Dr Robin Youngson

Dr Robin Youngson is a former engineer, a practising clinician, a systems thinker, system 'healer' and the Clinical Leader of Waitakere Hospital in Auckland. He was the founder of the Clinical Leaders' Association of New Zealand.

Dr Youngson graduated with an honours degree in engineering at Cambridge University. He worked for three years in oil exploration, saving funds to pay his way through medical school in Bristol. He took an honours degree in medicine and then became a Fellow of both the Royal College of Anaesthetists of England and the Australian and New Zealand College of Anaesthetists. He was the pioneering doctor on Childflight, a paediatric Air Ambulance Service in New Zealand. He started his first consultant job at Auckland Hospital as an anaesthetic specialist in 1994.

Dr Youngson was closely involved in patient-process redesign and quality improvement. The turbulent healthcare reforms of the 1990s led him to issues of leadership, particularly in response to the introduction of alien corporate and market ideology. The Clinical Leaders' Association was an attempt to get core professional values back into public healthcare.

In the last five years, Dr Youngson has worked with a visionary team of managers and professionals at Waitemata DHB in the development of the new Waitakere Hospital. He is also co-facilitator of the Waitakere Trauma Reference Network, a cross-sector and community response to injury prevention, involving local government and multiple community and public-service organisations.

He is Acting Chair of the National Health Epidemiology and Quality Assurance Advisory Committee and an inaugural member of the International Steering Committee for the new World Health Organization Collaborating Centre on Patient Safety.

Dr Youngson has presented and taught widely on issues of clinical service redesign, patient-centred reform, clinical leadership, patient safety, open disclosure and compassion in healthcare. He is an inspiring keynote speaker.

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Humanity and compassion in the practice of medicine

I began my professional life very far distant from the ideas and concepts I now present. In my first brief career as an engineer, I was the role model for rational and deterministic thinking. I have a strong scientific and academic background, with an honours degree in engineering at Cambridge University in England, and then an honours medical degree at Bristol University. My chosen hospital speciality is anaesthesiology. I am double-qualified, as Fellow of both the Royal College of Anaesthetists in England and the Australian and New Zealand College of Anaesthetists. You could not imagine a more rational, black-hat thinker, thoroughly versed in the culture, beliefs and assumptions of a highly trained, technical specialist working in a large teaching hospital. In my everyday work, most of the patients I met were transformed from a human being to a mere 'physiological preparation' during the course of an anaesthetic. I could inject drugs, adjust the anaesthetic and watch all the numbers change on the monitors. I chose a speciality where I didn't have to talk to patients or conduct outpatient clinics. I was the master of science and technology. A background in engineering was a great preparation for this technical work.

You will gather from this presentation that I might have learned there is something more to the practice of medicine.

I still practise anaesthesia but that is mostly working in maternity services, where almost all of my patients are awake. It is joyful and rewarding practice. I have some formal leadership roles and much of my learning and insight comes from work outside clinical medicine. I had the privilege of working for five years with a visionary team of people developing the new Waitakere Hospital. Culture change was one of our major concerns — trying to create a hospital environment that was healthy and safe for patients and families but also for the professionals who work there. Compassion and loving kindness are core values. I continue in the role as Clinical Leader of the hospital. I am also a member of EpiQual, the National Health Epidemiology and Quality Assurance Advisory Committee. This statutory committee has responsibility for the Improving Quality strategy and we provide independent advice to the Minister of Health.

A fellow traveller and teacher

I would like to begin my presentation by introducing a fellow traveller, a former patient of mine called Jessie. Jessie often travels with me when I am speaking or teaching. She is a constant presence at my side and she has been one of my greatest teachers.

When I first met Jessie, she was 85 years young. She came to my hospital clinic in a wheelchair, somehow looking crumpled and lopsided, having suffered a devastating stroke twenty years before. Her left side was completely paralysed and useless. From time to time, her useless arm would slide off her lap and dangle, withered and limp, over the side of the chair. She'd haul it back by reaching across with her right hand. She was somewhat

overweight and the tissues of her face sagged in untidy folds like an unmade bed. She had only half a smile but there was mischief and light in her eyes. Despite an appalling catalogue of medical complaints, she still managed to live alone and I quickly began to sense an indomitable spirit.

