra.approval@nhs.net

14 February 2017

Dear Amy Taylor,

Letter of HRA Approval

Study title:	**Exploring compassion and compassionate behaviours in cancer care: A mixed methods study**
IRAS project ID:	**212566**
REC reference:	**16/HRA/6128**
Sponsor	**Sheffield Hallam University**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

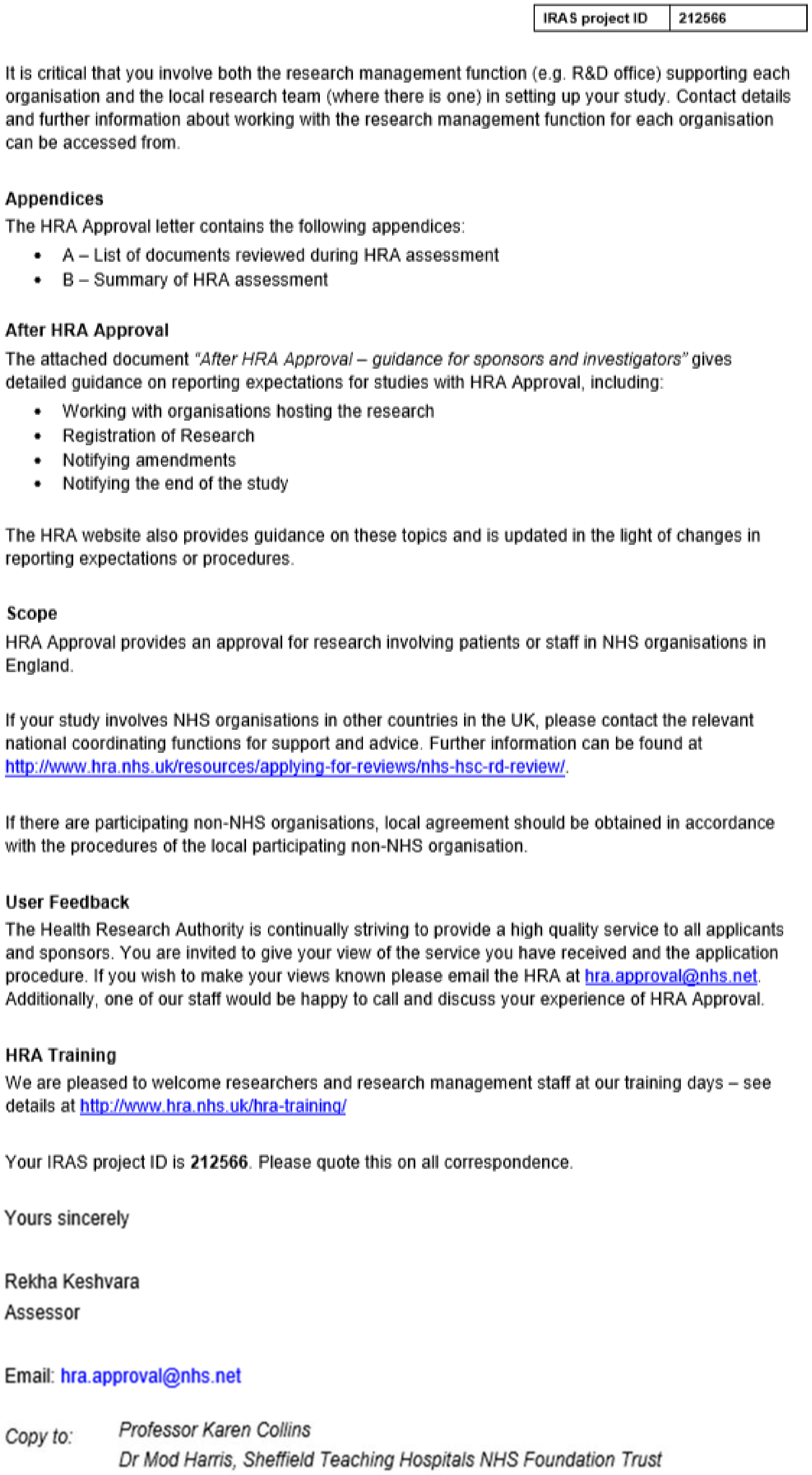
Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.



IRAS project ID	212566

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please email the HRA at hra.approval@nhs.net. Additionally, one of our staff would be happy to call and discuss your experience of HRA Approval.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **212566**. Please quote this on all correspondence.

Yours sincerely

Rekha Keshvara
Assessor

Email: hra.approval@nhs.net

Copy to: *Professor Karen Collins*
Dr Mod Harris, Sheffield Teaching Hospitals NHS Foundation Trust

Appendix 4:

Trust research and development/innovation approvals

Site A:

[redacted]

Dear Ms Taylor,

Re: Exploring compassion and compassionate behaviours in cancer care: A mixed methods study

Thank you for presenting this study to the Cancer Clinical Trials Executive on 13th February 2017. Reproduced below are the relevant extracts from the meeting:

"Amy Taylor presented this study, which aims: 1. To generate a shared healthcare definition of compassion within the context of radiotherapy, 2. Identify how compassion is conceptualised and displayed within a radiotherapy healthcare context, 3. Develop a theoretical model of compassion to optimise understanding and aid teaching and development in healthcare pedagogy.

Staff should be more compassionate, and higher education should be teaching students about compassionate behaviours. However there is not currently an adequate, co-created definition of compassion within healthcare. The few definitions that currently exist are focused on pity, empathy, and sympathy without any detail on compassionate behaviour. Patients don't agree with this existing definition as they feel it is patronising.

The trial will include semi-structured focus groups of three subgroups: pre-registration student therapy radiographers, therapy radiographers, and patients/carers/family members. Based on these findings, the trial will use a bespoke questionnaire (designed by PI, CI, and selected focus group participants) to survey a wider proportion of the population of cancer patients, families and carers, therapy radiographers and student therapy radiographers. The aim is to identify if the answers generated by the Focus groups are generalizable to the wider population aiding the validation of findings from the Focus groups. Approximately 600 questionnaires will be distributed.

Patient and carer recruitment will be through non-NHS support and information centres affiliated with the three NHS radiotherapy departments. No support or resource from CCTC is required.

Sarah Danson provided supportive peer review.

Travel expenses will be paid for patients and carers. Staff and students will be surveyed in work/clinical training time.

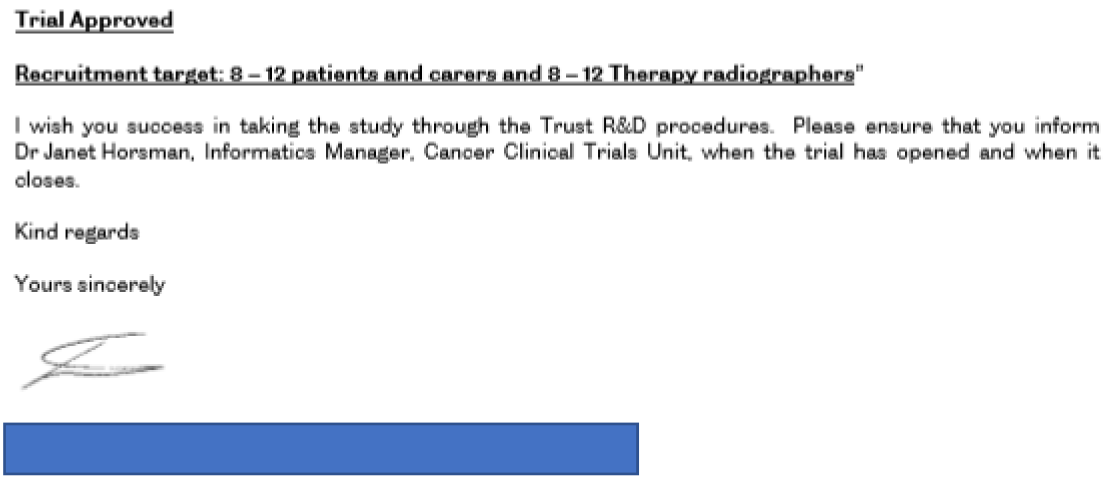
Amy Taylor to find out if the trial is eligible for NIHR adoption.

Amy Taylor explained that the groups are being interviewed separately so that their answers can be compared and differences identified, e.g. how students view compassion at the being of their training may change once they are working in practice.

NHS
National Institute for Health Research
Clinical Research Network
Yorkshire and Humber

Page 1 (PTO)

