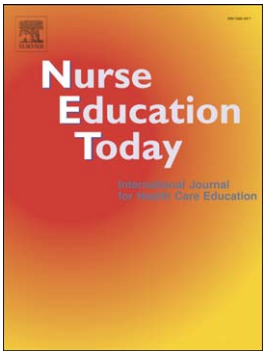
Accepted Manuscript



Exploring the compassion deficit debate

Rosie Stenhouse, Robin Ion, Michelle Roxburgh, Patric ffrench Devitt, Stephen D.M. Smith

PII: S0260-6917(16)00045-9
DOI: doi: 10.1016/j.nedt.2016.01.019
Reference: YNEDT 3186

To appear in: *Nurse Education Today*

Please cite this article as: Stenhouse, Rosie, Ion, Robin, Roxburgh, Michelle, Devitt, Patric ffrench, Smith, Stephen D.M., Exploring the compassion deficit debate, *Nurse Education Today* (2016), doi: 10.1016/j.nedt.2016.01.019

Title: Exploring the compassion deficit debate

Authors

Rosie Stenhouse

Lecturer

RMN, PhD

Nursing Studies

School of Health in Social Science

University of Edinburgh

Medical School, Teviot Place, Edinburgh, EH8 9AG

Rosie.Stenhouse@ed.ac.uk

Robin Ion (Corresponding author)

Senior Lecturer

RMN, MSc

Abertay University, Division of Mental Health Nursing and Counselling, Bell St, Dundee , DD1 1NG

r.ion@abertay.ac.uk

Michelle Roxburgh

Lecturer

RN, PhD

School of Nursing, Midwifery & Health, University of Stirling, Stirling, Scotland, UK

c.m.roxburgh@stir.ac.uk

Patric ffrench Devitt

RGN/RSCN, MSc

Leeds Teaching Hospitals Trust, Leeds

patricdevitt@gmail.com

Stephen D M Smith

RGN, RMN, PhD,

Edinburgh Napier University

Sighthill Court, Edinburgh , EH11 4BN, United Kingdom

E: ste.smith@napier.ac.uk

Title: Exploring the compassion deficit debate

ABSTRACT

Several recent high profile failures in the UK health care system have promoted strong debate on compassion and care in nursing. A number of papers articulating a range of positions within this debate have been published in this journal over the past two and a half years. These articulate a diverse range of theoretical perspectives and have been drawn together here in an attempt to bring some coherence to the debate and provide an overview of the key arguments and positions taken by those involved. In doing this we invite the reader to consider their own position in relation to the issues raised and to consider the impact of this for their own practice. Finally the paper offers some sense of how individual practitioners might use their understanding of the debates to ensure delivery of good nursing care.

INTRODUCTION

This paper brings together the arguments presented in a number of pieces published in Nurse Education today over the past two and half years and which examine the ongoing debate around compassion and care that has followed high profiles failures in the UK health system (Francis 2013). It is aimed at nurses from across the spectrum of practice: clinicians, managers, academics and students in the full range of specialisms and sub-specialisms and in all fields of practice. Our intention is to promote considered discussion of what individuals might learn from these catastrophes and how they might contribute to reducing the likelihood of similar occurrences in the future. We provide a summary of the various positions and evidence, encouraging the reader to engage with each of the original papers via the hyperlinks in the text. Our aim is to help readers to navigate their way through the debates and identify their position on each of the different perspectives. In the second half of the paper we invite the reader to reflect on their reading and to identify how their position leads

them towards action. We would encourage both individual reflection and group discussion on the issues raised. The paper concludes with some observations about what might be done and suggests some additional resources that might be drawn upon to deepen engagement with these issues.

BACKGROUND

The delivery of quality healthcare is a priority for governments, healthcare providers and health professionals across this world. While there are obviously variations, which will partly be a reflection of issues such as level of economic development and the percentage of gross domestic product spent on health, set against a range of outcomes; including life expectancy rates of morbidity and quality of life measures, it is reasonable to assume that, in the main, care is often good and, in fact, probably improving. Recent evidence from a relevant opinion poll in the UK suggests that satisfaction with care is good; „Overall public satisfaction … increased to 65 per cent in 2014 – the second highest level since the British Social Attitudes survey began in 1983. Dissatisfaction fell to an all-time low of 15 per cent" (British Social Attitudes Survey, 2014). For many, this will be confirmation of their belief in the dedication, commitment and professionalism of nurses, doctors and their colleagues from a range of disciplines. The strength and depth of such beliefs can perhaps be measured in the allegiance to some of the foundational stories which surround the health professions. In nursing, Florence Nightingale remains a touchstone for compassion, while Dorothea Dix, Ellen Dougherty and Mabel Keaton Staupers are similarly held in high regard.