Jessie came to my pre-operative clinic because she had bowel cancer and her surgeon was fearful of submitting her to the perils of surgery, with her advanced age and with so many complicating medical conditions.

In my hospital, I had created the very first anaesthesiology clinic and I wrote to all my surgical colleagues, inviting them to send me their 'worst' cases, those deemed too risky for major surgery. I promised I would do my best to assess and predict the level of risk involved in surgery/anaesthesia and to help patients come to a decision about whether the risk of surgery outweighed the potential benefits.

Some of the patients were sent to me because the surgeons wanted someone else to give the patients the bad news. I took my job, and myself, very seriously.

Jessie was quite the 'worst' patient that ever came to my clinic. It took me a long time to summarise all the information from her bulky hospital charts, to enquire into her current symptoms and to perform a physical examination.

She was in big trouble. Her bowel cancer was continually bleeding and she was becoming severely anaemic. The tumour was causing obstruction and it was hard for her to eat. The colicky abdominal pains were troublesome. In addition to her massive stroke, Jessie had a long list of serious medical complaints. She had complicated and severe heart disease. Her main heart valve was almost petrified and severely narrowed. Her coronary arteries were clogged. She teetered continuously on the edge of a heart attack and suffered frequent attacks of anginal chest pain. Her severe anaemia greatly exacerbated her cardiac condition and she was breathless with a build-up of fluid in her lungs. She had diabetes, high blood pressure, raised cholesterol and damaged kidneys. She took 11 different medications.

My report to the surgeon spanned three pages. I concluded that Jessie had only a 50 per cent chance of surviving her operation and her prospects of ever leaving hospital were dismal. There was very little we could do to improve her condition, although correction of her anaemia with a blood transfusion would reduce the cardiac risk.

With a heavy heart, I did my best to explain to Jessie the enormity of the surgical risk.

'What's the alternative?' she asked.

'If you don't have surgery, the blockage in your bowel will get worse, the bleeding will continue, and you will probably die of heart failure and bowel obstruction.'

'Is there any other form of treatment for the bowel cancer?'

'No,' I replied, shaking my head. 'We would do our best to keep you comfortable.'

'Well, I really don't have a choice, then…Robin, I want you to take on my case, I want you to do my surgery. I'll take my chance. I've had a good life and if I die having surgery then it's not anyone's fault. I won't blame you!'

I then began to explain to Jessie that we could reduce the risk of her surgery if we gave her a

blood transfusion: 'Jessie, we need to give you a blood transfusion to take some of the strain off your heart. Because of the bleeding in your bowel, you have become very anaemic and your blood count is down to 82. It should be about 130. With your blood so thin, it doesn't carry enough oxygen so the heart has to work very hard to pump extra blood around the body. Also, the heart muscle itself isn't getting enough oxygen to sustain that extra workload. That's why your heart failure is getting worse and why you're getting angina so often.'

Jessie then smiled sweetly at me and told me she would not be having a blood transfusion! She must have seen the expression of dismay on my face. 'Robin, I'm a Jehovah's Witness and my religion does not permit blood transfusion. I understand that increases the risk but I would rather die and go to Heaven than survive and be damned. I'm sorry it makes it more difficult for you but I'll just have to take my chances.'

In a moving gesture, she took my hand in hers. 'Robin, I put my faith in you. I know you'll do the best job you can and God will be watching over you.'

This was getting very personal! Clinical detachment was at threat here. Not only was she addressing me by my first name, but she was holding my hand and invoking her God to watch over me. Next she'd be asking me to join her in prayer!

My next clinic patient was waiting. I told Jessie that I would write to her surgeon recommending surgery, even though the risk was very high. She thanked me for my time. As I called in the next patient, I sincerely hoped that the awful challenge of giving an anaesthetic to Jessie would fall to one of my anaesthetic colleagues.

A note of explanation is probably warranted here. Many people assume that the role of the anaesthetist is merely to put the patient off to sleep at the beginning of the case and to wake up the patient at the end. This is a gross oversimplification. During complex surgery, the surgeon is fully occupied with the technicalities of the procedure and doesn't have an overview of the patient's condition. Surgery can be a major stress to the human body, causing profound changes in physiology, altered organ function, major blood loss, and so on. It's the job of the anaesthetist to keep the patient safe and alive during surgery. In a case like Jessie that involves very sophisticated intensive care and life-support measures finely adjusted for each moment of the surgery. This is a 'knife-edge' balancing act where the slightest error can result in a downward spiral of deteriorating organ function, falling blood pressure and cardiac arrest. This may be the end result, even without error. Hence my heartfelt wish that someone else would face this sobering responsibility.

