

Compassionate care? A critical discourse analysis of accreditation standards

Cynthia Whitehead, Ayelet Kuper, Risa Freeman, Batya Grundland & Fiona Webster

Background

As physicians and educators, we know that our learners must acquire sound biomedical knowledge and well-honed technical skills. What has been less well articulated in the literature, however, is the understanding that trainees must learn to provide care in a compassionate manner.¹⁻³ The assumption that a ‘good’ healthcare provider practices with caring and compassion has been a taken-for-granted notion in health professions education for many years. This accepted truth aligns with ideas about the value of holistic care, patient-centred care, and empathetic communication. Believing that compassionate care is important does not make it easy to come up with precise definitions, let alone guide us as to how best to teach compassion to trainees. Even when medical educators endorse these values, there is no certain path to ensuring that they are inculcated in trainees and effectively incorporated into the curriculum.

As a research team, we were interested in examining notions of compassionate care in family medicine training. We undertook this research as part of an initiative which aims to promote the teaching and practice of compassionate care.⁴ Our research team therefore had a practical aim in mind for our overall program of research: to systematically identify and then integrate factors that most influence the teaching and practice of compassionate care. In this portion of the research, we aimed to consider what might promote or limit the inclusion of such values in educational structures, frameworks and curricula. We know that formal standards and accreditation requirements have significant effects on

driving and shaping curriculum and assessment.⁵⁻¹¹ If we want to reinforce particular values, therefore, an essential step is to analyze formal standards in detail so as to best use them to promote desired changes.

Outcomes-based frameworks have recently become a common way to depict curricular priorities^{12, 13} and formalize them into accreditation standards. These outcomes-based frameworks define physician roles in areas such as advocacy, communication and collaboration, in addition to technical skills and biomedical knowledge. In choosing to be explicit about multiple non-technical, non-biomedical areas of physician competence, these curricular frameworks aim for a more nuanced and holistic notion of a good/competent doctor than simply being a medical expert. The stated intent is to describe (and then produce) a competent health care professional who integrates these various roles. Whether the intent of outcomes-based approaches is achievable, however, has been the subject of considerable academic debate. Outcomes-based frameworks are conceptually grounded in behaviourist assumptions.¹⁴ Competencies must be observable and measurable,¹⁵ a challenging requirement for values such as compassion. In addition, there is a growing body of literature critiquing outcomes frameworks as reductive,¹⁶ overly simplistic,¹⁷ limiting of educational flexibility,¹⁸ and narrowing learning paradigms.¹⁹ Using a competency lens to frame curricular issues leads to the portrayal of competence as a static phenomenon²⁰ and residing only in an individual (rather than in a context/team).²¹

We recognize that it is no simple matter to sort out how accepted professional values are taught and learned. While some may dispute just how much formal curriculum shapes learner attitudes and values,²² many would agree that the formal curriculum is a central focus of educator attention and learner time and energy, especially in early (pre-clinical) years of medical education. Curriculum frameworks, therefore, provide evidence of what is valued, yet the relationship between formal standards, curriculum and professional values is obviously complex. Formal curriculum, of course, is not the only force affecting learner values and attitudes. The work of Hafferty in describing the “hidden curriculum” as “a set of influences that function at the level of organizational structure and culture”^{23(p404)} sheds light on the importance of the culture of training environments in terms of messages learners pick up about what is valued. The medical education literature is also filled with examples of the multitude of structural, institutional and curricular barriers that can adversely affect the ability to promote or retain aspects of compassionate care in training. Students become less empathetic as they proceed through training,²⁴⁻²⁶ faculty members are perceived as poor role models by learners^{25, 27, 28} and burnout of trainees and teachers is well recognized.²⁹⁻³¹ A medical curriculum based on biomedical content may not adequately prepare learners to bring generosity of spirit into complex practice settings.³² Professional power relations playing out within rigid hospital structures can limit the flexibility needed for creative, person-focused care.^{23, 33-35} Thus if we deem compassionate care important, we must examine how it is currently framed within educational contexts.