The recent significant concerns about quality of care that have surfaced in the UK (Hayter 2013; Nolan 2013; Randall and McKeown 2014) stand in stark contrast to the popular stereotype of the caring and selfless, healing professional with a vocation which is epitomised by Nightingale and her peers. At first glance it might be comforting to view this as a purely UK problem. There is, however, a significant body of evidence which suggests

that health services from many countries may harbour their own versions of the failures identified in the Mid Staffordshire NHS Trust (Francis 2013), albeit to a lesser or at least unknown extent. In Canada, Wojtowicz et al. (2014) reported on the concerns of student nurses about quality of care in mental health settings, while in Australia (Hazelton et al. 2011) described similar experience amongst newly qualified graduate nurses. Concerns about care have also been reported by nursing students in Turkey (Erdil and Korkmaz. 2009) and by medical students in Brazil (Lins et al. 2014) and in the United States (Santen and Hemphill. 2011) and by nurses in Sweden (Ericson-Lidman et al 2013) and Thailand (Nantsupawat et al 2011).

In the UK there has been significant debate around the reasons for the catastrophe which occurred at Mid Staffordshire NHS trust, described in painful detail in the subsequent report by Sir Robert Francis (Francis 2013). Explanations have drawn on a variety of positions in the attempt to shed light on this darker side of caring where neglect, incompetence or occasionally abuse has been evident (Ion et al 2015). The focus of the debate has, to date, been centred on the issue of compassion. Specifically, commentators have put forward arguments for and against the notion that care failures have occurred as a result of an absence of compassion amongst caregivers, in this case nurses (Timmins and de Vries. 2015). The discussion is characterised by an attempt to understand whether the failures can be accounted for by a fundamental absence of compassion amongst care deliverers or whether situational and contextual factors might be better reference points in the journey to understanding. Three broad arguments have been put forward; the possibility that the issues were a result of social and organisational factors; a lack of compassion on the part of the health care staff; and the inability of nurse education to produce nurses who are capable of providing compassionate care.

THE DEBATE

In a series of papers Paley (Paley 2013; Paley 2014 Paley. 2015a; Paley 2015b) draws on social psychology to respond to the claims that nurses lacked the fundamental attribute of compassion. He considers a range of evidence which support the position that environmental and contextual factors shape behavior at least as much as do character disposition and personality traits. By way of example, he cites Daley and Batesonʺs (1973) Good Samaritan experiment which found that, when under time pressure, people who would normally be expected to stop and help a stranger in need would walk past, or claim they had not noticed the distress.

Paleyʺs accounts for individual failure by drawing on the many situational and organisational factors that influence the context in which nursing occurs arguing that to ignore these is to simplify the complexity of human behavior and motivation. Acknowledging that while some poor care may the result of uncaring attitudes, he suggests that a more plausible explanation lies in the fact that the overstretched nurses at Mid Staffordshire were simply too busy or too burdened with other tasks to notice that patients were suffering and needed their help. Here the individual is not to blame; rather the social context is such that any reasonable person might behave in the same way.

Again drawing on social psychology, Timmins and De Vries (2015) invoke cognitive dissonance to explain the erosion of standards and development of a discourse of „sub-optimalʺ care. They propose that nurses experience cognitive dissonance when the care performed differs significantly from their beliefs about what constitutes good or compassionate care. In order to deal with the discomfort that this creates they propose that nurses will work to improve the standard of care they provide (cognitive dissonance in this case is acting as a warning light to the practitioner of diminishing standards (see Paley 2015c) or, if it is not possible to reverse the situation, that they will draw on discourses of

pressure in terms of time and money to explain their actions. Where nurses draw on these discourses this leads to the development of new, sub-optimal norms which become part of the cultural context of care. Again they perceive the issues arising from the interplay between the individual and the system/context. This argument acknowledges that nurses do see poor care, but, if unable to address, for example as a consequence of the constant pressure under which they work, they revise down their beliefs about what constitutes good or acceptable care in order to deal with the negative experience of the dissonance caused between their ideal and lived experience of their work.