However, fate had determined this would be a very personal lesson for me. On the eve of surgery, I discovered to my dismay that I was allocated to the operating theatre where Jessie would have her operation.

With a heavy heart I went to consult with her on the ward. I felt duty bound to explain again the dire risks she was facing. Informed consent is a mainstay of professional practice. I do wonder, sometimes, whether it's really in the patient's best interest to half frighten them to death before major surgery?

Jessie cut me off short. 'Robin, we've discussed all that already. I understand the risks I'm taking but I put my faith in you. I know you will do the best you can.'

She held my hand again. This was disconcerting. She said to me, 'Robin, you're looking so worried about giving me my anaesthetic that I think I need to cheer you up. I'm going to tell you a joke!'

Now, bearing in mind this was an 85-year-old lady, half-paralysed in a wheelchair, and facing almost certain death in the next few days, the joke she told was magnificently bizarre and ridiculous.

Lifting her forefinger up to touch her lips, she blew a lopsided and wet-sounding raspberry. 'What's that?' she said!

'I have no idea,' I replied, shaking my head in confusion and disbelief.

'It's a fart trying to get past a g-string!' she said with a wicked twinkle in her eye.

I was now completely undone. Any semblance of the proper doctor–patient relationship had now dissolved in helpless mirth. When the tears were wiped away, I revised my estimate of her chances of survival. This was a human spirit not yet ready to depart the world.

We made our farewell and to my surprise I was able to put aside my fretful worrying to sleep soundly in preparation for the next day's challenge.

Jessie had a stormy time in surgery and post-operative care. She narrowly scraped through several crises, never once complaining. I went to see her again, three days after surgery when she was back on the ward.

She held my hand again. 'Robin, I prayed that you would survive my anaesthetic, and you did!'

Those events took place 10 years ago. Jessie has since passed on but she is always at my side. Often, when I speak at conferences or workshops, I will start my presentation with that story. I put an empty chair beside mine to signal her presence.

Jessie had a lot of lessons for me to share with the rest of the world. At the time, I wasn't open enough to learn all of the things she had to teach. But hardly a day goes by when I don't reflect on her inspiring example and challenge myself to match her incredible compassion and courage.

Over the years I have begun to understand some of her lessons.

The first lesson was that of simple humanity. Jessie, with devastating effectiveness, undid all of my defences and gave me an experience of shared humanity. She used one of the most powerful tools at our disposal — humour and laughter. It was the start of my journey of personal healing. It's something I teach a lot to my colleagues, the stepping aside from professional and expert roles for a moment to simply be a caring human being.

The second lesson was one of interconnection and interdependence. Before Jessie, I conceived of the doctor–patient relationship as a one-way street. I was the highly trained doctor, the expert, the person with authority and control. Caring was a one-way process. I cared for patients and I determined the process and the agenda. Patients didn't care for me. They were grateful, of course; they took my advice and they did what I told them. Those who didn't were 'difficult patients' or 'non-compliant' or 'manipulative'. But somehow, Jessie turned the tables on me. She was the one caring for me and supporting me in my difficulties. The relationship had become a two-way process.

The third lesson from Jessie was about choosing an attitude. In the face of severe disability and pain and the prospect of almost certain death over the next few days or weeks, she chose her attitude. She wasn't grumpy or ill tempered. She didn't complain. She didn't dwell on her misfortune. She chose instead to show concern and compassion for me as a vulnerable human being. She gave me support, she cheered me up, she told me a joke!

If Jessie could choose humour, laughter and compassion in her awful circumstances, what excuse have we ever to do less ourselves?

Attitude is highly contagious. And attitude exists at many different levels, from the individual, through the team, to the whole organisation. We sense it the moment we walk into a place like a hospital.

The last lesson Jessie taught was that laughter is the best medicine. No matter how dire the circumstances, there is a place for gentle humour and fun and a good belly laugh. If we can learn to laugh at ourselves then we open up our hearts to a deeper human connection and the humility to learn. Laughter is a wonderful release for tension and anger. A workplace that creates fun and humour through the daily challenges is a more joyous, creative and energising place to work.