Constructs such as compassion and caring elude simple definition, and can be explored from a variety of perspectives. Very generally, compassion has been described as “an emotion that has often been relied on to hook our imaginations to the good of others and to make them the object of our intense care”.^{36(p13)} It is positioned as “the basic human emotion”,^{37(p27)} one required of both individuals and institutions in any just society.

Within the discipline of Family Medicine, compassion is described as one of a set of three attributes (the other two being humility and forgiveness) necessary in order to be “a healing sort of person”.^{38(p589)} From this health professions lens, the attribute of compassion is linked to the “fundamental importance of relationships in healing”.^{38(p593)} Healing relationships are further elaborated as involving a covenant between practitioner and patient, in which the doctor promises to be faithful to a commitment to the well-being of patients.²

The construct of ‘caring’ is also considered important within health professions education and practice. It is frequently positioned as something that must be ‘added to’ the scientific practice of medicine. If medical care is, fundamentally, “face-to-face encounters between people who are suffering bodily ills and other people who need both the skills to relieve this suffering and the grace to welcome those who suffer”,^{1(p1)} caring involves the generosity and grace to relate with those who are suffering these ills. “Care with science”^{1(p1)} is a phrase that has been thought to encapsulate the essence of a good general practitioner.³⁹ Within this frame, the “judgements of facts” that comprise biomechanical theories of medicine^{39(p4)} are contrasted with “judgements of value” (especially pertaining to values of illness as it relates to life).^{39(p4)} The latter are seen to

provide a moral philosophy of general practice ^{39(p30)} (one founded on MacIntyre's theory of virtue ⁴⁰).

Analyses of caring also attend to the power imbalances that may exist between those cared for and those providing care. Moreover, ideals of autonomy and choice may not sit easily side-by-side constructs of the moral responsibility of physicians to care for patients.⁴¹ The contrast between a “logic of care” and a “logic of choice” identifies the power imbalance between practitioner and patient.^{42(chapter 1)} It is posited that this imbalance may in some circumstances be helpful to sick persons and their families who have limited knowledge of medicine, and may well find a role of an informed consumer unhelpful in times of suffering.⁴²

Some scholars, particularly from the field of nursing, are more cautious about the effects of power differentials between patients and providers in terms of notions of caring. When caring is positioned as an individual practice, it may be unable to incorporate important political, economic and social dynamics that underpin relationships between health professionals and patients and instead may become “vague, idealistic, inconsistent and inadequate”.^{43(p442)} More critical scholars consider attempts to define caring as “an endless project, whose monotony is matched only by its uselessness”.^{44(p196)} The constructed nature of caring is also highlighted as “a changing social construction” that is complex and multidimensional, needs to be considered from cross-cultural, ethnic and gender perspectives, and is the subject of interdisciplinary rivalry.^{45(p5)}

From our perspective, it is not necessary (nor even desirable) to have a precise definition of compassion or caring. We also recognize that, while we studied discourses of ‘compassionate care,’ even the precise connection between the terms ‘compassion’ and ‘care’ is neither simple nor necessarily intuitive. Our choice of this particular term derives from a recent initiative in our setting: a “Call to Caring” which aims to advance the teaching and practices of humane, compassionate, person-centred care.⁴ Any definition will be a particular construction, and an aim of this type of research is to articulate the nature of the construction, unearthing assumptions that underpin particular understandings of the concept in the particular set of texts being studied. Therefore, in order to begin to analyze ways in which compassionate care is positioned within formal training standards, it first has to be identified within these documents in a very broad way.

Nationally, our Family Medicine residency programs have recently been required to meet new competency-based accreditation standards.⁴⁶ We wanted to see how notions of compassion and caring were constructed within these new standards, and hoped we would find useful leverage points to embed these values in family medicine training. Therefore, our research questions for this project were: (1) What are the dominant discourses in the formal national standards and documents for family medicine residency training? (2) To what extent do these discourses promote or emphasize compassionate care? In this work we sought to include any and all words, phrases statements or proxies that might be identified with compassionate care.