Reflection

- What is your response to the argument that nurses lower their standards of care due to situational or contextual pressures?
- Thinking about your own professional practice, what are the practical consequences of your position?
- Reflecting on the team(s) you are a member of, what are the practical consequences of your position?

Staffordshire the nurses encountered distress on a daily basis, but that some appeared able to ignore it or pass it by. Darbyshire (2014) similarly rejects Paley's account of a workforce too busy to notice the suffering around it. While acknowledging the day to day demands faced by many nurses and the naivety of any argument which dismisses the influence of social, personal and contextual factors - which of us can truly say that our work has not on occasion been adversely affected by one or other of these? - he raises the deeply troubling possibility that some nurses are not up to the requirements of the role. In his view these are not nurses who fail to perform, or get it wrong occasionally when under significant stress, rather they are individuals who do not have the personal qualities and commitment to be nurses. It is indeed difficult to conclude otherwise in the case of the nurse he quotes as saying that patients:

"can fucking wait", because "I don't give a flying fuck" (Darbyshire 2014: 888)

This unsettling possibility strikes right at the heart of the foundation stories referred to earlier and which have become embedded in the public consciousness over many generations. Put simply, it may be that some of our nursing workforce do not have the personal qualities required for the role. The debate therefore is raised as to whether some nurses lack compassion and the other personal qualities required for nursing.

Reflection

- Think of a specific situation when you were pleased with the care your service provided.
- What were the qualities or attributes nurses demonstrated when providing this care?
- What actions could you take to in your practice setting to make it more likely that patients receive compassionate care?
- What is your view of the argument that some nurses do not have the personal qualities required for the role, specifically that they may lack compassion?
- What are the implications of your view for you and your approach to nursing?
- What action might you take if you found that you were working with a colleague who lacked compassion and who demonstrated this in their work with patients?

A related view is put forward by Roberts and Ion (2014). Drawing on the work of the philosopher, Hannah Arendt, who tried to explain the actions of those who took part in the holocaust, they argue that exposure to unacceptable behaviour leads to acceptance which in turn allows the individual to participate in activity that they might otherwise consider to be abhorrent. Critical to this behaviour is the failure on the part of the individual to distance

themselves from their everyday experience and to reflect or think about what they are actually engaged in. An Arendtian account of care failure might position the individual nurse as so concerned with managing the day-to-day demands prioritized by their service for example managing waiting lists and completing specific care tasks, that they are no longer able to see the real purpose of their role - the provision of care and the alleviation of suffering . Focused on getting things done, her work becomes the completion of tasks, jobs and the meeting of targets. The extent to which this occurs can be observed in the degree to which she becomes distanced from what should be her „real" purpose. For Arendt, this occurs not simply as a consequence of the situation in which the person finds themselves, but rather as a result of their failure to truly reflect upon and think through their actions and omissions. It is this failure to think that allows the individual to not only observe the everyday unacceptable without undue distress, but also to participate in and propagate it.

Reflection

- What, if any, aspects of the position put forward by Roberts and Ion do you agree with and where do you disagree?
- Consider the idea that being a nurse is just about following instructions and doing what you are told.
- What is your experience in relation to this and what is the impact of simply following instructions/doing what you are told on the quality of care you provide?
- If the ability to think critically about her work is essential for the nurse if she is to avoid the moral failure associated with neglect and the delivery of poor care, what would this level of reflection look like for you and your colleagues in your workplace?
- How can we ensure the profession recruits nurses who are capable of this level of critical reflection about practice?