THE 1ST STUDENT EXPERIENCE SURVEY 2014-15



Trial Approved

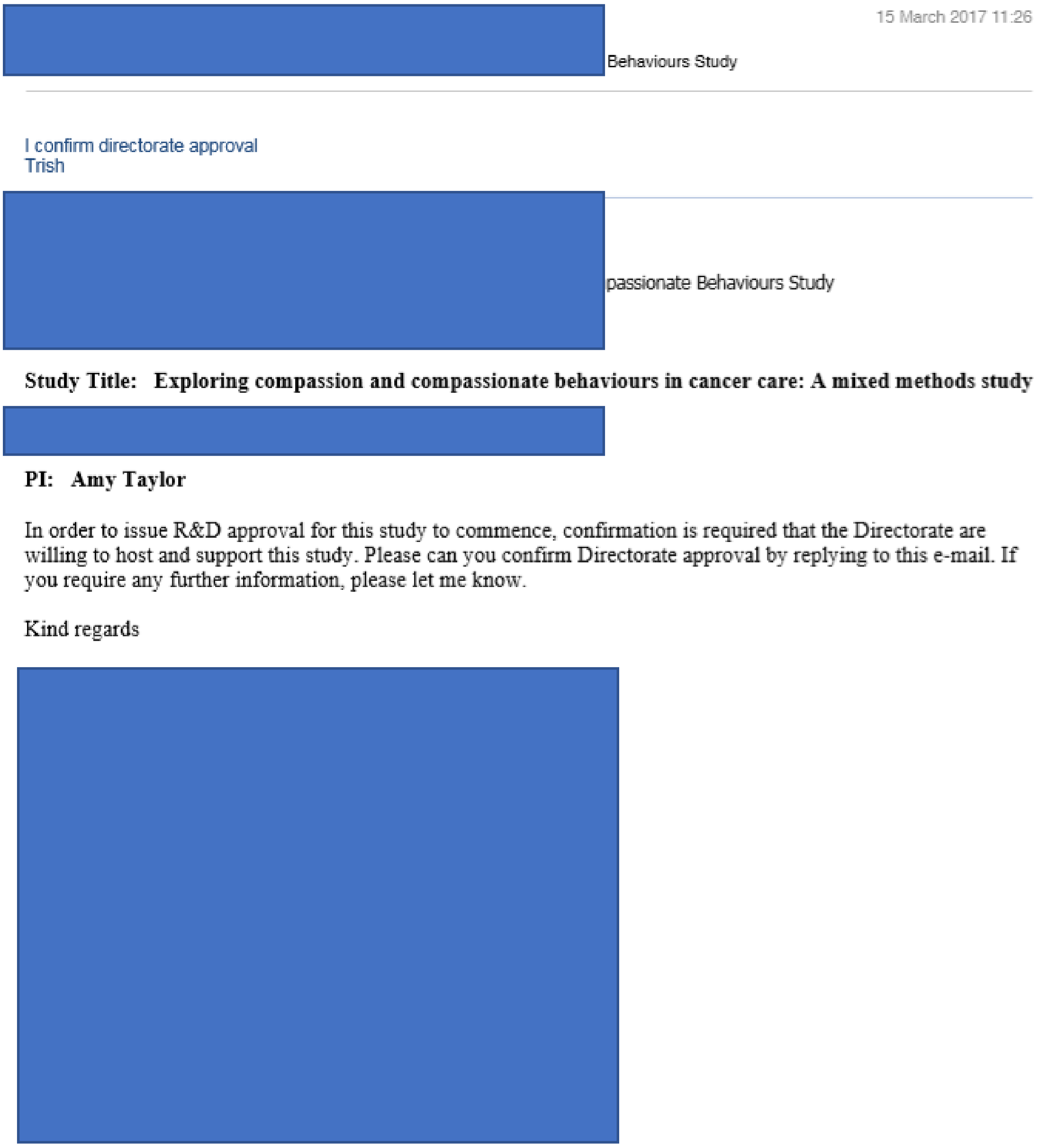
Recruitment target: 8 – 12 patients and carers and 8 – 12 Therapy radiographers"

I wish you success in taking the study through the Trust R&D procedures. Please ensure that you inform Dr Janet Horsman, Informatics Manager, Cancer Clinical Trials Unit, when the trial has opened and when it closes.

Kind regards

Yours sincerely

[redacted]



[redacted] Behaviours Study

15 March 2017 11:26

I confirm directorate approval
Trish

[redacted] passionate Behaviours Study

Study Title: Exploring compassion and compassionate behaviours in cancer care: A mixed methods study

[redacted]

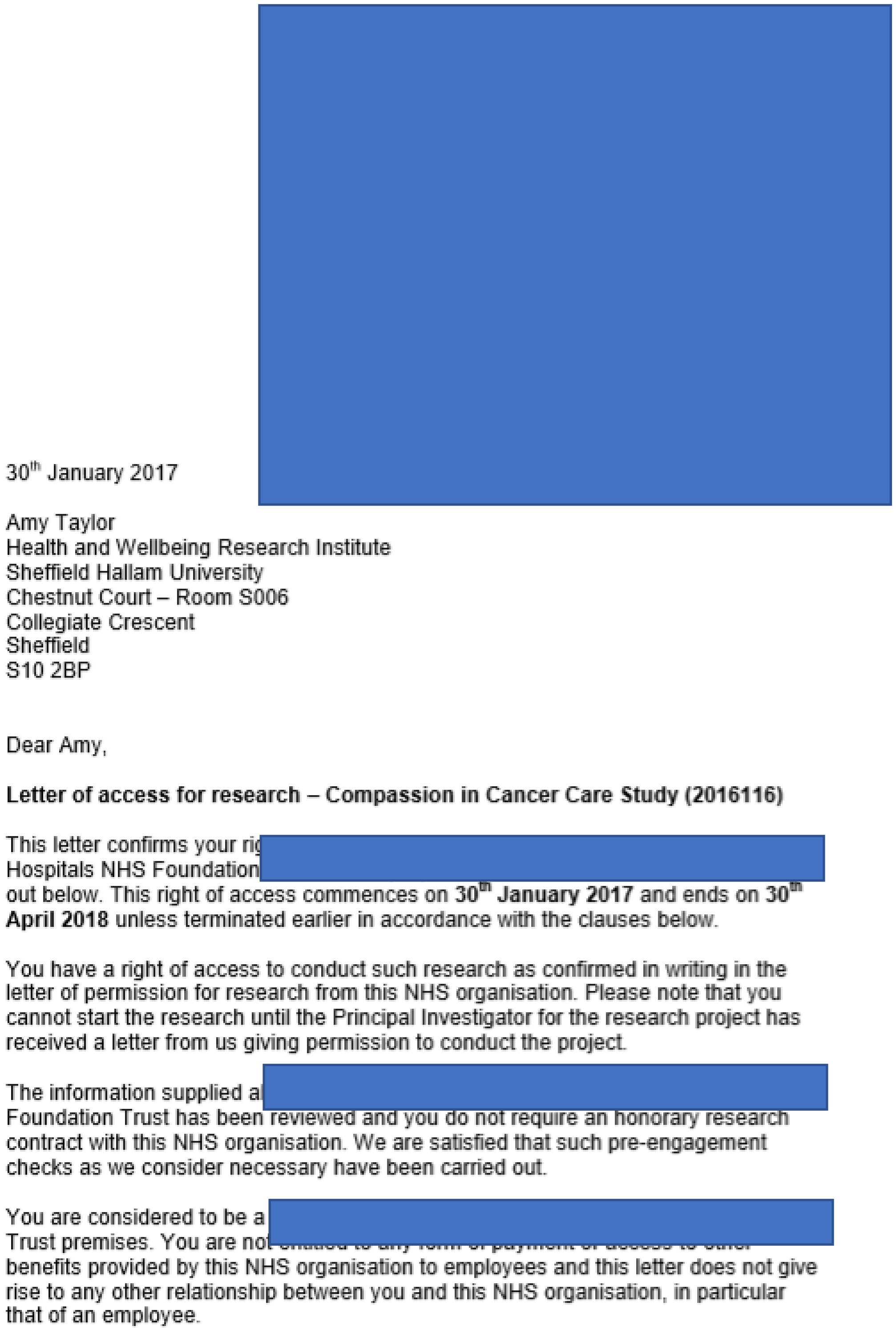
PI: Amy Taylor

In order to issue R&D approval for this study to commence, confirmation is required that the Directorate are willing to host and support this study. Please can you confirm Directorate approval by replying to this e-mail. If you require any further information, please let me know.

Kind regards

[redacted]

Site B



[redacted]

30th January 2017

Amy Taylor
Health and Wellbeing Research Institute
Sheffield Hallam University
Chestnut Court – Room S006
Collegiate Crescent
Sheffield
S10 2BP

Dear Amy,

Letter of access for research – Compassion in Cancer Care Study (2016116)

This letter confirms your ri[redacted] Hospitals NHS Foundation out below. This right of access commences on **30th January 2017** and ends on **30th April 2018** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

The information supplied a[redacted] Foundation Trust has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You are considered to be a[redacted] Trust premises. You are not benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research [redacted]
you will remain accountable
are required to follow the re
organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accorda [redacted]
policies and procedures, which are available to you upon request, and the Research Governance Framework.

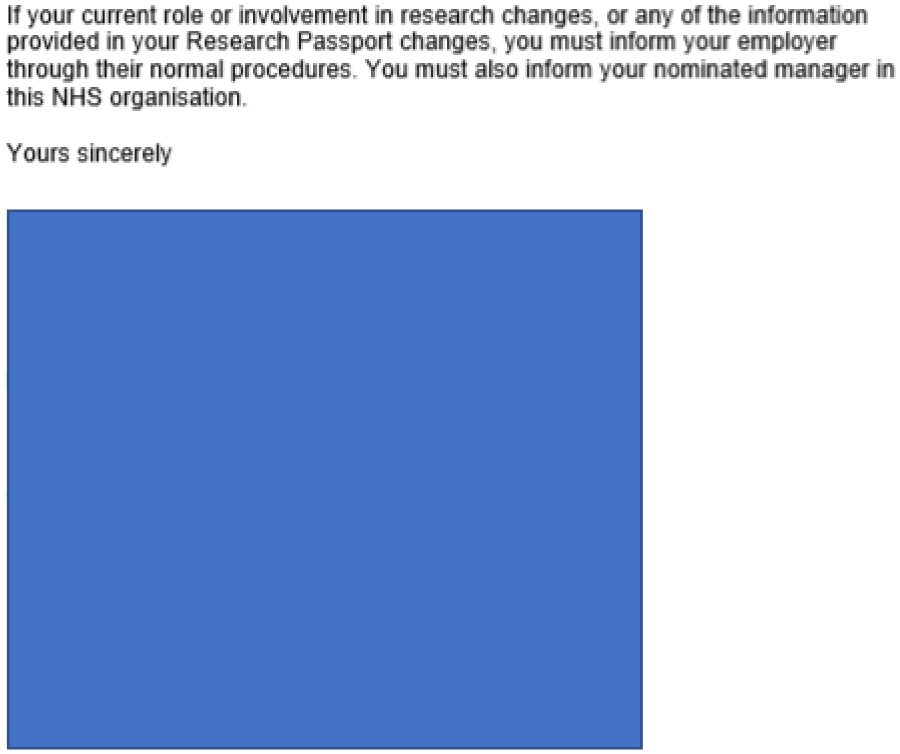
You are required to co-oper [redacted]
discharging its duties under
health and safety legislation
yourself and others while o
You must observe the same
staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