To conduct this research, we used a critical social science theoretical framework, beginning with the Foucauldian notion that current discursive notions in medical education, rather than being “natural” or “inevitable”, are constructed at specific historical times in particular situations for various social, economic and political reasons.⁴⁷⁻⁵⁰ This framing focuses attention on the ways that discourses influence social and institutional practices in medical education. Thus, how compassionate care is formulated in family medicine accreditation and policy documents affects how it is enacted in family medicine training and practice.

While the documents analyzed in this research relate to a specific residency training program in Canada, the context of that program gives our research question broad applicability. Canadian family medicine has recently adapted CanMEDS^{12, 51} for its competency framework and revised its accreditation standards to reflect this change. Since CanMEDS has been (and continues to be) widely adopted internationally, this analysis is of direct relevance for other countries and other health professions disciplines, and can be considered a case study with significance for other contexts.

Methods

We conducted a Foucauldian critical discourse analysis⁵² (CDA) of compassionate care in the formal documents and standards for postgraduate family medicine training in Canada. Discourse refers to ways of thinking, speaking and acting, including the boundaries that define what can or cannot be said about a specific topic.^{49, 53} Foucault does not provide a straightforward recipe with which to identify and examine discourses.

Instead, his work is open to interpretation, with different researchers taking up his work in different ways. CDA is a methodology used by many disciplines to look at how language relates to social practices, knowledge and power relations. While CDA is still a relatively new form of research in medical education, it is becoming increasingly recognized as a rigorous and valuable research approach within the field.^{14, 50, 54-56}

One recent review article provides historical and philosophical context on uses of Foucault in medicine,⁵⁷ another gives several examples of recent uses of Foucault in medical education.⁵⁸ Some authors draw upon Foucault's notion of archaeology, others on governmentality and others on technologies of the self.^{52, 59} Foucauldian approaches have been used, for example, to explore medicine's construction of death,⁶⁰ the future of medical education,⁶¹ discourses of telehealth and telecare,⁶² health research policy discourses,⁶³ constructions of competence,²⁰ globalization discourses,⁶⁴ interprofessional collaboration,⁶⁵ medical student selection⁶⁶ and ways that emotion is constructed in medical education.⁶⁷

We used an archeological approach to assembling and analyzing our textual archive, and note the similarity of our methodologic approach to that of several of other Foucauldian researchers.^{48, 55, 62, 63, 68} Specifically, we followed these steps:

- familiarization phase;
- assembling an appropriately comprehensive archive of texts;

- analysing the assembled archive to identify prominent key words and statements;
- analysing links between the identified dominant discourses and the values of compassionate care; and
- describing the effects and implications of the dominant discourses on the potential to advance educational practices related to compassionate care.

Our familiarization phase involved reading from a broad range of sources that might potentially allude to compassionate care, including accreditation documents for hospitals and health professions, academic journal articles, other academic books and papers, health professions education reports, government documents and websites, institutional documents and websites, and professional discipline documents and websites. We also conducted a literature search of compassionate care in medical education texts over the past 10 years (see Table 1). This phase provided an extensive overview of the subject.

Assembling an appropriate archive is an essential step in this type of research; strategies for defining a corpus of texts are described in detail by two of the authors of this paper in a recent AMEE Guide.⁵⁰ Since our research question for this project focused us on formal documents in Family Medicine Postgraduate training, relevant texts were not difficult to identify. The primary textual archive included Accreditation Standards from 2006⁶⁹ and 2013⁷⁰ and the Triple C Competency-based Curriculum,⁴⁶ which is the official description of the national residency curricular standards. Secondary textual

documents included other official reports and curricular documents that describe the recent revisions⁷¹⁻⁷⁴ (see Table 2).

The primary textual archive was analyzed to identify key words and statements that form notions of compassionate care within official Canadian Family Medicine training documents. We looked both for direct statements about compassionate care and also for potential proxies (e.g. synonyms, related ideas) for it. We explored notions of compassionate care that could be constructed from these statements, i.e. considering who was making the statements, in what contexts and for what purposes. We also looked for the positioning of these statements within the documents to identify how prominent they were, particularly as compared to other discourses.

Because our research question focused on formal standards, our archive consisted only of documents that were publicly available on institutional websites, in the academic literature and in the grey literature. Research ethics approval was therefore not required as per the published rules of the Research Ethics Board at the University of Toronto.