Angels can fly because they take themselves so lightly.

These four lessons — simple humanity, interdependence, choosing an attitude, and laughter — are a wonderful prescription for the beginning of personal transformation and developing open-hearted compassion.

At this point, I'll offer a definition of compassion. The one I like most comes from the WordReference.com English Dictionary: 'Compassion is the humane quality of understanding the suffering of others and wanting to do something about it.'

A lack of compassion

We need to face a sober reality in the everyday experience of patients in our institutions. Medical-school training was a distressing experience for me. I saw many brutal things done to patients in the name of medical practice and I'm not sure it has changed very much in the intervening twenty years. We somehow have constructed organisations, full of well-intended professionals, where the experience of the patient is that of a callous system, often unresponsive to their feelings and needs.

That state of affairs is commonplace as anyone will know who has been helplessly dependent as a patient in the system. Two years ago my 18-year-old daughter had a serious road accident and broke her neck. Her complex fractures were managed conservatively, so she was confined to a hospital bed for three months, in spinal traction. She lay flat on her back with her head immobilised. She could see only the ceiling. She couldn't see out of the window, she couldn't see people who came into the room, she couldn't watch TV or read a book, and she couldn't wash or feed herself. Her dignity and independence, and her emotional and psychological needs, were grossly neglected. Meal trays would be brought into her room, put down out of her sight and reach, and then taken away again untouched. There were many caring and kind staff members but they were overworked. The overall system showed a callous disregard for her emotional and psychological well-being. Despite repeated pleas from our family, no aids were provided to relieve her disability or to maintain her dignity.

Eventually, I myself designed and built all her disability aids and installed them in the hospital room. She had a laptop computer mounted on the bed frame, where she could see the screen and use the keyboard. We arranged an internet connection so she could surf the web and communicate with email. A web-cam on her bed showed her the view out of the window or the faces of people coming into the room. She could watch movies and listen to talking books. She used graphics software to do creative work. I constructed an upside-down shelf to hold books or magazines. Family and friends created a daily roster to ensure she had nourishing and tasty food. Our family spent more than $1000 on hospital car parking for the privilege of keeping our daughter alive.

We pursued a complaint to the Health and Disability Commission (HDC), not about the clinical care that was of a good standard, but about the lack of caring. The Commissioner was unable to report a breach of patient rights on the evidence available. Mediation with the district health board was offered but we declined the invitation. We were not optimistic that a process of mediation would address the system failings and the lack of caring. We sincerely hoped that our daughter's case might set a precedent for a new ruling on a required standard of care including the need for compassion. In that respect, we felt that our complaint had failed. The Commissioner raised many concerns with the health board in a formal 'educational letter' to the Chief Executive. Our conclusion is that the HDC Code of Rights and the process of investigation need to be strengthened to bring a stronger focus on the quality of care and compassion.

On a positive note, my family will always remember the individual professionals who through their actions showed just how much they did care. The ambulance officer, who tended to my daughter for the long period she lay trapped in the wreckage, stayed behind at the hospital to meet the distressed parents in the waiting room of the trauma unit. She hugged us and told us that our injured daughter was not left alone. When I think of that simple act, I am completely undone. The transit nurses in the hospital took such exquisite care of our daughter during her complex journey of trauma assessment, to CT scans and so forth. When they wheeled her on the trolley, they stopped at every single join in the carpet to carefully lift each wheel over the bump and not cause further pain by jolting her fractures. They were sensitive to our own distress and they gave much practical help and support during that bewildering and awful first day.

I was already sensitised to these issues of caring and compassion. In 1998 I founded an organisation called CLANZ, the Clinical Leaders Association of NZ.[1] One of the CLANZ projects was a collaboration with Nga Ngaru Hauora O Aotearoa (National collective of Maori Health providers) to create a learning resource for health professionals about the experience of patients within the healthcare system. The 'Working Together' video contains the stories of five patients telling us first-hand about the experience of being a patient. One of the stories is told by Diane, who tells of the death of her husband in hospital and of the failure of caring. I will use that video in my conference workshop. It will bring tears to your eyes. When I use these stories in workshops with health professionals, everyone acknowledges that these failings are commonplace, everyday events.

How could this arise in a business in which the core purpose is caring? It has taken me a long time to answer that question. It is something we must change.

How did we lose compassion?