[redacted] nify you against any
or breach of the Data
Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

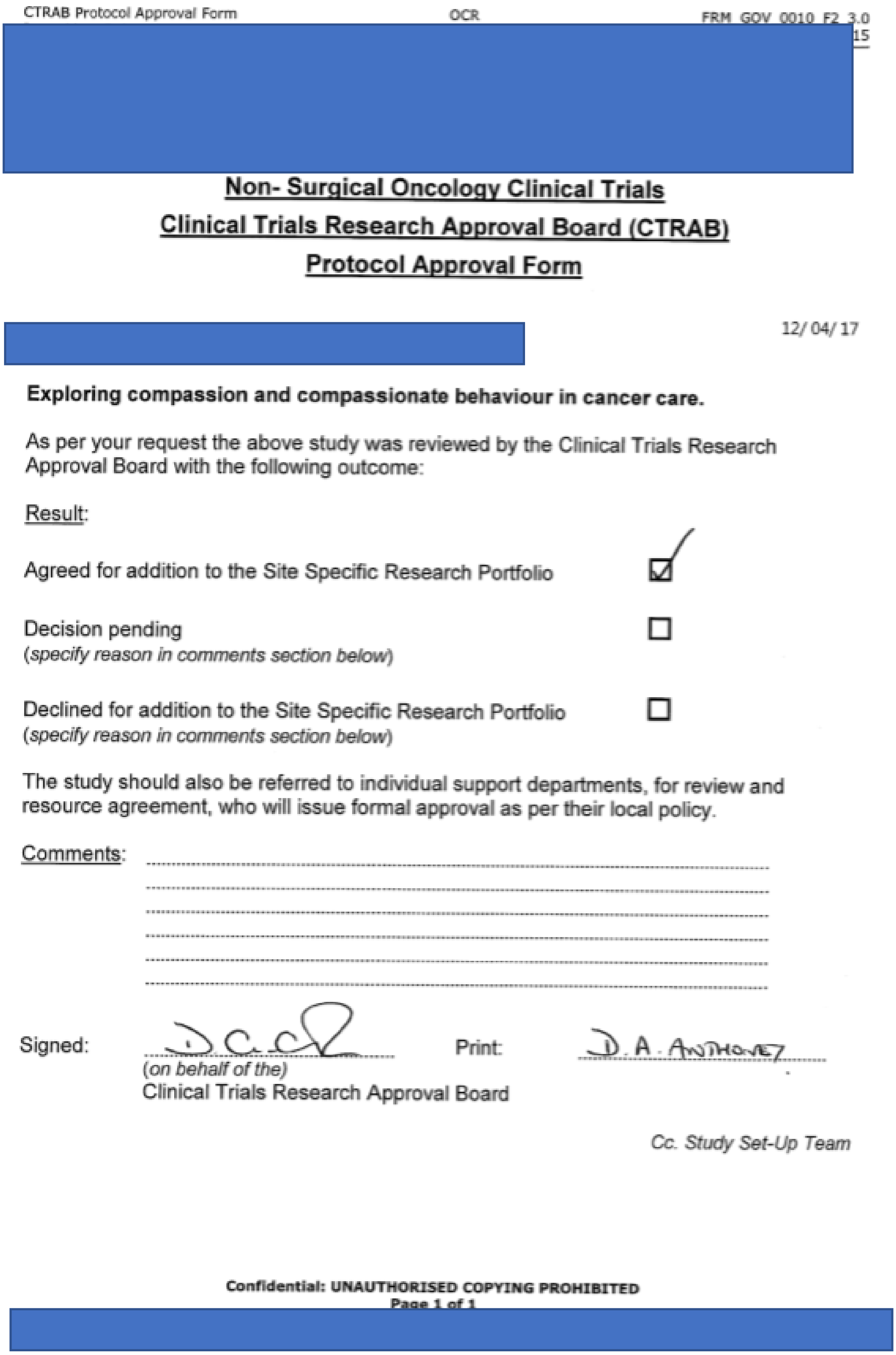


If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

[redacted]

Site C



CTRAB Protocol Approval Form OCR FRM_GOV_0010_F2_3.0

[redacted]

Non- Surgical Oncology Clinical Trials
Clinical Trials Research Approval Board (CTRAB)
Protocol Approval Form

[redacted]

12/ 04/ 17

Exploring compassion and compassionate behaviour in cancer care.

As per your request the above study was reviewed by the Clinical Trials Research Approval Board with the following outcome:

Result:

Agreed for addition to the Site Specific Research Portfolio ☑

Decision pending ☐
(*specify reason in comments section below*)

Declined for addition to the Site Specific Research Portfolio ☐
(*specify reason in comments section below*)

The study should also be referred to individual support departments, for review and resource agreement, who will issue formal approval as per their local policy.

Comments: ....

Signed: .... Print: D. A. ANTHONEZ
(*on behalf of the*)
Clinical Trials Research Approval Board

Cc. Study Set-Up Team

Confidential: UNAUTHORISED COPYING PROHIBITED

[redacted]

Appendix 5:

Pilot Focus Group Feedback

I acted as moderator for the focus group that Amy conducted with service users to explore the concept of compassion.

As moderator it was my role to take notes and observe the group dynamics, these are some of my observations:

1. Amy welcomed participants and explained the purpose was to understand their perspectives on the topic
2. She asked that they talk one at a time and respect confidentiality
3. She emphasised that there were no wrong answers and wanted people to freely express their views
4. She had prepared 2 trigger statements to share with the group that promoted discussion this was particularly effective as participants discussed and debated different view points
5. Amy actually said very little apart from asking individuals to expand or clarify what they were saying
6. The different trigger statements provided a good structure and Amy kept to time
7. She encouraged participants who had said little to share their views and this came over as very supportive and ensured all opinions were heard
8. Amy works with service users and has good communications with them and I was struck how as focus group facilitator she adopted a more ‘distant’ communication that was respectful of each participant’s viewpoint. She never expressed a viewpoint but acknowledge each persons contribution.
9. I thought the participants in this group were interested in the topic and showed a lot of respect for each other, which perhaps may not be the case with a different group. Amy will need to prepare for situations where some participants dominate or have difficulty voicing their views.

Appendix 6:

Pilot focus group participant information sheet

Participant information sheet: pilot focus group

Study title:	Exploring compassion and compassionate behaviours in cancer care: A mixed methods study
Investigator	Amy Taylor
Telephone number	

Participants name:

I would like to invite you to take part in a focus group which I will be undertaking at the higher academic institution where you are involved in the partners in learning group.

Before you decide I would like you to understand why the focus group is being done, what it would involve for you and provide you with an opportunity to ask if anything is not clear.

1. What is the purpose of this study?

The aim of the focus group is to find out what your understanding of compassion is and how you think it is displayed within healthcare.

The research is interested in your opinion; there are no right or wrong answers which you can give during the focus group.

2. Why have I been invited?

You have been invited to participate as you:

- Have previously been diagnosed with cancer and/or are a family member or carer for someone who has been diagnosed with cancer.
- Are currently involved in the academic delivery as part of the partners in learning group.

3. Do I have to take part?

Your decision to take part in this study is entirely voluntary. Whether you take part or not will not affect your current or future involvement with the higher education institution.

You may refuse to participate or you can withdraw from the study at any time.

4. What will happen to me if I take part?

If you agree to participate you will be asked to complete a consent form and attend on a date given by the researcher. The group will consist of you and other members of the partners in learning group.

The discussion will be audio recorded but all information will be made anonymous and can only be accessed by the researcher.

5. Expenses and payments

There will be no payment for your attendance, refreshments and biscuits will be provided during the focus group.

6. What will I have to do?

If you agree to take part in the study you will be asked to do the following things:

- Provide consent
- Attend on the date given to you.
- Discuss with the group questions asked by the researcher

7. What are the possible disadvantages and risks of taking part?

There are no identified risks associated with this study.

8. What are the possible benefits of taking part?

The main benefit to participation is the opportunity to develop and improve the future care received by patients undergoing radiotherapy, as the results of this research hope to aid the teaching of compassion in radiotherapy education.

9. Will my taking part in this study be kept confidential?

The discussion will be audio recorded but all information will be made anonymous and can only be accessed by the researcher.

Notes may be taken during the session but all notes will be anonymous and any identifying details will be taken out of any final report and any publication so people reading these will not be able to identify you.
The written notes will have all links to you removed at the end of the study and will be kept for 5 years after the study has ended.

The documents relating to the administration of this research, such as the consent form you sign to take part, will be kept in a folder called a site file or project file. This is locked away securely. These documents will be destroyed five years after the end of the study.

10. What will happen to the results of the focus group?

The anonymised results will be written up as part of the researcher PhD. You will not be identifiable in any published report.

You will be provided with a summary report of the study to demonstrate what the focus groups have found.

11. What if there is a problem or I want to complain?

If you have any queries or questions please contact:

Amy Taylor

amy.taylor@shu.ac.uk

Sheffield Hallam University, Faculty of Health and Wellbeing

Alternatively, you can contact my supervisor: Karen Collins **Email k.colins@shu.ac.uk**

If you would rather contact an independent person, you can contact Peter Allmark: email p.allmark@shu.ac.uk Telephone number 0114 225 5727. He is a member of the relevant University ethics committee.

Appendix 7:

Participant consent form: Pilot focus group

Participant consent form: Pilot focus group

Study title:	Exploring compassion and compassionate behaviours in cancer care: A mixed methods study
Investigator	Amy Taylor
Telephone number	

Participant name	

	Please read the following statements and put your initials in the box to show that you have read and understood them and that you agree with them	**Please initial each box**
1	I confirm that I have read and understood the information sheet dated 15.07.2016 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2	I understand that my involvement in this study is voluntary and that I am free to withdraw at any time, without giving any reason and without my status as a student or legal rights being affected.	☐
3	I agree to take part in this study	☐

To be filled in by the participant

I agree to take part in the above study

Your name	Date	Signature

To be filled in by the person obtaining consent

I confirm that I have explained the nature, purposes and possible effects of this research study to the person whose name is printed above.

