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Chapter

Compassion Versus Care in Healthcare Institutions: What's the Difference?

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Abstract

In February 2013, the Francis Report outlined what it described as 'systematic failings' at Mid Staffordshire NHS Foundation Trust resulting in the death and suffering of many patients through neglect (in the UK context, hospitals can apply to gain foundation trust status. Foundation trust hospitals are part of the National Health Service (NHS) but are not directed by central government and have greater freedom to decide the way services are delivered. They adhere to core NHS principles of free medical treatment based on need and not the ability to pay.) A lack of compassion, particularly among nursing staff, was identified as one of the contributing factors to poor care. The NHS was founded on the core value of compassion that today is one of six values all NHS staff are expected to demonstrate. Frequently invoked as a means to ensuring good patient care, it is a concept that is contested by a number of writers who argue that such moral emotions are not only unnecessary but dangerous. The purpose of this work is to explore the difference between compassion and care (but not medical treatment) in the context of the NHS. The paper draws on the work of Anca Gheaus, who argues there is a distinction to be made between the two and that while it is possible to be compassionate towards everybody, the ability to care, is limited to fewer people and is a more intense and engaged activity. Regarded as the founding myth of the NHS, the work also draws on the parable of the Good Samaritan to make the distinction between the two concepts more visible, and argues the roles played by the Good Samaritan and the innkeeper, remain relevant to the workings of today's healthcare system. It also reflects on the need for kindness within the system.

Keywords: Care, compassion, Francis Report, Good Samaritan, NHS

1. Introduction

In February 2013, the Francis Report [1] outlined what it described as 'systematic failings' at Mid Staffordshire NHS Foundation Trust (foundation trusts are still part of the National Health Service (NHS) but are not directed by central government and have greater freedom to decide the way services are delivered.) [2] These systematic failings resulted in the death and suffering of many patients through neglect. In looking to identify the causes of these failings, a lack of compassion particularly among nursing staff, was identified as one of the contributing factors. In his response to the Francis Report, the prime minister, David Cameron, recommended nurses 'be hired and promoted on the basis of having compassion as a vocation' and not just academic

qualification to 'ensure that it plays a part in every healthcare interaction [3]. Cameron's suggestion that nurses' pay should be made dependent on their ability to demonstrate compassion in their jobs, gives rise to what Anne Bradshaw [4] describes as 'a McDonald's – type nursing care rather than heartfelt care.' In Bradshaw's view [4], failures in the NHS cannot be attributed to failures in nursing care but is arguably the result of the rejection by a pluralistic society of 'Judaeo-Christian values' that no longer regards such values as relevant or valuable. In their absence, a utilitarian model of healthcare has emerged that is 'market-driven and bureaucratised' and is an approach that has overtaken the value of care [4]. Following an economic downturn in the 1970s ideas from economics started to have an impact on medicine. Economists such as Alan Maynard advanced a utilitarian argument that criticised healthcare delivery in the UK as an inefficient use of resources, claiming it was unethical because it deprived other patients of services [5].

According to Bradshaw [4] 'Judaeo-Christian virtues, such as compassion, […] used to play a significant, though often unstated part in medicine and nursing in the western world' but this moral framework came to be rejected by nursing leaders who 'were anxious to remove the quasi-religious base for care.' The change first occurred in the USA but later began to influence UK nursing that up until the 1970s saw generations of student nurses trained using the classic nursing textbook written by Evelyn Pearce [4]. In her writings, Pearce emphasised the importance of nurses developing 'a moral character' and the need to exercise 'kindness, compassion and unselfishness which contact with sick people demands.' [3] As a result of these changes, UK nurses entering training with a presumption of a moral framework akin to that emphasised by Pearce 'underwent a professional socialisation and doctrinal conversion that repudiated such values.' [4] Instead, nursing began to be influenced by contemporary views of care emerging from the USA that included the works of Carole Gilligan and Nell Noddings. Both these writers espoused a view of feminine morality that countered the Kantian view of rights and justice, and resisted the ethics of care being formalised into abstract principles [6]. In the case of Noddings, she regarded the moral impetus to care as:

> *'An engrossed subjective experience and not a moral norm. It is neither generalizable nor universalizable and depends on an affirmative response in the cared-for. From this perspective, "compassion" is an emotional response dependent on reciprocation, and not a virtue to be cultivated as an aspect of individual character.' [4].*

For Bradshaw [4] writings on the 'feminine ethic of care' is problematic as it provides no 'moral basis for the nurse to help the unresponsive, indifferent or even hostile and unsympathetic stranger. Not normative, and derived from the feminine nature, it is problematic for the male nurse too.' Anca Gheaus [6] agrees and argues the ethics of care is not a women's morality but a universal morality and 'the ability to care well are things in which women and men can (and should) be socialised' and if conceived as an exclusively feminine morality, will only lead to 'exclusion, oppression and neglect.' Other criticisms by feminist writers against feminist moral reasoning in terms of care have also been raised. A typical worry about such an ethics of care is noted by Claudia Card:

> *'Resting all of ethics on caring threatens to exclude as ethically insignificant our relationships with most people in the world because we do not know them, and we never will. Regarding as ethically insignificant our relationships with people remote from us is a major constituent of racism and xenophobia.' [7].*

In this work I intend to explore these two views in the context of healthcare. In doing so, I hope to signpost a way though these opposing views; that is, between

the view that moral emotions such as compassion are necessary for delivering good healthcare and those who oppose such views and argue compassion is irrelevant in healthcare settings because 'it is an engrossed, subjective experience.' To do so, I explore the concepts of compassion and care and rely on the work of Anca Gheaus [6] who argues that there is a distinction to be made between other regarding virtues such as compassion and that of care. In the work I also refer to the parable of the Good Samaritan and argue that the respective roles played by two of the key characters, the Samaritan and the innkeeper, are a good example of this distinction.

Today, compassion is included as one of six values in the NHS Constitution [8] and is frequently invoked as a means for ensuring good patient care. Despite its inclusion, it is a concept that is contested by a number of writers who argue such moral emotions are not only unnecessary but dangerous [3]. In the literature, care has defined in general terms as a disposition and activity of meeting needs [9] but according to Gheaus, although care is similar to other moral emotions such as compassion, it is a more intense and engaged activity [6]. Recounting the parable of the Good Samaritan - considered to be the prototype of the British welfare state - the paper reflects upon the respective roles played by the Samaritan and the innkeeper in the parable as a means to illuminating the difference between these two concepts. The paper proposes that the concept of care might be a more useful means of safeguarding good patient care because it involves the desire to actively help when possible whereas compassion is more of an attitude one may have towards people in general. The argument developed here references the findings of the Francis Report [1] and the failures in care identified at Mid Staffordshire NHS Foundation Trust. Obstacles to providing good care are discussed in the final sections of the paper.

2. My brother's keeper

In the 1970s the British Secretary of State for Health, Barbara Castle, stated that the NHS 'is the nearest thing to the embodiment of the Good Samaritan that we have in any aspect of our public policy.' [10] In 1970 Richard Titmuss published his study of British blood donors, *The Gift Relationship* and in it he describes how the universal impulse to help strangers was simply enacting a fundamental truth of human existence and 'to love oneself, one must love strangers.' [11] In Bradshaw's view [4] this specific understanding of care in nursing differs from contemporary understandings and in 'a modern supposedly secular and plural society' it is disingenuous to claim its values and says there is a need to acknowledge that new models of care have different underpinning values. The NHS Constitution currently emphasises six values that staff are expected to demonstrate as part of their work including: 'Working together for patients; compassion; respect and dignity; improving lives; commitment to quality of care; everyone counts.' [8] According to the Constitution, compassion is central to the care provided in the NHS and is achieved by:

> *'Respond[ing] with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care.' [8].*