Findings

The CFPC published new Accreditation Standards in January 2013⁷⁰ (AS 2013), which replaced the previous Accreditation Standards of 2006⁶⁹ (AS 2006). The AS 2013 standards explicitly link to the Triple C Competency-based Curriculum⁴⁶ (Triple C). These three core documents formed our primary archive.

In our examination of AS 2013, we did not find any direct statements about compassionate care. Throughout AS 2013, the term ‘care’ is used to refer to patient care in particular settings (ambulatory care, hospital care), domains of practice (maternity care, care of the elderly), and specific groups (marginalized, disadvantaged, underserved). Continuity of care is also an area that is specifically highlighted (p17-18). In these uses of the term, ‘care’ is an object rather than an action, a noun rather than a verb (see Table 3). We next examined AS 2013 for potential hints, allusions or proxies for the term ‘compassionate care.’ In critical discourse analysis, any of these may contribute to the formation of a discourse. However, we were not able to identify any such hints, allusions or proxies in this text.

We also looked back at AS 2006. AS 2006 did include several statements positioned very prominently in the preamble that, while not using the exact term, might be considered compassionate care proxies, for example:

Family physicians understand and appreciate the human condition, especially the nature of suffering and patients’ response to sickness... Family physicians respect the primacy of the person. The relationship has the qualities of a covenant—a promise, by physicians, to be faithful to their commitment to the well-being of patients, whether or not patients are able to follow through on their commitments. Family physicians are cognizant of the power imbalance between physicians and patients, and of the potential for abuse of this power. (AS 2006, p7)

AS 2006, therefore, incorporated certain aspects of the doctor-patient relationship that could be considered to relate to compassionate care.

The specific term ‘compassionate care’ did not appear in the Triple C. The word ‘compassion’ is found once, in an appendix describing enabling competencies of the Professional Role (p85). ‘Caring’ is used twice, both times in appendices: first in reference to the patient-centred clinical method in the Family Medicine Expert Role (p71) and next in discussion of the Professional Role: “Family physicians have a societal role as professionals who are dedicated to the health and caring of others.” (p85).

In Triple C, we tried to identify key areas of curricular focus in which aspects of compassionate care might be embedded. “Triple C” refers to three specific constructs: Comprehensive Care and Education, Continuity of Education and Patient Care and Centred in Family Medicine (Triple C p2-3). Since Triple C, by definition and by design, frames these three “C’s” as the core foundation of training, we examined each “C” to look for potential connections of each to compassionate care.

Comprehensive Care and Education is framed in terms of domains of clinical care (Triple C p2). It is also described as occurring “across the spectrum of health promotion and disease prevention” (p20) and incorporating types of illness (acute treatment, chronic disease management, rehabilitation, palliation) (p20). The focus of this section is on clinical content areas of patient care, not on an approach to caring. Discursively, by

positioning ‘care’ as pertaining to clinical domains, it is distanced from relationships and emotions, and instead linked to clinical content. This reduces the relational focus of care.

Continuity of Education and Patient Care divides into education and care. In the section on continuity of education, one benefit (amongst many described) of providing continuity of the learning environment is fostering patient-centred care (p24), which is perhaps a potential proxy for compassionate care. More specifically, continuity of care is constructed as occurring across six domains of care (chronologic, informational, geographic, interpersonal, family and interdisciplinary) (p22). One of these six — interpersonal — includes a statement about “establishment of rapport and a trusting relationship between a physician and patient” (p22) as but one part in its definition (interpersonal continuity also refers to relationships with other health care providers). The notion of the doctor-patient relationship is therefore present within the concept of continuity of care and is another potential proxy for compassionate care. However the focus is minimal, comprising only a small portion of the framing of the construct of continuity of care.