Name of investigator	Date	Signature

Version 1: July 2016

Appendix 8:

Pilot focus group guide

Facilitator:

Invigilator:

Number in attendance:

(8 mins) Introduction and housekeeping:

- Thank you:
- Purpose: PhD development, test method, feedback
- Format: audio recorded, - voluntary, 2 sections- overview.
- Rules: Respect each other; try not to talk over etc. No right or wrong answers.

(30 mins) Section 1: What does compassion mean to the participants?

- Provide participants with definition 1:

"Sympathetic pity and concern for the sufferings or misfortunes of others"

This would imply that compassion is a feeling or an emotion, is this what compassion means to you?

- Provide participants with definition 2:

"Deep awareness of the suffering of another accompanied by the wish to relieve it"

This definition indicates a desire to do something about the suffering; do you think that compassion is an action?

(20 mins) Section 2: Experiences of being in a Focus group

Possible trigger questions:

- How have you felt being involved in this focus group?
- Is this a topic they felt comfortable talking about in front of others?
- Are there any reasons why you would not wish to be involved?

Is there anything else you would like to add?

(2 mins) Thank you and close of focus group.

Appendix 9:

Focus group attendee demographic information

Patients & Carers

Participant Name:
……………………………………………………………………………………………

Participant ID:
……………………………………………………………………………………………

Centre of recruitment:
……………………………………………………………………………………………

Gender:
……………………………………………………………………………………………

Age (Years):
……………………………………………………………………………………………

Ethnicity:
……………………………………………………………………………………………

Attending as a:

(Please circle)

Patient diagnosed with cancer Carer Family member Friend

Additional information you would like to add about yourself:

(Optional)

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……………………………………………………………………………………………
……………………………………………………………………………………………
……………………

Therapeutic Radiographers

Participant Name:
……………………………………………………………………………………………

Participant ID:
……………………………………………………………………………………………

Centre of recruitment:
……………………………………………………………………………………………

How long have you been qualified (Approx.)?
……………………………………………………………………………………………

AFC grade:
……………………………………………………………………………………………

Do you have a specialist role?

(Please circle) Yes No

If yes, please give your title:/details
……………………………………………………………………………………………
……………………………………………………………………………………………

Gender:
……………………………………………………………………………………………

Age (Years):
……………………………………………………………………………………………

Ethnicity:
……………………………………………………………………………………………

Additional information you would like to add about yourself:

(Optional)

……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………

Student Therapeutic Radiographers

Participant Name: ………………………………………………………………………………………

Participant ID: ………………………………………………………………………………………

Year of study: ………………………………………………………………………………………

Programme of study:

(Please circle)

BSc Radiotherapy & Oncology PgD Radiotherapy & Oncology

Gender: ………………………………………………………………………………………

Age (Years): ………………………………………………………………………………………

Ethnicity: ………………………………………………………………………………………

Additional information you would like to add about yourself:

(Optional)

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Appendix 10:

Student Therapeutic Radiographers participant information sheet.

Participant information sheet: Focus group

Study title:	Exploring compassion and compassionate behaviours in cancer care: A mixed methods study
Investigator	Amy Taylor
Telephone number	

Participants name:

I would like to invite you to take part in a focus group which I will be undertaking at your place of study.

Before you decide I would like you to understand why the focus group is being done, what it would involve for you and provide you with an opportunity to ask if anything is not clear.

1. What is the purpose of this study?

The aim of the focus group is to find out what your understanding of compassion is and how you think it is displayed within healthcare.

The research is interested in your opinion; there are no right or wrong answers which you can give during the focus group.

2. Why have I been invited?

You have been invited to participate as you are a student Therapeutic Radiographer studying at Sheffield Hallam University

3. Do I have to take part?

Your decision to take part in this study is entirely voluntary.

You may refuse to participate or you can withdraw from the study at any time.

Your refusal to participate or wish to withdraw would not influence in any way your current or future studies or grades on this or any module/course at Sheffield Hallam University.

4. What will happen to me if I take part?

If you agree to participate you will be asked to complete a consent form and attend on a date given by the researcher. The group will consist of you and other student therapy radiographers.

The discussion will be audio recorded but all information will be made anonymous and can only be accessed by the researcher.

5. Expenses and payments

The focus group will occur during your standard academic calendar and therefore you will not incur any additional expenses.

6. What will I have to do?

If you agree to take part in the study you will be asked to do the following things:

- Provide consent
- Attend on the date given to you.
- Discuss with the group questions asked by the researcher

7. What are the possible disadvantages and risks of taking part?

There are no identified risks associated with this study.

8. What are the possible benefits of taking part?

The main benefit to participation is the opportunity to develop and improve the future care received by patients undergoing radiotherapy as the results of this research hope to aid the teaching of compassion in radiotherapy education.

9. Will my taking part in this study be kept confidential?

The discussion will be audio recorded but all information will be made anonymous and can only be accessed by the researcher.

Notes may be taken during the session but all notes will be anonymous and any identifying details will be taken out of any final report and any publication so people reading these will not be able to identify you.
The written notes will have all links to you removed at the end of the study and will be kept for 5 years after the study has ended.

The documents relating to the administration of this research, such as the consent form you sign to take part, will be kept in a folder called a site file or project file. This is locked away securely. These documents will be destroyed five years after the end of the study.

10. What will happen to the results of the focus group?

The anonymised results will be written up as part of the researcher PhD. You will not be identifiable in any published report

11. What if there is a problem or I want to complain?

If you have any queries or questions, please contact:

Amy Taylor

amy.taylor@shu.ac.uk

Sheffield Hallam University, Faculty of Health and Wellbeing

Alternatively, you can contact my supervisor: Karen Collins **Email k.colins@shu.ac.uk**

If you would rather contact an independent person, you can contact Peter Allmark: email p.allmark@shu.ac.uk Telephone number 0114 225 5727. He is a member of the relevant University ethics committee.

Appendix 11:

Focus groups consent form

Sheffield Hallam University

Participant consent form: Focus Group

Study title:	Exploring compassion and compassionate behaviours in cancer care: A mixed methods study
Investigator	Amy Taylor
Telephone number	

Participant name	

	Please read the following statements and put your initials in the box to show that you have read and understood them and that you agree with them	**Please initial each box**
1	I confirm that I have read and understood the information sheet dated ……. for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2	I understand that my involvement in this study is voluntary and that I am free to withdraw at any time, without giving any reason and without my status or legal rights being affected.	
3	I agree to take part in this study	

To be filled in by the participant

I agree to take part in the above study

Your name	Date	Signature

To be filled in by the person obtaining consent

I confirm that I have explained the nature, purposes and possible effects of this research study to the person whose name is printed above.

Name of investigator	Date	Signature

Version 4: 12.05.2017 IRAS ID 212566

Appendix 12:

Therapeutic Radiographer participant information sheet

Participant information sheet: Focus group

Study title:	Exploring compassion and compassionate behaviours in cancer care: A mixed methods study
Investigator	Amy Taylor
Telephone number	

Participants name:

I would like to invite you to take part in a focus group which I will be undertaking at your place of employment.

Before you decide I would like you to understand why the focus group is being done, what it would involve for you and provide you with an opportunity to ask if anything is not clear.

1. What is the purpose of this study?

The aim of the focus group is to find out what your understanding of compassion is and how you think it is displayed within healthcare.

The research is interested in your opinion; there are no right or wrong answers which you can give during the focus group.

2. Why have I been invited?

You have been invited to participate as you are a registered Therapeutic Radiographer.

3. Do I have to take part?

Your decision to take part in this study is entirely voluntary.

You may refuse to participate or you can withdraw from the study at any time.

Your refusal to participate or wish to withdraw would not influence in any way your current or future employment or any future involvement with Sheffield Hallam University.

4. What will happen to me if I take part?

If you agree to participate you will be asked to complete a consent form and attend on a date given by the researcher. The group will consist of you and other therapy radiographers.

The discussion will be audio recorded but all information will be made anonymous and can only be accessed by the researcher.

5. Expenses and payments

No expenses will be provided but the focus group will occur at your place of work during the working day so minimal disruption will occur.

6. What will I have to do?

If you agree to take part in the study you will be asked to do the following things:

- Provide consent
- Attend on the date given to you.
- Discuss with the group questions asked by the researcher

7. What are the possible disadvantages and risks of taking part?

There are no identified risks associated with this study.

8. What are the possible benefits of taking part?

The main benefit to participation is the opportunity to develop and improve the future care received by patients undergoing radiotherapy as the results of this research hope to aid the teaching of compassion in radiotherapy education.

9. Will my taking part in this study be kept confidential?

The discussion will be audio recorded but all information will be made anonymous and can only be accessed by the researcher.

Notes may be taken during the session but all notes will be anonymous and any identifying details will be taken out of any final report and any publication so people reading these will not be able to identify you.
The written notes will have all links to you removed at the end of the study and will be kept for 5 years after the study has ended.

The documents relating to the administration of this research, such as the consent form you sign to take part, will be kept in a folder called a site file or project file. This is locked away securely. These documents will be destroyed five years after the end of the study.

10. What will happen to the results of the focus group?

The anonymised results will be written up as part of the researcher PhD. You will not be identifiable in any published report

11. What if there is a problem or I want to complain?

If you have any queries or questions please contact:

Amy Taylor

amy.taylor@shu.ac.uk

Sheffield Hallam University, Faculty of Health and Wellbeing

Alternatively, you can contact my supervisor:

Karen Collins **Email k.colins@shu.ac.uk**

If you would rather contact an independent person, you can contact Peter Allmark: email p.allmark@shu.ac.uk Telephone number 0114 225 5727. He is a member of the relevant University ethics committee.

Appendix 13:

Patients and carers recruitment poster

Sheffield Hallam University

Call for volunteers

Hi I'm Amy Taylor, I'm currently doing some research with Sheffield Hallam University looking at what compassion means in cancer healthcare.