Historically, the development of the compassionate character provided the nursing profession with its ethos until its rejection in the 1970s. Up until then, nurse training involved becoming kind and compassionate, as well as becoming technically competent with 'the character of the nurse considered just as important as the knowledge she possesses.' [4] But with the traditional system of nurse training

considered no longer acceptable, nursing leaders set the profession on 'an entirely new course.' [12] In 1986 the UK Central Council for Nursing, Midwifery and Health Visiting (UKCC) published proposals that saw the implementation of *Project 2000* and the traditional apprenticeship style of nurse training giving way to a model that saw nurses acquire student status. With these changes, concerns were raised that nursing had become too academic and had 'ditched its core vocation to care.' Nurses it was claimed, had become 'too posh to wash' and the bedpan - 'the enduring symbol' of traditional nursing was now being emptied by someone else [12].

In Bradshaw's view [4] the term 'care in nursing' has traditionally been understood as an axiom and is a normative moral practice of compassionate help for the stranger in need. Bradshaw believes this is the understanding the UK government, the Royal College of Nursing and the NHS Confederation appear to presuppose in their discussion of the subject and is a view underpinned by the parable of the Good Samaritan that has its origins in the Old Testament. In the ancient *Book of Leviticus*, Israelites are commanded to welcome strangers and told to: 'treat resident aliens as though they were native born and love them as yourself.' [13] In the New Testament the parable of the Good Samaritan also recalls this command. It recounts the story of a traveller attacked by bandits and left to die on the roadside and the response of the four characters who encounter the victim including the Samaritan (despised by the Jewish people), the priest (a privileged member of Jewish society), the Levite (a lawyer, inferior to the priest but still belonging to a privileged group in Jewish society) and the innkeeper (despised by Jews and Samaritans alike.) [10] Drawing on religious and racial tensions common among Jews and Samaritans at that time, the story tells of how two esteemed pillars of Jewish society (the priest and the Levite) refuse to help the victim as he lay gravely injured by the roadside because of fear of attack and also fear of being defiled through touching the victim. Instead, it is the Samaritan who comes to the victim's aid and as he dresses the victim's wounds, flouts laws about ritual impurity common among both Jews and Samaritans. During the course of the story, listeners are also told that the Samaritan was a seller of oil and wine, an occupation both Jews and Samaritans despised, as such traders were considered 'very shady people, indeed, even criminals.' [10] Because of this listeners would have been surprised at the Samaritan's actions and of his 'willingness to go to the margins of society in his ministry of healing [that] defined the depth of his compassion.' [10] The role played by the fourth character, the innkeeper, (a class of people generally considered to be thieves and robbers) adds a further unexpected twist to the story as Arbuckle explains:

> *'The inn in the story was a den of thieves, and the head thief was the innkeeper, yet he was prepared to help the victim, for a price [...] Knowing what to expect from the innkeeper, the Samaritan simply bribed him in order to guarantee that the patient would be looked after and kept alive. He left the innkeeper a certain amount but promised more when he returned.' [10].*

According to Arbuckle the Samaritan was a 'shrewd businessman' and as well as having the material goods to help the victim, he also had the relevant management skills as was evident in his dealings with the innkeeper. Alert to the weaknesses of human nature, the Samaritan bribed the innkeeper so he would care for the victim and is an example says Arbuckle, of the values of efficiency and excellence. For Arbuckle, there is a convergence between the values inherent in the Good Samaritan parable and the founding values of the welfare state in Britain and he identifies two kinds of values (final and instrumental) that are relevant to both:

> *'Final, that is, meaning a desired end state, and [...] instrumental, that is, those actions that are adequate or essential to achieve the desired end.' [10].*

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3. Reasoning from love to the moral inclusion of strangers

In examining the relationship between compassion and care Bradshaw [4] suggests the word compassion is associated with religious belief, especially Christianity and that caring as an activity requires 'cultivating the virtue of compassion in the carer' that in the context of nursing, is acquired through training. On this view, compassion is understood as suffering together with another and is more than an emotion or feeling but a whole praxis that has 'a moral and intellectual component that is universalisable.' [4] For Bradshaw, compassion is not an abstract theoretical idea but is lived out in the practice of the carer - a view also held by Florence Nightingale.