The third “C”, Centred in family medicine, is positioned as relating to curricular control, context and content (p3). The document further elaborates that key aspects of this ‘‘C’’ are:

The focus of the experience, the primary setting and teachers for training, the amount of time spent in individual clinical settings, and the learning processes emphasized (p35, emphasis in the original)

Hence, centredness in family medicine is framed in terms of where trainees see patients, who teaches them, and how much time they spend in family medicine settings. None of these notions particularly link to providing care that is compassionate. Instead, they relate to settings and logistics. Linking ‘care’ to settings and logistics further removes it from the realm of relationships.

In our analysis of Triple C, therefore, we found only very limited connection between the three C’s and ideas that could in some way be linked to constructions of care as compassionate. Wanting to be sure that we were not missing alternate constructions, we explored in detail two areas which appeared to be potential proxies: the doctor-patient relationship and patient-centred care. The doctor-patient relationship is described in these texts as a way to improve health systems and limit costs (Triple C, p10). It is also considered a foundational element of family medicine (p11). The language used to discuss the doctor-patient relationship focuses on the importance of ensuring that residents are trained in comprehensive settings where they can provide continuity of care (p13). While it might potentially be inferred that these two C’s (comprehensive and continuity) will enable trainees to develop into physicians who have ongoing relationships with patients, the shift away from statements about the relationship itself to aspects of time, structures and domains of care has the effect of underplaying attention to

the relationship between doctor and patient. This is further reinforced by the framing of these C's in terms of efficiency and accountability elsewhere in the text (see for example, pps 23, 34, 42). The most thorough description of the doctor-patient relationship has been relegated to an appendix, which describes the Four Principles of Family Medicine, in which the centrality of the doctor patient relationship is highlighted. In previous accreditation documents, these principles were previously extremely prominent and framed the entire document. Not only are they no longer at the fore, these principles have now been subsumed and placed in the service of competencies.

Turning to the second potential proxy identified in Triple C, the patient-centred clinical method, we were able to identify multiple areas in AS 2006 where the patient-centred clinical method was highlighted as the desired mechanism of interaction. Repeated statements in AS 2006 focus on the importance of the patient-centred clinical method in terms of increasing clinical efficacy through understanding patients' feelings, expectations, ideas and fears. In AS 2013 the patient-centred clinical method is not mentioned at all in descriptions of the core 2-year residency program. In Triple C, the patient-centred clinical method is referred to with respect to continuity of the learning environment for residents (p16). We were also able to locate it in several of the CanMEDS-FM Roles descriptions, which appear as an appendix to Triple C. The patient-centred clinical method is discussed in the Family Medicine Expert section, with a set of enabling competencies that include exploring the patient's illness experience, understanding the "whole person" including "life history, personal and developmental issues as well as their context," and "consciously enhance the patient-physician

relationship recognizing characteristics of a therapeutic and caring relationship” (Triple C p 71).

Furthermore, the Communicator Role descriptors emphasize that:

The patient-physician relationship is central to the role of the family physician.

Family physicians integrate a sensitive, skillful, and appropriate search for disease and illness. They demonstrate an understanding of patients’ experiences of illness, their ideas, feelings, and expectations and of the impact of illness on the lives of patients and families. They use repeated contacts with patients to build on the patient-physician relationship and to promote the healing power of interactions.

Family physicians have an understanding and appreciation of the human condition, especially the nature of suffering and patients’ response to illness.

(Triple C p73)

Other recent CFPC formal reports included in our secondary archive of texts also focus on patient-centredness as a core facet of training.^{75, 76} For example, The Evaluation Objectives list six essential dimensions of competence, one of which is the patient-centred approach. However, rather than relating it to compassionate care, the patient-centred approach is described as “a hallmark of family medicine and represents one of the most efficient and effective methods for dealing with problems” (Eval Obj, p 4). Indeed, while patient-centred care may have the potential to be a proxy for compassionate care, in these documents, patient-centred care is most frequently framed as a useful technique for extracting accurate information from patients. Patient-centred care is therefore constructed as an effective and efficient way to diagnose and treat disease, rather than as

a way to provide compassionate care.

Discussion

It is by no means easy to sort through the components that comprise compassionate care. Whether we will ever be able to achieve consensus on a definition is uncertain. Whether it can be measured and/or taught is even less clear. If these basics are elusive, perhaps we need to question whether such values can or should be part of formal accreditation and curricular standards. However, we know that dominant discourses shape how we think and act. Discourse analysis highlights how language affects practices and what is valued and given prominence.