I think the problem really began in the Age of Enlightenment — the age of Newton and Voltaire and 'the triumph of the intellect over base emotion'. That time was the major genesis of Western thinking about the nature of the universe and theories of knowledge. From Newtonian mechanics comes a clockwork analogy of the world, a deterministic view in which understanding of the parts led to prediction about the function of the whole.

Medicine has adopted an increasingly fragmented, mechanistic and detached view of the patient. Clinical detachment and objectivity are core values in medical practice. There is little room for understanding of complexity or interdependence. The icing on the cake is what Edward de Bono calls 'Black Hat Thinking',[2] a critical and pessimistic thinking style. Physicians adopt these characteristic assumptions and thinking styles so comprehensively that I coined the term 'iatrocognition' to name this deadly disease. When doctors deny their own humanity, patients suffer and so in turn do the doctors.

I believe much compassion is lost through fear and defensiveness. In the anxiety-provoking world of early clinical practice, when we feel so lacking in confidence, we adopt this detached clinical role as a defence against our own feelings of inadequacy. Many of the experiences of clinical training are brutal in the extreme.

When I had been a doctor for eight days, I did my first weekend on call as a house officer. I was continually on duty for 34 hours, in which time I had only three hours' sleep. Of the 15 emergency patients I admitted, six died. I vividly recall cycling home five miles on Monday evening. I had held my emotions in check for the whole duty period, but I was overwhelmed with grief and shock on being released from duty. I wept uncontrollably during the journey home. My wife was shocked and horrified — she scarcely recognised the husband she had sent to work three days earlier.

It was only the beginning of a long process of brutalisation. More recently I recall a Saturday afternoon working as the on-call anaesthetic registrar. Early in the afternoon, the alarm bells suddenly rang in the theatre recovery room. I was puzzled because I knew there were no patients in the room. I ran to the room and an appalling sight greeted me. A young woman in advanced pregnancy had collapsed with cerebral haemorrhage. While I futilely tried to resuscitate the mother, the obstetrician performed an emergency caesarean section with his bare hands, wearing his street clothes. Both mother and baby were dead. It was shocking in the suddenness and the lack of proper 'clinical' rituals. I had scarcely certified the death when I was called urgently to the operating theatre. A 19-year-old motorcyclist presented with multiple injuries. His left leg was almost torn off. He died on the operating table two hours later.

I was expected to complete my 14-hour shift and pretend that nothing had happened. I actually did that. I had a cup of tea and then anaesthetised four more patients. I bizarrely wondered whether I should inform my patient that my last two cases had died in theatre?

In the face of these inhumane expectations, we retreat to a place of supposed emotional detachment and formalised doctor–patient relationships. As time passes, we become wrapped up in a notion of professional identity and self-esteem which I call 'expert professionalism'. Like a player on the stage, we become skilled at using the uniform,

the symbols and props of our profession to maintain that distance and to exert power and control. It's a vulnerable place to inhabit because the very foundation of underlying beliefs and assumptions is deeply flawed.

One challenge to these unquestioned assumptions about objectivity and clinical detachment comes from a strange place. Daniel Goleman is the bestselling author and leading psychologist who researched and popularised the concept of emotional intelligence.[3] Goleman is increasingly interested in cross-cultural concepts and the fusion of Western neuroscience with ancient traditions. In 2000, he attended a week-long retreat in Dharamsala with the Dalai Lama, with leading-edge Western psychologists and neuroscientists, and Tibetan lamas. It's a fascinating cross-cultural dialogue and exploration. Goleman describes the dialogue in one of his recent books, *Destructive Emotions*.[4]

An early difficulty in the dialogue is that it proved impossible to translate the word 'emotion' into Tibetan. The Buddhists had no concept of emotion as separate from cognition and there was no Tibetan word equivalent to 'emotion'. In the ancient Buddhist tradition, there are many mental states but all of them combine the elements of cognition and emotion as an inseparable whole. Negative mental states such as anger, anxiety or attachment are described as obscuring or afflictive mental factors that distort and cloud perception. According to Buddhist tradition, the only mental state in which the subject can accurately perceive the world is open-hearted compassion. This notion contrasts strongly with the Western theory of 'clinical detachment'. During the dialogue, leading Western neuroscientists reported the latest studies on brain function. Functional MRI now allows us to see the brain working in real time. The activation of cognitive and emotional centres can be seen on the scans. No instance of cognitive activity could be found without a corresponding activation of the emotional centres. Emotion and cognition are two sides of the same coin. Patients with brain injury in the emotional centres are unable to make rational decisions. Emotion is essential to the process of applying intuition, wisdom and judgment to make apparently 'rational' decisions. Rational detachment is a Western delusion.