I am interested in hearing your thoughts on compassion and I am looking for volunteers to be part of a focus group held here at ……….

If you are interested please speak to one of the staff here at the ………….. who can give you an information pack.

The information pack is designed to help you decide whether you would like to take part, by taking the information does not mean that you have to be involved, you can change your mind at any time.

Appendix 14:

Patients and carers participant information sheet

Sheffield Hallam University

Participant information sheet: Focus group

Study title:	Exploring compassion and compassionate behaviours in cancer care: A mixed methods study
Investigator	Amy Taylor
Telephone number	

Participants name:

I would like to invite you to take part in a focus group which I will be undertaking at your local cancer support centre.

Before you decide I would like you to understand why the focus group is being done, what it would involve for you and provide you with an opportunity to ask if anything is not clear.

1. What is the purpose of this study?

The aim of the focus group is to find out what your understanding of compassion is and how you think it is displayed within healthcare.

The research is interested in your opinion; there are no right or wrong answers which you can give during the focus group.

2. Why have I been invited?

You have been invited to participate as you have previously been diagnosed with cancer and/or are a family member or carer for someone who has been diagnosed with cancer.

3. Do I have to take part?

Your decision to take part in this study is entirely voluntary.

You may refuse to participate or you can withdraw from the study at any time.

4. What will happen to me if I take part?

If you agree to participate you will be asked to complete a consent form and attend on a date given by the researcher. The group will consist of you and other patients, carers and family members.

The discussion will be audio recorded but all information will be made anonymous and can only be accessed by the researcher.

5. Expenses and payments

There will be no payment for your attendance but travel expenses will be provided.

Refreshments and biscuits will be provided during the focus group.

6. What will I have to do?

If you agree to take part in the study you will be asked to do the following things:

- Provide consent
- Attend on the date given to you.
- Discuss with the group questions asked by the researcher

7. What are the possible disadvantages and risks of taking part?

There are no identified risks associated with this study.

8. What are the possible benefits of taking part?

The main benefit to participation is the opportunity to develop and improve the future care received by patients undergoing radiotherapy, as the results of this research hope to aid the teaching of compassion in radiotherapy education.

9. Will my taking part in this study be kept confidential?

The discussion will be audio recorded but all information will be made anonymous and can only be accessed by the researcher.

Notes may be taken during the session but all notes will be anonymous and any identifying details will be taken out of any final report and any publication so people reading these will not be able to identify you.
The written notes will have all links to you removed at the end of the study and will be kept for 5 years after the study has ended.

The documents relating to the administration of this research, such as the consent form you sign to take part, will be kept in a folder called a site file or project file. This is locked away securely. These documents will be destroyed five years after the end of the study.

10. What will happen to the results of the focus group?

The anonymised results will be written up as part of the researcher PhD. You will not be identifiable in any published report.

You will be provided with a summary report of the study to demonstrate what the focus groups have found.

11. What if there is a problem or I want to complain?

If you have any queries or questions, please contact:

Amy Taylor

amy.taylor@shu.ac.uk

Sheffield Hallam University, Faculty of Health and Wellbeing

Alternatively, you can contact my supervisor: Karen Collins **Email k.colins@shu.ac.uk**

If you would rather contact an independent person, you can contact Peter Allmark: email p.allmark@shu.ac.uk Telephone number 0114 225 5727. He is a member of the relevant University ethics committee.

Appendix 15:

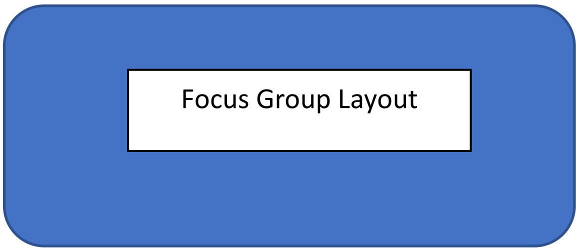
Focus Group Guide

Participants/site:

Date:

Moderator:

Participants: n=



Part 1: Introduction, Housekeeping & Ground rules (5 Mins)

- Welcome
- Explanation: purpose, my role, moderator's role, audio recording, anonymous
- Right to withdraw, no influence on course
- Rule: No right or wrong, no talking, respect and privacy
- Format: 1 sections:
  - 1) General discussion
  - 2) Statement and discussion.

START RECORDING.

Part 2: Section 1 - General discussion (20-25 minutes)

Question for the group - What do you think compassion is?

Possible prompts:

- Where have you heard the word used?
- Why do you think it is used in this environment?
- What do you think when you hear the word compassion?

Part 3: Section 2 – Review of themes from the literature (20 mins)

Show the participants the non-compassionate case of *"Fred"*

Ask the participants - Having read this:

- What are your thoughts about that scenario?

Possible prompts:

Inform participants that - Based on the literature compassion is believed to be displayed in healthcare through 3 ways:

1) Non-verbal
2) Verbal
3) Professional behaviours

Ask participants to think about the 3 ways compassion is displayed

- how do these relate to the scenario?
- What could/should the TR have done instead
- how could compassionate have been displayed?

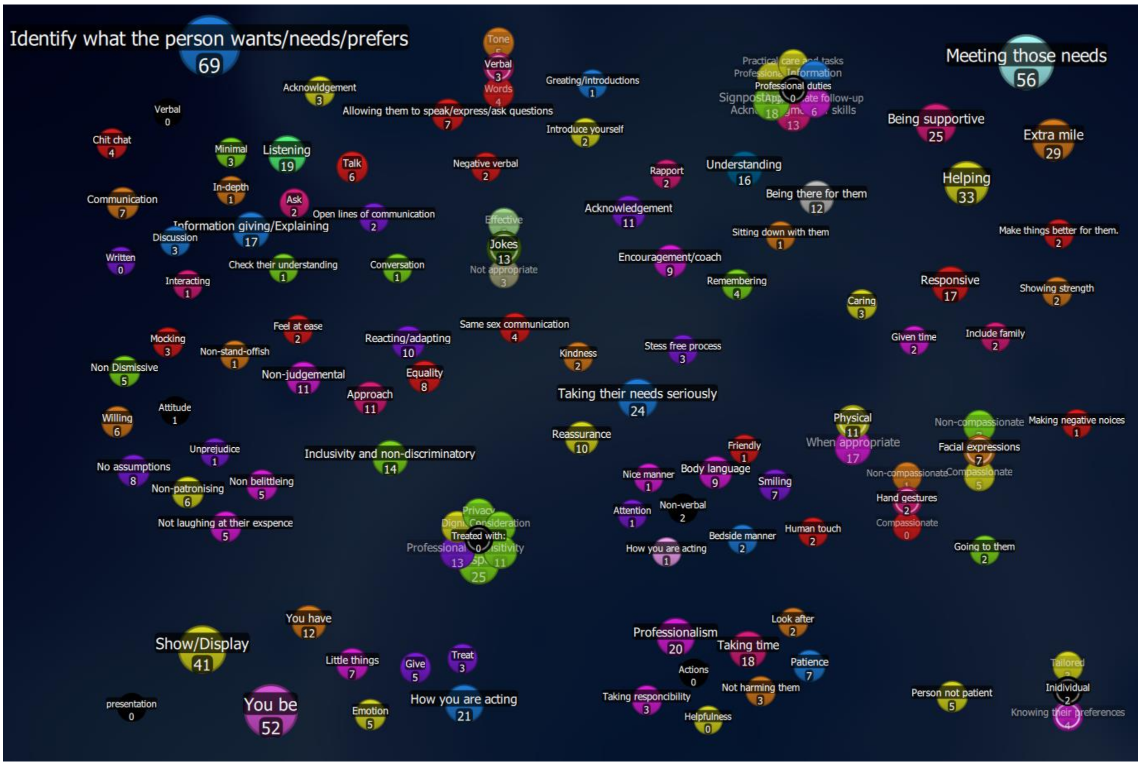
**Is there anything else you would like to add? **

Part 4 Close of the focus group

- Thank you
- Member checking/co-production workshop involvement
- Questions.

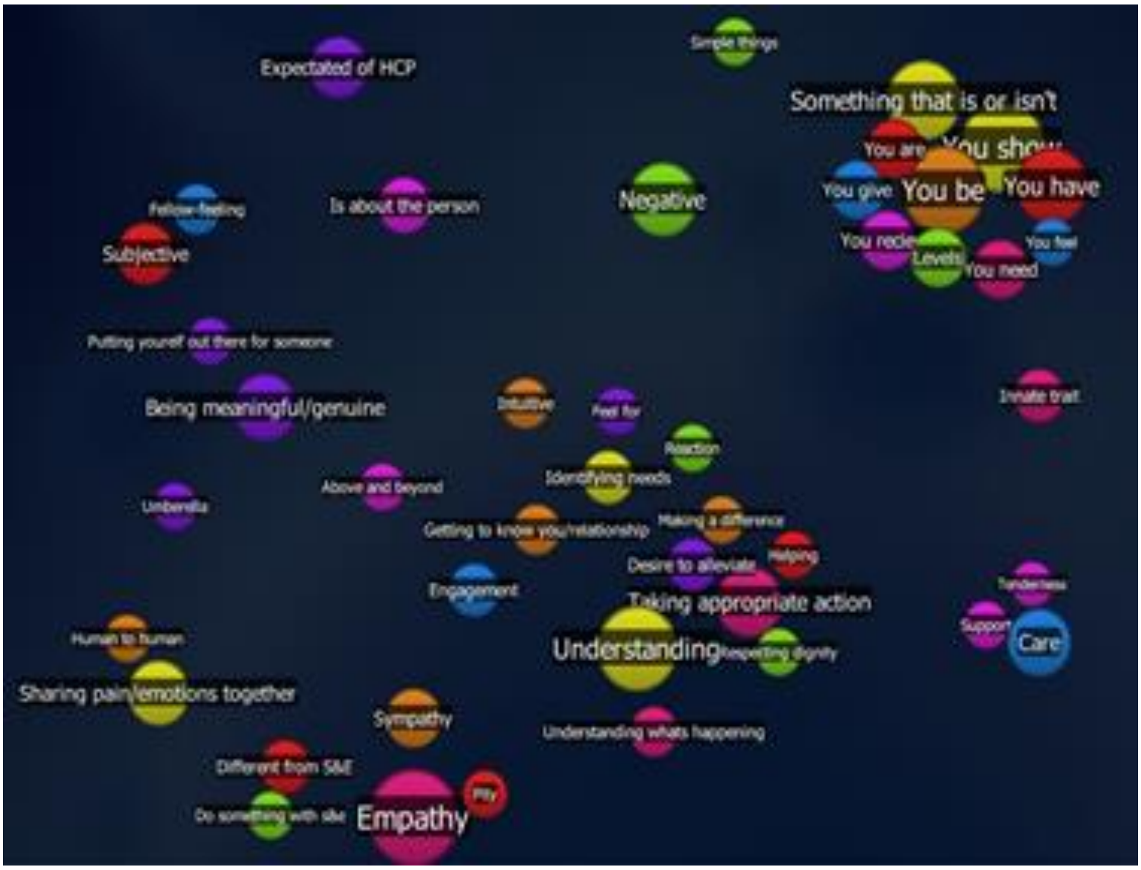
Appendix 16:

Research question one data codes (Stage 1 coding)



Therapeutic Radiographers

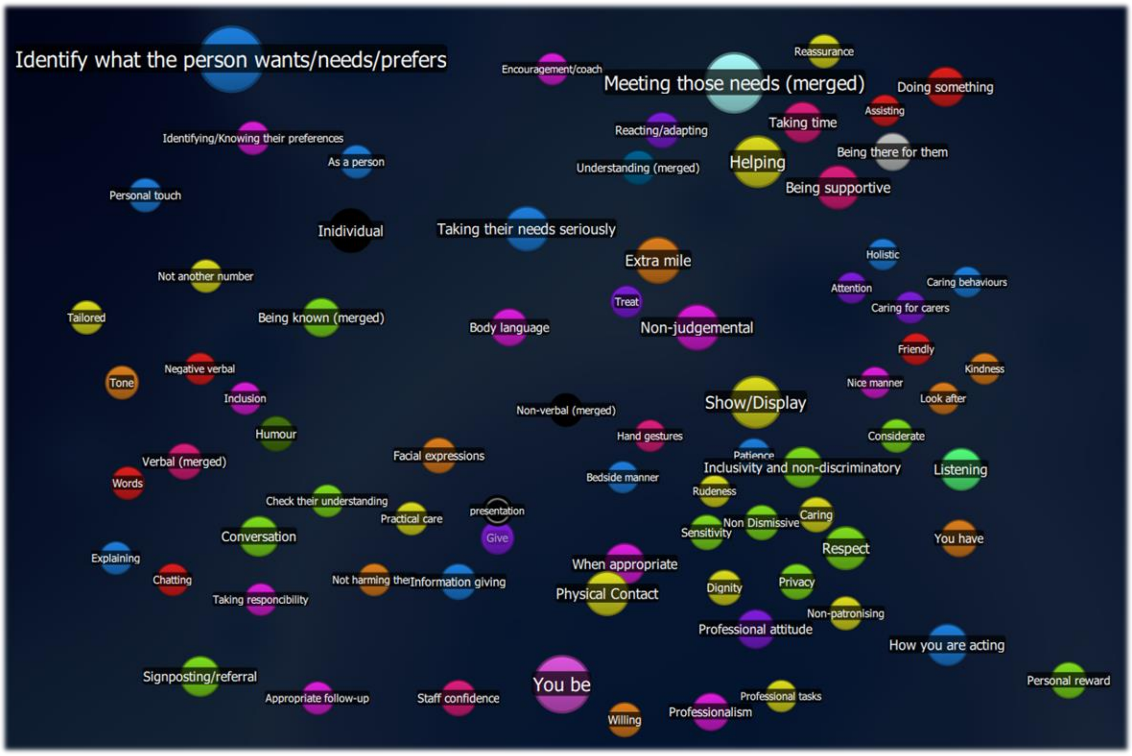
Student Therapeutic Radiographers



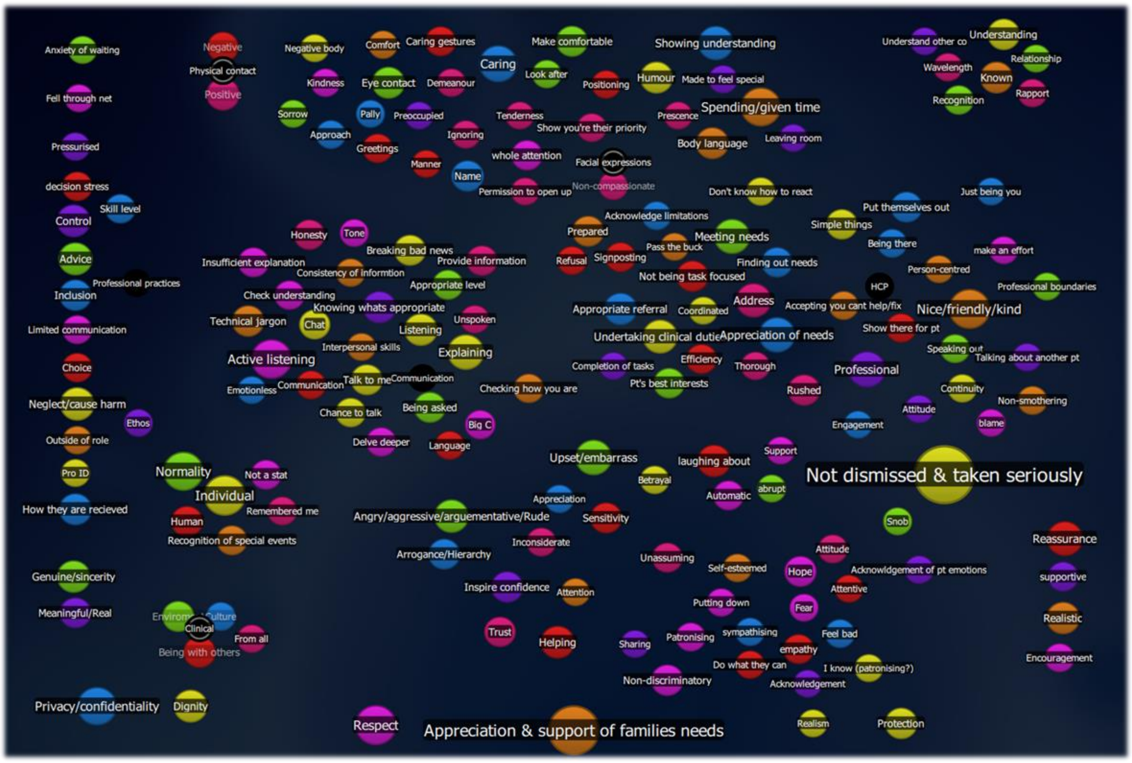
Patients and carers

Appendix 17

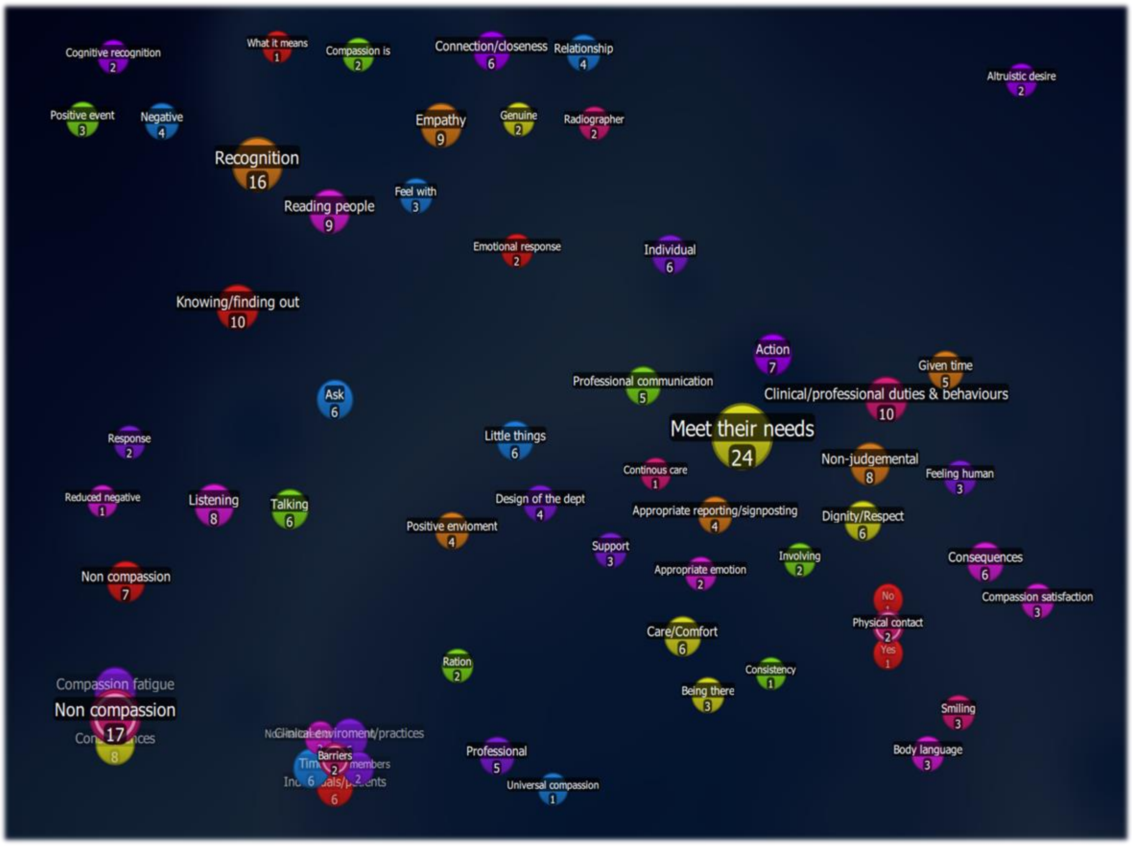
Research question two data codes – (Stage 1 coding).