The papers discussed thus far take us from explanations that identify the social context or some aspect of the individual as the major reason for lack of care. An alternative but complementary position is provided Darbyshire (2013) in a paper in which he considers the extent to which nurse education holds some responsibility for the crisis in care. Here he asks educators to consider whether the equivalent of „managerialism" – „educationalism" – is overwriting nursing in some academic, curricular, and professionalising sense. The result of this being the nurse who no longer understands the full nature of their role. In the UK this explanation of education as the problem has found support with some , for example, Willis (2015) suggesting that it might be time to radically revise the way in which nurse education is configured. While there is much in Willis" report that most nurses would readily agree with, one of his more contentious suggestions is that, as is currently the case in North America, Australia and much of the rest of Europe, the UK should abandon its currently organization of pre-registration education around the four fields of practice (Adult, Learning disability, Children"s and Mental Health Nursing) in favour of a single initial point of registration after which specialism would be possible. The „generic nurse" debate as it has become known has a long history and is based on the notion that it would result in a broader workforce that shares a common set of core skills and so will be better equipped to deal with the challenges it faces, and consequently less likely to fail those it serves. For Ion and Lauder (2015), this is not the case, they argue that such a move would dilute the specialisms in favour of a „jack of all trades" nurse who would have skills in all fields of practice, but competence in few and expertise in none.

Reflection

- What do you consider might be the benefits or disadvantages of generic nurse education?
- What impact might generic nurse education have on your field of practice?
- To what extent would changes in the education of nurses address the problems that have been outlined earlier as failures in care?
- What changes would you like to see made to nurse education that may support the future development of nurses whose practice is grounded in caring and compassion?

These papers provide broad and sometimes contradictory accounts of why the events at Mid Staffordshire Foundation Trust might have happened. They do not address the specifics of how we might deal with the problems raised. Of course, Francis (2013) made over 300 recommendations for improving care. However it could be argued that this list becomes arbitrary as individuals and organisations, as well as government, will all prioritise different elements. It is notable however that these recommendations do address individual, educational and organisational aspects. There are some big suggestions made in terms of the *Shape of caring* (2015) that we may need to fundamentally change the type of education that we provide, there is also a focus on whether we are recruiting the right people into the profession (initially into education) in the first instance. These are long term changes and it is unclear whether these are the right things to do.

DISCUSSION

The different theoretical explanations proposed in these papers suggest different routes to a solution to the problem. For instance, if one considers Paley's arguments about social context to be the strongest then the solution would seem to come in the form of changing the

healthcare context. However, the healthcare context may be understood as encompassing the totality of a service or it may be narrowed to the particular clinical context in which an individual works.

In order to perceive that we as individuals might have any power to change the context in which we work, it is helpful to consider how the healthcare/institutional context is discursively constructed. *"A Discourse is a socially accepted association among ways of using language, of thinking, feeling, believing, valuing, and of acting that can be used to identify oneself as a member of a socially meaningful group or „social network", or to signal (that one is playing) a socially meaningful „role"."* (Gee 2008: 143). These discourses *"constitute a set of values, ways of thinking, beliefs, language, props, actions and other things that are associated with a particular subject identity*" (Stenhouse 2014: 424). Thus, individuals within the healthcare context occupy and enact a range of discourses that make them recognisable as a nurse, medic, manager, policy maker, patient and so on. Such discourses, as carriers of values and social norms are associated with the distribution of social goods and therefore power (Gee 1990). It therefore follows that, if the healthcare context is constructed discursively, individuals have some ability to change the context to a greater or lesser extent depending on their position (power) within it. Our position– whether as a student nurse, health care assistant, charge nurse or manager - therefore has implications for our sense of agency. For individuals to experience any form of agency in relation to organisational change it is necessary to consider what can be done at the micro level through changes in local practice and policy. Not to do so risks leaving us in a state of being overwhelmed by the enormity of the problem and our lack of power within the macro (wider institutional) context and therefore paralysed and disempowered.

If however, we consider individual explanations for the failures in care we become focused on deficits in the individual nurse or healthcare professional. Such deficits must then lead us to find answers to questions of what qualities or attributes it is necessary to possess prior to

entering nurse education (Snowden et al 2015); how education might facilitate the development of the required attributes or values; how we might identify and measure the values or attributes which we desire in nurses (Snowden et al 2015); and how we can enable nurses to retain their values base and attributes following qualification and entering the workforce. Thus the responsibility is placed on nurse education and, following qualification, the the employer to select the right people into nursing and then into health services.

