Researching compassionate leadership to care for NHS carers

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Covid-19 has shown that leadership in handling a healthcare pandemic is consequential for life and death. There are accordingly growing calls for a leadership in the NHS centred less on productivity and efficiency and more concerned with the wellbeing of those impacted by leadership decisions, not just patients but also staff. This is a call for compassionate leadership, centred on alleviating follower's suffering, a call that was growing louder even before Covid-19 (Curtis et al., 2017; de Zulueta, 2016). Evidence of this awakening, not only within the NHS, includes the increasing number of workshops, publications and change initiatives centred on compassionate leadership. There is even a Masters degree on compassionate leadership being offered at a UK university. As an academic who has studied compassion within organizational settings for the past decade, I view interest in compassionate leadership as a welcome development. Correspondingly, I urge that enthusiasm may be getting ahead of the limited existing research. In this article, I will briefly outline my reservations about pursuing compassionate leadership without sufficiently researching the topic contextually before I propose a way forward for addressing knowledge gaps.

A lot has been learned about the individual health benefits of compassion over the past 20 years in neuroscience, including on self-compassion, which is also being used as a therapy. Leadership, however, is more than a mental state or psychological disposition, it is a complex socio-relational process. Theorising compassionate leadership has to go beyond the individual level. And it has to go beyond describing the psycho-physical benefits of compassion, or the work benefits of having a more compliant and engaged compassionate workforce that saves the NHS money. Leadership involves planning, coordinating, monitoring and motivating others in achieving defined objectives. It further requires structure and resources and often entails grappling with competing interdependent needs for belonging, performance, organization and learning. Developing compassionate leadership within compassionate workplaces where leaders at all levels notice the suffering of their colleagues direct reports, empathise with it, seek to understand its circumstances and respond to address the distress, requires more than sending staff off for training on how to bring more compassion into their workplace-healthcare practice. This is particularly if, as has been the case over the past decade of austerity, at the same time staff are being under resourced and loaded with ever higher productivity demands.

An effect of promoting a compassionate leadership that is not grounded in contextual organizational research, specifically within the healthcare context, but rather on the findings of neuroscience, psychology or coaching, is that compassion will become just another buzzword and things would remain the same. This would be a lost opportunity. Internationally workplace bullying and harassment are over-represented, including in the NHS where some thirteen per cent of staff report being bullied by managers and some twenty per cent report being bullied by colleagues (NHS Employers, 2020). Most surprising

about these statistics is that healthcare workers generally enter the profession motivated by compassion (Curtis et al., 2017). Studies in social psychology such as the Bystander Effect or the Stanford Prison Experiment demonstrate, however, that context matters in the expression or repression of compassion. Two decades of research by my colleagues and I further indicate organizational level mechanisms that facilitate workplace compassion (Simpson et al., 2020). One of them is compassionate leadership, important for role-modelling compassion, demonstrating that it is important to take care of employee concerns. Others include paying attention to workplace culture, articulating and reinforcing humanistic values, creating an environment that supports psychosocially safe communication, promoting relational architecture and instituting supportive policies and routines, including those related to hiring and promotion. The speed in which support is provided when staff meet with hardship, the scope and scale of the support provided, as well as how readily support can be customised to suit individual needs are further considerations in creating a compassionate organization.

The findings of existing knowledge about organizational compassion and compassionate leadership can be useful as a starting point for researching compassionate leadership from amongst existing practices within standout NHS divisions, departments or teams. The essential research question here is, when the leadership provided to NHS staff is compassionate, what does it entail? Building on this question and existing knowledge further questions can be formulated: How is compassionate leadership in the NHS distinguished from other leadership approaches such as servant leadership, emotionally intelligent leadership, or authentic leadership? How do compassionate leaders (NEAR): *Notice* signs of employee suffering*,* *Empathise* with the pain, *Appraise* the underlying causes and conditions of suffering and *Respond* to mitigate its effects departmental or divisional levels in the NHS (as opposed to the level of one-to-one, or group interactions)? How do compassionate leaders in the NHS conserve and develop employee resources (emotional, social, relational, physical), considering that loss of resources is an underlying cause of suffering? How do they address competing paradoxical demands to be kind *and* strong, supportive *and* decisive, idealistic *and* pragmatic, particularly in an institutional context where policy and bureaucratic process can be unaccommodating of individual needs? How do they support compassion as a co-active, co-communicative process to ensure support is not imposed upon individuals as a box ticking exercise, without addressing their actual needs? Seeking answers to questions of this nature will provide an opportunity to identify and highlight existing compassionate leadership capabilities and practices that already have roots in the home soil of the NHS. Seeding and transplanting compassionate leadership practices to other NHS divisions and trusts will stand a greater chance of success when they have already passed the test of having been grown under local conditions and constraints. To conclude, let us get compassionate leadership training, development and policy settings right by researching the topic contextually within the NHS to ensure they are grounded in the earth of best practice.

References

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