Therapeutic Radiographers



Student Therapeutic Radiographers



Patients and carers

Appendix 18

Research question one thematic maps - (Part 2 theme development)

Therapeutic Radiographers

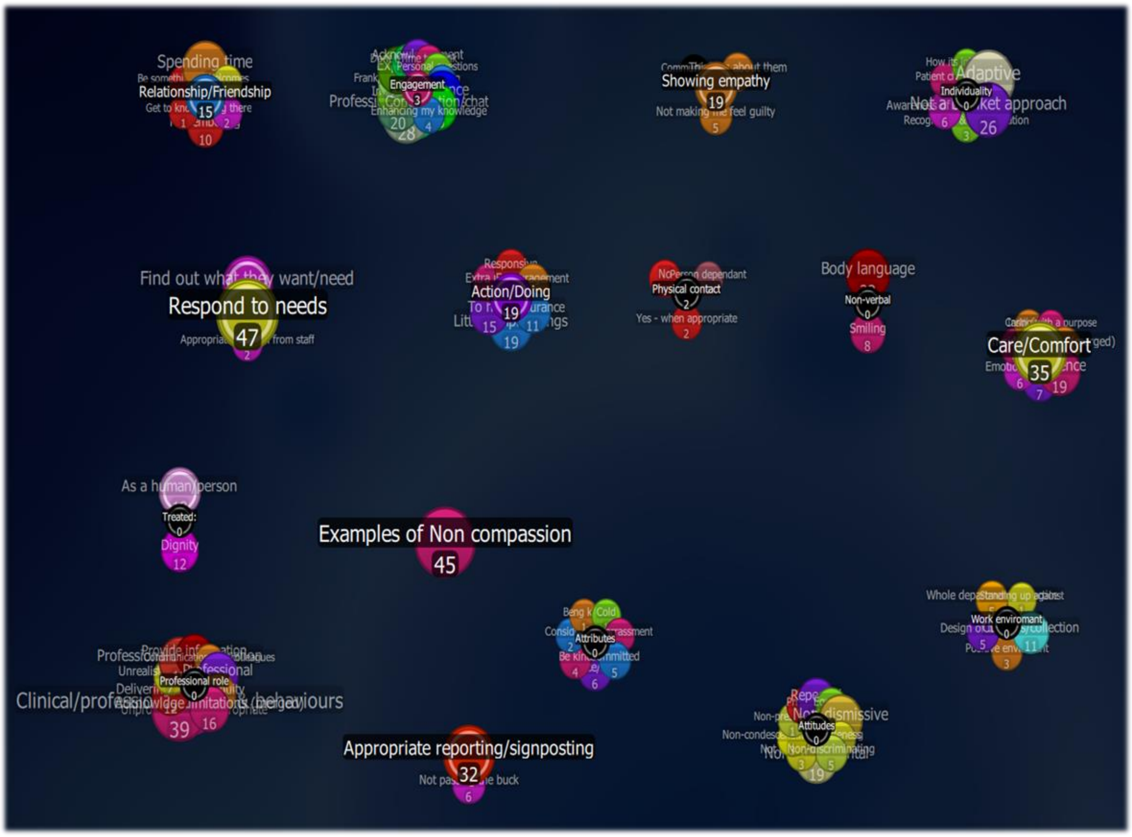
Student Therapeutic Radiographers

Patients and carers

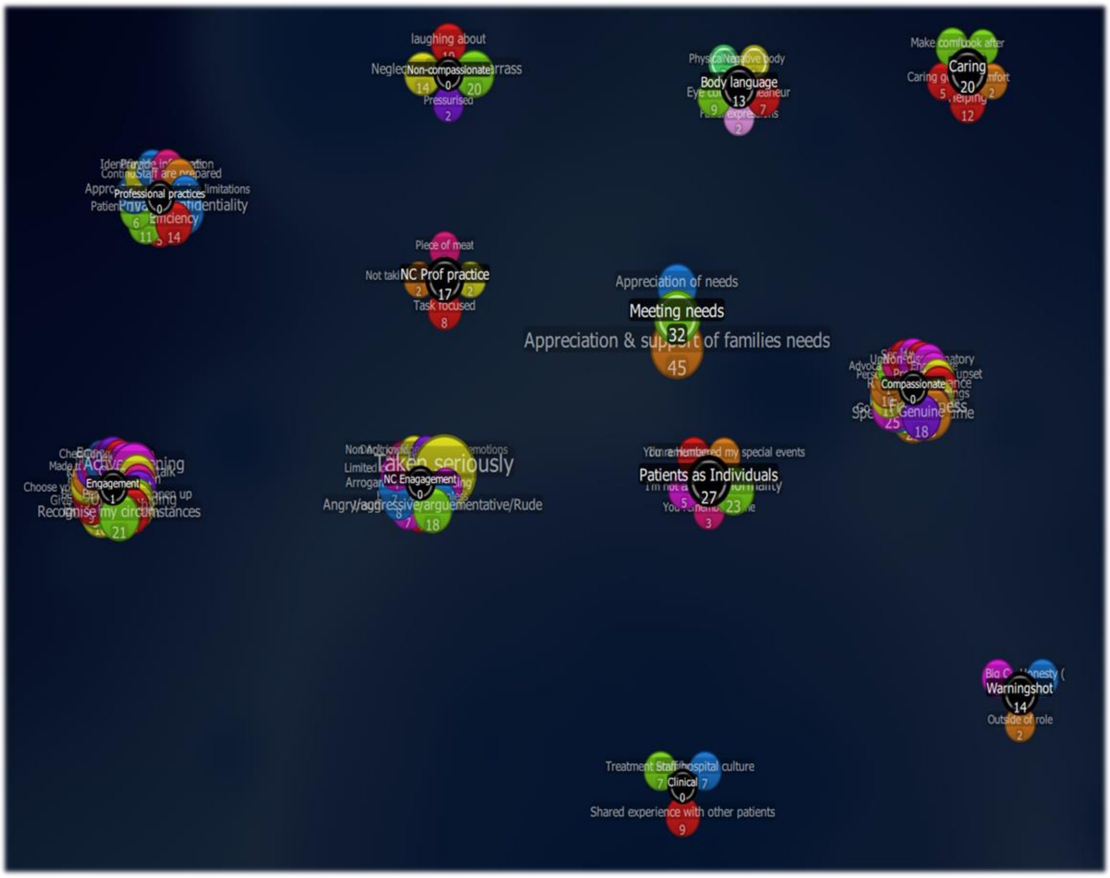
Appendix 19

Research question two thematic maps - (Part 2 theme development)

Therapeutic Radiographers



Student Therapeutic Radiographers



Patients and Carers

Appendix 20

Co-production workshops guide

Site:

Date:

In attendance:

No.	Name	Participant group
1		
2		
3		
4		
5		

Allocate attendees to table and provide each group with:

- Flip chart and pens – to record discussion and keep order of the tasks.
- Post-it notes – to write any comments or themes which they may not have felt were directly related to the task but felt would contribute to the discussion/findings.
- A set of the author's research questions so that they could refer to these to refresh memories or refocus discussion back on to the purpose of the task.

Provide an overview of the session (15 mins):

- Background on what had been completed thus far to provide the context and purpose of the sessions and serve as a potential memory refresher for those than came to FG.
- Explain the format of the afternoon (tasks, working together, detail of individual tasks will be provided before each starts)
- House-keeping – no fire alarms and location of toilets etc.
- Ground rules – respect for the opinion of others, there are no right or wrong answers and how I'm not there to comment but to listen.
- How some of the extracts maybe of the FG they were involved in or even their words but had been anonymised.
- Privacy of the information discussed within side the room.
- Obtain verbal consent for attendees having their photographs.

Tasks

Task 1a (30 mins)

Task1b (40mins)

Task 2 (40 mins)

Lunch (40 mins)

Close and thank you (5 mins)

Appendix 21

Summary of Clusters

Communication, **body language** and **tone** all relate to the ways compassion can be demonstrated through communication both verbal and non-verbal and the interconnectivity between these (Photo 1).

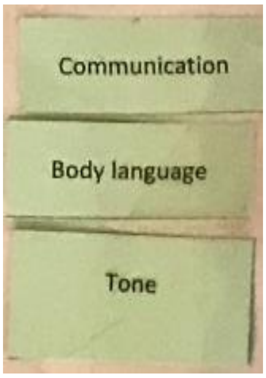


Photo 1: Non-verbal and verbal communication

Attentive, spending/giving time, active listening and **permission to open up** are all ways which engagement can occur and/or be demonstrated (Photo 2).

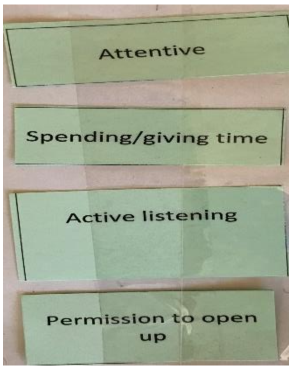


Photo 2: Engagement

Awareness of the person, check for understanding, choose your words carefully, sensitivity, honesty and **realistic** were grouped together as it was felt these represented interactive behavioural approaches and practices essential when using verbal communication (Photo 3).

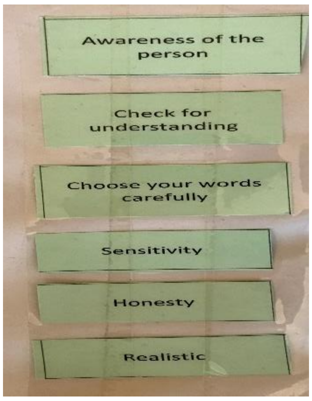


Photo 3: Interactive approaches

Rapport, empathy, trust, understanding, welcoming, bedside manner, genuine, reassurance, encourage and **sympathse** were collated as these were percieved demonstratable ways that compassion could be shown through both non-verbal and verbal communication (Photo 4).