Clinical detachment as a defensive mechanism is therefore profoundly flawed. Every patient injury is a wound in the doctor's heart also. The effect is to exacerbate deeply held fears and the sense of personal inadequacy, starting a vicious cycle that is profoundly dehumanising. The wonderful discovery is that open-hearted compassion can reverse that process and lead practitioners back to humanity and personal healing. In Western society we often think of compassion as something we do for others. In contrast, the Buddhist view is that compassion is simultaneously for the self and others. The practice of compassion heals the giver as well as the receiver.

The dialogue also covers many other illuminating subjects, such as recent findings on the neuro-anatomy of compassion and the plasticity of the adult brain. It appears that the daily practice of compassion actually causes structural changes in the brain that have the effect of strengthening positive emotions, increasing equanimity, and 'immunising' against negative emotions. Physical brain changes underlie one's change in temperament and character. We go to the gym to build up our muscles. How often do we exercise and practise compassion to build up our positive brain centres?

Compassion and personal/ professional transformation

In my hospital I do a lot of teaching and coaching. I run a weekly peer-support group for our interns. I hope that through our dialogue they might find support to retain their compassion and humanity as they struggle with the challenges of their first jobs in medicine. I often use the CLANZ videotape of patient stories in my teaching.

Some time ago, I led a dialogue on caring and compassion with our Clinical Board. Several months later, one of our senior clinical leaders came up to me in the hospital corridor, in a state of some excitement. She touched my arm. There was something profound she wanted to tell me. I'll call her Mary.

Mary described how she had been referred a patient on one of the medical wards. This frail, elderly lady had multiple medical complaints including diabetes and partial blindness. She had been in hospital two weeks. Mary began her formal, clinical assessment but quickly noticed that the patient was distressed. She put down her notes and asked if she could help. The old lady told her that every day she had asked the nurses if she could use the cordless phone, to phone home. She was clearly very anxious and distressed about some circumstance at home and was desperate to get in touch. Every time, she was rebuffed by the nurses who told her that the cordless phone was not for patients and she should use the card phone in the corridor. That was the one for patients!

Mary decided to help. She excused herself from the ward and took the lift down to the ground floor. She bought a $5 phone card and returned to the ward. She took the old lady by the arm and led her to the phone. She dialled the number and ascertained that she had the right person — the elderly patient's niece. She handed the phone over to the elderly lady. This was the first time in two weeks that anyone had stopped to help this lady and attend to her distress. The old lady was overcome with the kindness and she cried. From that day, she began to show improvement in her hypertension, angina and heart failure.

Mary then took up her notes and did her 'real' job. The simple act of kindness had taken perhaps ten minutes. At the end of the day, Mary reflected on events and realised that she had derived greater satisfaction from that simple act of kindness than anything else she had done in her work for many months. In fact, she had lately been feeling tired, dissatisfied and heading for burnout. When she came to work the next day, she had reconceptualised her role as a professional. She decided to be a caring human being first and a clinical expert second. Every day, she looked for opportunities to perform simple acts of kindness, to be fully present and to listen to patients' concerns and act on them. That day, she came to a crossroads in her career and chose a different path. The results were evident to me. In the corridor outside the hospital cafeteria, as she told me of her personal transformation, she radiated joy. I was deeply touched.

I can add my own story of personal transformation. As I write these words, I am sitting in my hospital on a Sunday afternoon, on duty for calls to the maternity unit. I am the on-call anaesthetist doing epidurals for pain-relief in labour and providing anaesthesia for emergency caesarean sections or other medical procedures.

I work a 24-hour shift and sometimes there are many calls in the night. Childbirth is not an office-hours business. Sometimes I'm

called out several times in the night, becoming fatigued and sleep deprived. In those circumstances, it's only natural to feel somewhat grumpy and sorry for yourself. I used to carry my grumpiness into work with me and be intolerant of frustrations, delays or missing equipment. It was an uphill struggle to find the necessary equipment, to ask the midwife to get the mother positioned for the epidural, and to communicate instructions. Sometimes the epidural didn't work well and I'd be called out of bed again. I was overwhelmed with negative thoughts, tired and grumpy.