But in the context of healthcare, Anna Smajdor [3] argues that such moral emotions are not only unnecessary but also dangerous because our capacity to love and feel compassion is so circumscribed that '[U]nless we regard healthcare professionals as saints, we cannot demand that they guarantee an unlimited flow of compassion for each patient' and that:

> *'Medical professionals need to protect themselves as well as performing their medical duties, and if we demand compassion in addition to medical expertise and knowledge, we are setting our healthcare professionals up for failure.' [3].*

In Smajdor's view the terminology surrounding the word care is unhelpful because '[T]o care can be either to feel a certain way, or to carry out certain activities' and compassionate care is only really possible when, for example, we are a mother caring for her child or a wife for her husband. This kind of 'relational' care ethic is all very well when we are treating loved ones but as healthcare professionals do not routinely treat loved ones, it is dangerous and unfair relying on compassion as the motivation for ensuring essential tasks are carried out.

Anca Gheaus in her work, rejects the view that the relational aspect of care is a barrier to the moral inclusion of strangers and argues the relational nature of human beings has an epistemic role to play in defining the scope of human morality [6, 7]. Acknowledging that allowing personal relationships and emotions to be part of the argument that informs morality runs the risk of treating those unrelated to us unfairly, Gheaus argues it can still be a source of value in determining the proper scope of our morality as it is:

> *'Imaginable, that […] intelligible, emotional connections (which I call here 'love') based on the universal need people have for each other, can do the work left unfinished by the argument from actual connectedness.' [7].*

Defining love as 'personal' and directed towards a particular individual Gheaus argues this type of love can form the basis of our ability to respond morally to strangers. It is an argument she claims that is not dissimilar to religious love for humanity (which is universal and impartial) as it too, has sometimes 'been considered to facilitate an ability to see the equal worth of all human beings.' [7] By invoking people's relationships and need for each other, Gheaus argues we can engage in moral reasoning because of the relational fact that we are creatures who need to love others and also need others' love.' And although we relate differently to loved ones compared to strangers, she argues we should be morally concerned for strangers because they are 'at least potentially – *somebody's* loved ones.' [7].

In reasoning from love to morality Gheaus [7] draws on feminist ethics, including the works of Sara Ruddick (1989) [14] and Eva Kittay (1999) [15] both of whom 'indicate a way of reaching universalising moral conclusions from the existence of particular, personal bonds of love.' She also draws on the work of the philosopher

Raimond Gaita [16] and his book *A Common Humanity* (2000) where he invites us to think of how our commitments to those we love, are relevant for the obligations we have towards other people in general. In his work, Gaita argues that precisely because we are able to love some individual human beings, we are able to gain a full understanding of the moral value of people in general and he illustrates his point with the story of a nun's visit to the wards of a psychiatric hospital where he worked for a period in the 1960s. In the story, Gaita describes the moral responses of the doctors and nurses looking after the patients as diverse, ranging from brutal to kind. He also tells of how despite the expression of compassion by some of the regular staff, it was only the visiting nun that related to the psychiatric patients as equals and in doing so, acknowledged their full humanity. This came as a revelation to Gaita, who believed the nun's attitude was made possible by her love for the patients – in this case universal, Christian or saintly love. But once revealed Gaita believed this love was independent of the nun's religious background and accessible also to those who do not hold metaphysical beliefs.