It is unlikely that such a complex issue will be solved by a single approach, and, as such, it may be helpful to consider how the different explanations of the failures lend themselves to different approaches to a solution. We take it as given that there is much to celebrate about the work of nurses, but we also acknowledge the need to face up to the reality that poor care and associated problems with professionalism do exist and that their existence crosses professional disciplines and geographical boundaries. Our purpose has been not to attribute blame, but to try and understand how and why cares failure occurs and to promote individual thinking about what each of us can do to avoid, or at least minimise, the chances of further catastrophic failure occurring in the care setting.

CONCLUSION

A number of explanations are offered for the recent failures in healthcare. Our purpose has not been to take the moral high ground from the vantage point of the relatively comfortable uplands of the University setting - aside from anything else we recognise the need for change in the academy itself. The purpose of this paper has been to guide you, the reader through the ensuing debate and encourage reflection on the impact of such explanations and clarification of your position within these debates. Whilst you may have already been aware of your own position, consideration of a range of perspectives offers the opportunity to find different approaches to resolving the issues identified.

ADDITIONAL RESOURCES

The resources identified below address issues raised in the debate and are provided for reader who wish to further develop their thinking on this topic.

Coffey, M., Pryjmachuk, S. and Duxbury, J. A. (2015), The shape of caring review: what does it mean for mental health nursing? Journal of Psychiatric and Mental Health Nursing, 22: 738–741. doi: 10.1111/jpm.12254

Darbyshire, P., Ralph, N. & Caudle, H. 2015, "Editorial: Nursing's mandate to redefine the sentinel event", Journal of Clinical Nursing.

Hayter, M. 2013, "The UK Francis Report: the key messages for nursing", Journal of Advanced Nursing, vol. 69, no. 8, pp. 1-3

Hazelton, M., Morrall, P., Rossiter, R. & Sinclair, E. 2011, "Encounters with the 'dark side': New graduate nurses' experiences in a mental health service", Health Sociology Review, 20, 2,. 172-186

Rees, C., E., Monrouxe, L., V. & McDonald, L., A. 2015, "'My mentor kicked a dying woman's bed...' Analysing UK nursing students' 'most memorable' professionalism dilemmas", Journal of Advanced Nursing, 71, 1, 169-180.

Roberts, M. & Ion, R. 2014, "Preventing moral catastrophes in modern health care systems by facilitating the development of a Socratic ethos: A big idea from an Arendtian perspective", Nurse Education Today, 34, 12, 1411-1413.

Paley J (2014) Cognition and the compassion deficit: the social psychology of helping behaviour in nursing. Nursing Philosophy 15(4), 274-287. doi: 10.1111/nup.12047.

Timmins, F. & de Vries, J.M. 2015, "Editorial: Follow the yellow brick road- the compassion deficit debate where to from here?" Journal of Clinical Nursing, 24,. 19-20, 2689-2694

Van der Cingel, M. 2014, "Compassion: The missing link in quality of care", Nurse Education Today, 34. 9, 1253-1257.

REFERENCES

British Social Attitudes Survey 2014
Accessed from:
http://www.kingsfund.org.uk/search/site/British%20social%20attitudes%20survey

Darbyshire P (2013) Nursing"s crisis of care: what part does education own? *Nurse Education Today* 33: 305–307

Darbyshire P (2014) Character assassination? Response to John Paley, “social psychology and the compassion deficit” *Nurse Education Today* 34: 887-889

Erdil F, & Korkmaz F. (2009) Ethical Problems Observed By Student Nurses. *Nursing Ethics,* 16 , 5,. 589-98 doi: 10.1177/0969733009106651

Ericson-Lidman, E, Norberg, A, Persson, B, & Strandberg, G 2013, 'Healthcare personnel's experiences of situations in municipal elderly care that generate troubled conscience', *Scandinavian Journal Of Caring Sciences*, 27, 2, . 215-22 doi: http://dx.doi.org/10.1111/j.1471-6712.2012.01017.x

Francis R (2013) *Report of the Mid Staffordshire Foundation Trust Public Inquiry* The Stationary Office: London
Accessed from: https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

Gee JP (2008) *Social linguistics and literacies: ideology in discourses* Routledge: Oxon

Hayter, M. (2013), The UK Francis Report: the key messages for nursing. J*ournal of Advanced Nursing*, 69: e1–e3. doi: 10.1111/jan.12206

Hazelton, M., Rossiter , R., Sinclair, E. and Morrall, P., (2011) Encounters with the 'dark side': New graduate nurses' experiences in a mental health service. *Health Sociology Review,* 20**,** 2, 172-186.