Now I choose a different attitude. I finally learned one of Jessie's lessons.

I choose to put different thoughts in my head. When I'm called out in the middle of the night I think about the extraordinary privilege of being invited to take part in an intimate and life-changing event. I take great care with the spirit and presence I bring into the room. I enter the room with gentleness and quietness and compassion. I notice the effect this has on the mother in reducing fear and distress. I greet and acknowledge the other people in the room. I ask after the midwife, enquire whether she has been busy or had any sleep or rest. I do the epidural with the minimum of fuss and then witness the miracle of pain relief. It is a joyous experience. I don't care how tired I am. I go home with love and joy in my heart.

How amazingly the world changed when I chose to have a different attitude! I used to sometimes think that the midwives resented my coming to do an epidural. They were sometimes surly and uncommunicative, they would neglect to introduce me to the mother or other family members in the room, I would have to ask for assistance, the equipment wouldn't be ready. Now I feel like an honoured visitor. I am greeted warmly. I have the sense that my praises have been sung to the mother even before I step into the labour room. An extra-special effort will be made to anticipate what I need to make preparation for the procedure.

I no longer feel afraid and defensive in my dealings with patients. The formerly dreaded clinic is now a joy. I take so much pleasure in meeting patients and their families. I do what I can to help them. When things go wrong, I have the confidence in my caring and relationship skills to be able to support a patient, even if I have made an error or done harm. When you bring open-hearted compassion, patients will forgive almost anything. I choose to be a caring human being first and an expert second. It has been a long journey.

So I know in my heart that the answer to the problems of healthcare lies in healing healthcare, not fixing it. Our institutions will finally be safe and caring for patients and families when they are safe and caring for the professionals. We need to challenge the underlying assumptions and beliefs in Western medicine that lead to so much fragmentation and dehumanising of practice. We need to change the language we use and we need to make explicit that compassion lies at the very core of everything we do.

We have to learn humanity and compassion as individuals, as teams, as departments and as whole organisations. When individual practitioners become more humane, then so do teams, departments and the whole system. If the system is humane, individuals within the system quickly adopt a different set of behaviours. Changes at any level resonate up and down.

Where to begin?

At this conference, I am proposing a national campaign — to bring compassion back to the centre of everything we do. I suggest we begin by noticing the language, what is present and what is missing.

We so unthinkingly use our everyday language and assumptions that we stopped noticing. We don't know what fish talk about but we can be damn sure it's not about the water! It's hard to see what we're immersed in.

The language of control, authority and mechanistic strategies pervades an increasingly competitive and fragmented business world. Textbooks on organisational leadership are full of military and machine language and this unconscious terminology has contaminated healthcare. Consider the vocabulary we use every day, so pervasive it has become invisible: we talk about workforce and manpower, we have chief executive officers and director-generals of health, we triage patients, we manage outputs, we implement strategic plans, we use improvement toolkits, and to make ourselves heard we use bullet-points on PowerPoint slides!

When we do begin to look, what is missing is equally striking. Compassion and caring are assumed to be core values in healthcare. These values motivate most people who enter into the caring professions. But given the brutalising process of health professional training and the dehumanising beliefs and practices, don't we need to be explicit once again that compassion should lie at the core of everything we aspire to?

Neither the NZ Health Strategy nor the Health Workforce Strategy mentions compassion.

I examined the websites of major national and international organisations driving forward healthcare improvement. These sites contain hundreds of reports on improvement strategies, toolkits, leadership models and so forth. I search for the word 'compassion'.

In the Institute for Healthcare Improvement in the US, there was not one instance of the word 'compassion' in any improvement strategy.

In the NHS Modernisation Agency, there were zero 'hits' for compassion in the entire website.

In the Australian Council for Safety and Quality in Healthcare there were zero 'hits' for compassion in the entire website.

The Code of Health and Disability Services Consumers' Rights in New Zealand establishes the right to be treated with dignity and respect, but there is no right to be treated with compassion. That says it all.

I invite you to join me in a campaign to restore compassion as a core value in New Zealand healthcare.

Jessie would approve.

References

1 For more details see www.clanz.org.nz.
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