Our findings revealed a relative absence of attention to compassionate care in current formal standards in Family Medicine in Canada. While potential proxies such as the doctor-patient relationship and patient-centred care are present, they have become less prominent discursively, and the language used to describe them is not explicitly linked to notions of compassionate care. Instead, these constructs are directly linked to the dominant framing of competencies and outcomes.

What is the relevance of the absence of a discourse of compassionate care in the current formal standards of Family Medicine in Canada? One possibility is that the notable change in focus from the 2006 to the 2013 standards towards accountability, efficiency and promoting the valuing of generalist expertise is not a move away from values of compassionate care. Greater accountability, efficiency and valuing of generalist expertise

might be considered by some to be appropriate ways to promote compassionate care. Another possibility is that outcomes-based frameworks themselves limit attention to values. Perhaps the current focus on competency is at the root of the problem. If in competency frameworks everything must be definable, teachable and measurable, is the competency movement itself the problem? McLeod,⁷⁷ in a study of medical students' identity construction finds that competence and caring are two separate discourses. Moreover, she finds that discourses of 'competence' dominate discourses of 'caring' in students' work to develop professional identity. If constructions of competence repress notions of caring, what then? As a community of medical educators, we may need to consider whether competency frameworks should hold the central place they currently do in health professions education.

Another possible explanation of our findings is that notions of holistic and patient-centred care are so embedded in Family Medicine's disciplinary self-identity that these are being assumed. Certainly, the writings of McWhinney³ and the extensive work by Stewart et al⁷⁸ have been foundational in constructing the work of family doctors as built upon caring relationships with patients. We may be teaching and role modelling these values as part of our understanding of the nature of family medicine, regardless of curricular standards. The fact that these elements are not prominent in current standards does not mean that they have been lost in practice or intentionally devalued. This shift may be an entirely unintended consequence of the creation of documents that aim to look at the discipline of Family Medicine in a new way. One limitation of our study is that it is archival work. We have not looked at enactments in practice. Ethnographic observations

of performance in practice settings would provide information as to whether the shifts in language in textual documents are reflected in current practices.

However, the fact that the language of compassionate care is hard to find in current standards requires serious consideration. Absence matters, for if something is not discussed, it risks becoming less valued. If we consider the practice of compassionate care to be important, we need to pay attention to the formal descriptions of our training programs and to our accreditation standards. No matter how much the values of compassionate care are currently embedded in the hearts and minds of family medicine practitioners, if formal standards are not explicitly promoting these values they are almost certainly going to be accorded less attention in the future. As medical educators, we must very seriously consider whether the language we use reflects the educational values we wish to promote. If we are not clear about our core values in our formal documents, we risk losing essential aspects of medical training. As our current learners become our next generation of teachers and practitioners, will they still hold these values to be self-evident if they have not experienced them as essential during their formative years?

While this study has looked in detail at the formal standards and accreditation requirements for one particular discipline in one country, these findings have much wider relevance. The conundrum of how to develop formal standards related to complex social constructs poses a real challenge for the international community of medical educators. Important research has been conducted, for example, with respect to cross-cultural issues and notions of professionalism.⁷⁹ While we must ensure that important values are not

made invisible, we must at the same time avoid imposing rigid definitions for complex constructs. For what sorts of practices and values are standards appropriate? Do standards necessitate standardization? Are there other ways to enable proper attention to important values?

In addition to contributing to discussions about the nature and uses of standards in health professions education, this research also adds to the literature by describing research results that reveal absences and ‘negative’ findings. We set out to find ways to leverage formal standards to embed values of compassionate care in Canadian Family Medicine Residency Training. We were not successful. Instead, we identified the absence of explicit discourses of compassionate care in current national standards. While the importance of this particular absence is, naturally, a matter of opinion and debate, the results of this research highlight the value of identifying not only what **is** present and prominent in medical education documents, curricula or assessment tools, but also reflecting on whether something of value might be missing in our current educational constructs and products.

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