Ion, R., Smith, K., Nimmo, S., Rice, A,M., and McMillan, L,. (2015) Factors influencing student nurse decisions to report poor practice witnessed while on placement *Nurse Education Today* http://dx.doi.org/10.1016/j.nedt.
2015.02.006.

Ion R & Lauder W (2015) Willis and the generic turn in nursing *Nurse Education Today* 35: 841-842

Lins, L., Herbas, S., Lisboa, L., Damasceno, H. & Menezes, M. 2014, "Perception of illegal practice of medicine by Brazilian medical students", *Journal of Medical Ethics,* 40, 6, 432-434. doi: 10.1136/medethics-2012-101190

Nantsupawat, A, Srisuphan, W, Kunaviktikul, W, Wichaikhum, O, Aungsuroch, Y, & Aiken, L 2011, 'Impact of Nurse Work Environment and Staffing on Hospital Nurse and Quality of Care in Thailand', *Journal Of Nursing Scholarship*, 43, 4, 426-432 http://dx.doi.org/10.1111/j.1547-5069.2011.01419.x

Nolan, P., 2013. (2) The Francis Report: Implications and consequences. *Nursing ethics,* 20, , 840-2.

Paley J (2013) Social psychology and the compassion deficit *Nurse Education Today* 33: 1451-1452

Paley J (2014) Cognition and the compassion deficit: the social psychology of helping behaviour in nursing. Nursing Philosophy 15(4), 274-287. doi: 10.1111/nup.12047

Paley J (2015a) Francis, fatalism and the fundamental attribution error: a reply to Philip Darbyshire *Nurse Education Today* 35: 468–473

Paley J (2015b) Compassion and the fundamental attribution error: a reply to Rolfe and Gardner *Nurse Education Today* 35: 474-479

Paley J (2015c) Absent bystanders and cognitive dissonance: A comment on Timmins & de Vries *Nurse Education Today* 35: 543-548

Randall D & McKeown M (2014) Editorial: failure to care: nursing in a state of liquid modernity? *Journal of Clinical* 23 (5–6), 766–767.

Roberts M & Ion R (2014) A critical consideration of systemic moral catastrophe in modern health care systems: a big idea from an Arendtian perspective *Nurse Education Today* 34 (5): 673–675.

Rolfe G and Gardner L (2013) Invisible gorillas and red herrings: a response to Paley (2013) *Nurse Education Today* 34: 954–957

Santen, S.A. & Hemphill, R.R. (2011), "A window on professionalism in the emergency department through medical student narratives", *Annals of Emergency Medicine,* 58, 3, 288-294 doi:10.1016/j.annemergmed.2011.04.001

Snowden A, Stenhouse R, Young J, Carver F, Carver H & Brown N (2015) The relationship between emotional intelligence, pervious caring experience and mindfulness in student nurses and midwives: a cross sectional analysis *Nurse Education Today* 35(1): 152-158

Stenhouse R (2014) Hearing voices: re/presenting the findings of narrative research into patient experience as poems *Journal of Psychiatric and Mental Health Nursing* 21: 423-437

Timmins F & de Vries JMA (2014) Nurses are not bystanders: a response to Paley *Nurse Education Today* 34: 1269-1271

Timmins F & de Vries JMA (2015) Follow the yellow brick road – the compassion deficit debate where to from here? *Journal of Clinical Nursing* 24: 2689–2694 doi: 10.1111/jocn.12917

Willis (2015) *Raising the bar. Shape of caring: a review of the future education and training of Registered Nurses and Care Assistants* Health Education England: London Accessed from: http://hee.nhs.uk/wp-content/blogs.dir/321/files/2015/03/2348-Shape-of-caring-review-FINAL.pdf

Wojtowicz, B., Hagen, B. & Van Daalen-Smith, C. 2014, "No place to turn: Nursing students' experiences of moral distress in mental health settings", *International Journal of Mental Health Nursing,* vol. 23, 3, 257-264 10.1111/inm.12043