Photo 4: Non-verbal and verbal display

Holistic, caring for carers, checking how I am, caring, continuity of care, considerate, make comfortable, supportive and **patience** were grouped as they are all forms of caring and demonstrating care (Photo 5).

Photo 5: Caring

Enhancing my knowledge, signposting and **empowerment** were believed to be for a person receiving compassionate care. These are not only undertaken for or towards the patient as part of compassionate care, but they can also be a consequential benefit for the patient when completed effectively (Photo 6).

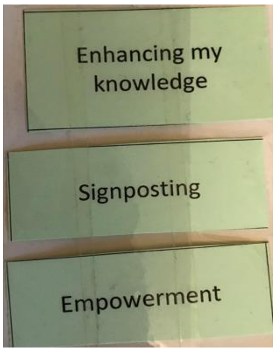


Photo 6: For the person

Not another number, not a blanket approach, personal touch, reacting and adapting and **give me a choice** are all about the person being treated as a human being and not simply as a patient as a means of demonstrating compassion (Photo 7).

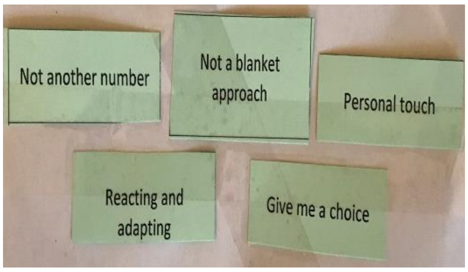


Photo 7: Humanistic

Professionalism, dignity, respect, privacy/confidentiality, non-judgemental and **willing** are all related to professional attributes and qualities of a registered healthcare professional (Photo 8).

Photo 8: Professional attitude

Appreciation of needs, recognise my circumstance, go the 'extra mile', doing something and **meeting needs** were collated. These represent the foundation of understanding the patient, their requirements and the comprehension of their role and responsibilities for undertaking an appropriate response which accomplishes are desired outcome (Photo 9).

Photo 9: Understanding

Hope (Photo 10) and **person centred** (Photo 11) remained independent as it was felt both could be cross-cutting over several categories.

Photo 10: Hope

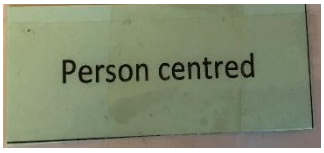


Photo 11: Person centred

Perception is both the ability of the individual to understand how their own behaviours, attributes and actions are perceived by another and to understand that each person will perceive their behaviours in different ways (Photo 12).

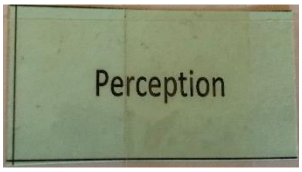


Photo 12: Perception

Treatment environment remained independent as although influenced by those working within it and the culture they create; it was also about the physical environment where they received their treatment and care (Photo 13).

Photo 13: Treatment envionment

The categories were arranged within their cluster groups in preparation for their use at the NTPPIE (Photo 14).

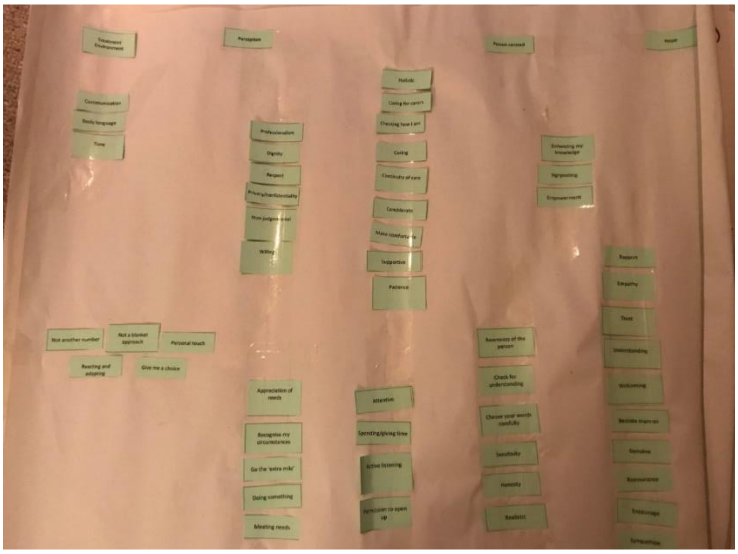


Photo 14: Fifty-five behaviours, attributes and practices

Appendix 22

North Trent Patient and Public group agenda

North Trent Patient and Public Involvement Group
Consumer Research Panel Business Meeting

Format:

1. Update and review of PhD project (15 minutes)
2. Overview of session (10 minutes)
3. Discussion of extracts (15 minutes)
4. Task 1: Defining compassion (RQ1) (30 minutes)
5. Task 2: Compassionate display (RQ2) (30 minutes)
6. Lunch (45 minutes)
7. Thank you & close (5 minutes)

Appendix 23

Research question two: One-hundred and twenty-three compassionate behaviours generated across the focus groups

Shared experience with other patients	Treatment Environment	Staff / hospital culture
Signposting	Advice	Patient centeredness
Appropriate referral	Continuity of care	Identification of needs
Provide information	Staff are prepared	Staff acknowledge limitations
Privacy/confidentiality	Efficiency	You remembered me
I’m not a statistic	I’m a human being	You remember my special event
I want normality	Spending/giving time	Sympathise
Go the ‘extra mile’	Respect	Dignity
Realistic	Person centred	Advocate for others

Unassuming	Sensitivity	Hope
Attentive	Non-discriminatory	Encourage
Protect from upset	Reassurance	Simple things
Supportive	Friendliness	Genuine
No technical jargon	Checking how I am	Explain to me
On my level	Give me a choice	Be thorough
Choose your words carefully	Be humorous	Know me
Make me feel special	Rapport	Perception
Recognise my circumstances	Being there	Empathy
Understanding	Permission to open up	Trust

Attention	Chance to talk	Active listening
Automatic	Delve deeper	Communication
Empowerment	Check understanding	Body language
Physical contact	Demeanour	Warning shot
Big C	Honesty	Caring
Helping	Caring gestures	Make comfortable
Look after	Comfort	Meeting needs
Appreciation and support of family needs	Appreciation of needs	Staff confidence
Professional efficiency	Practical care	Appropriate follow up
Professionalism	Taking responsibility	Information giving

Non-patronising	Willing	Patience
Non-dismissive	Inclusivity	Non-judgemental
Considerate	Caring for carers	Holistic
Chatting	Tone	Check for understanding
Conversation	Bedside manner	Taking time
Doing something	Reacting and adapting	Assisting
Not another number	Personal touch	Personal questions
Not making me feel guilty	Professional questions	Involvement
Frank and to the point	Time to think	Enhancing my knowledge
Delivering treatment	Positive environment	Culture

Appropriate emotion from staff	Hear me	Know about them
Awareness of the person	Not a blanket approach	Welcoming

Appendix 24

Matrix of the fifty-five categories, site and frequency of selection within the each of the co-production workshops

Site A:	Site B	Site C	Total
Genuine (3)	Genuine (3)	Genuine (1)	3 (7)
Empathy (2)	Empathy (3)	Empathy (1)	3 (6)
Dignity (1)	Dignity (3)	Dignity (1)	3 (5)
Body language (3)	Body language (1)	Body language (1)	3 (5)
Supportive (2)	Supportive (2)	Supportive (to all) (1)	3 (5)
Rapport (2)	Rapport (1)	Rapport (1)	3 (4)
Appreciation of needs (2)	Appreciation of needs (1)	Appreciation of needs (1)	3 (4)
Sensitivity (2)	Sensitivity (1)	Sensitivity (1)	3 (4)
Trust (3)	Trust (2)		2 (5)
Reacting and adapting (2)	Reacting and adapting (2)		2 (4)
Honesty (2)	Honesty (2)		2 (4)
	Patience (3)	Patience (1)	2 (4)
Tone (3)		Tone (1)	2 (4)
Go the extra mile (2)	Go the extra mile (2)		2 (4)
Respect (2)	Respect (2)		2 (4)
Understanding (2)	Understanding (1)		2 (3)
Active listening (2)	Active listening (1)		2 (3)
Spending/giving time (2)		Spending/giving time (1)	2 (3)
Welcoming (2)	Welcoming (1)		2 (3)
Professionalism (1)	Professionalism (2)		2 (3)
Holistic (1)	Holistic (2)		2 (3)
Hope (1)	Hope (2)		2 (3)
	Caring (2)	Caring (1)	2 (3)
	Meeting needs (1)	Meeting needs (1)	2 (2)
	Permission to open up (1)	Permission to open up (1)	2 (2)
Caring for carers (1)	Caring for carers (1)		2 (2)
Person-centred (1)	Person-centred (1)		2 (2)
	Communication (3)		1 (3)
		Willing (1)	1 (1)
		Reassurance (1)	1 (1)
		Sympathise (1)	1 (1)
		Choose your words carefully (1)	1 (1)
		Personal touch (1)	1 (1)
	Privacy/Confidentiality (1)		1 (1)
	Considerate (1)		1 (1)

	Check for understanding (1)		1 (1)
	Checking how I am (1)		1 (1)
	Bedside manner (1)		1 (1)
	Doing something (1)		1 (1)
	Not another number (1)		1 (1)
	Perception (1)		1 (1)
	Non-judgemental (1)		1 (1)
	Treatment environment (1)		1 (1)
	Continuity of care (1)		1 (1)
Realistic (1)			1 (1)
Give me a choice (1)			1 (1)
Not a blanket approach (1)			1 (1)
Make comfortable (1)			1 (1)
Awareness of person (1)			1 (1)
Recognise my circumstances (1)			1 (1)
Encourage (1)			1 (1)
Attentive (1)			1 (1)
Enhancing my knowledge (1)			1 (1)
Signposting (1)			1 (1)
Empowerment (1)			1 (1)

Table 20.1 Matrix of the fifty-five categories, site and frequency of selection within the each of the workshops