Agreeing with Gaita that love has an epistemic role to play in our morality, Gheaus however considers the account of the nun's revelatory love as problematic as a means to universal moral inclusion because it is potentially unsustainable. Instead, Gheaus argues that an example of secular love, that is personal love directed at a particular individual, would be more convincing because the nun's love can best be understood as impartial and unconditional and therefore more sustainable as a general attitude than it would be coming from any of the nurses or doctors involved in caring for the patients. For Gheaus, it is not mere coincidence that the daily hands on care for the patients was done by the non-compassionate nurses, and the ongoing responsibility borne by the compassionate but condescending doctors while the nun was just a passer-by. Gheaus' argument here is that in the context of ordinary, everyday challenges, striving to maintain unconditional love is difficult, if at all humanly possible, and impartial love, disentangled from knowledge of the particularities of the beloved, is more easily amenable to being unconditional. On this view, an example of ordinary, partial and therefore more fragile love would be more convincing for two reasons:

> *'First because this is the love which most of us experience. And second, because as already noted, this ordinary love unlike impartial and unconditional Christian love is not as such a moral emotion.' [7].*

A further feature identified by Gheaus of personal, partial love that is constitutive of our human morality, is that of beings 'who need each other', and whose 'moral agency is in part determined by our need to be in (loving) relationships.

In her discussion of human need, Onora O'Neill argues that utilitarian thinking assigns no special importance to human need and leaves vital dilemmas unclarified and unresolved, despite the fact that all human action is predicated on 'a plurality of mutually vulnerable beings who never achieve more than limited and specific forms of rationality, independence and self-sufficiency.' [17] Developing an abstract Kantian argument that rejects 'principled indifference to others' she argues for a theory of obligations similar to that found in Christian and other religious traditions and also 'present in the idiom of much of our social life.' [18] In contrast to a utilitarian perspective that endorses the pursuit of happiness without specific concern to meet needs, or a human rights perspective that often fails to allocate obligations to help those in need, O'Neill proposes an obligations theory that is premised on not 'bas[ing] our lives on principles that are indifferent to, or neglectful of others.' [18] On this view 'the fact that we cannot help everyone only shows that we have no obligation to help everyone and not that we have no obligation to help anyone.' [18]

According to O'Neill 'ethical traditions that extol universal benevolence, love for all mankind, or concern for all' are misleading because nobody can provide help or care for all others and therefore the rejection of indifference cannot be expressed in action for all others [18]. As help or care for all others is not possible, the rejection of indifference is demonstrated through the provision of '*some* care to sustain *some* others in *some* ways' [18] that is not trivial or sporadic and sustains at least some of their capacities and capabilities.

Not contingent on any special relationship, these obligations are called *imperfect obligations* because concern for all is not possible and therefore selective and 'the pattern and occasions of virtuous action may leave much open for judgement.' [18] Regarded as a moral duty, *imperfect obligations* cannot be claimed as a matter of right and are distinct from *perfect obligations* which gives the right to one party to take legal action against a party that has failed to perform a particular duty. In O'Neill's view, contemporary liberal thinking marginalises imperfect obligations and excludes all but justice from their ethical perspective and takes pride in being 'agnostic about the good of man.' [17] If we want to establish intellectually robust norms in health, O'Neill suggests it would be preferable to start from a systematic account of obligations, rather than of rights because it makes it easier to spot incoherence in the system [17].

4. Compassion versus care: what's the difference?

For Gheaus the terms love and care partially overlap. In the literature 'care' has been defined in general terms as a disposition and activity of meeting needs [9]. In her analysis Gheaus [6] argues that when thinking of the word care there are several understandings of the word in the literature including: care as a type of work, care that signifies a special emotional bond between persons, and care as a virtue – a type of moral motivation as in 'caring about.' Distinguishing between several possible concepts of care in the literature and their relationship to each other, Gheaus [6] argues the different concepts do not necessarily exclude each other but that each presupposes the others to some extent. Rather than attempt to reduce the various meanings of the word found in the literature to a single concept, Gheaus [6] argues for a multi-layered understanding of care and proposes that we can best understand care and its moral significance, by connecting it to the idea of needs. The adoption of a multi-layered understanding that is connected to the idea of needs, makes it possible in Gheaus' view, to identify different contexts of care such as healthcare 'that are not based on care as an emotion close to love' but depending on context, can enable us to care for distant others [without] any emotional connection towards those one is embracing.' [6] In the many different senses in which the word care is used in the feminist literature, Gheaus argues the concept of need is a common feature and that:

> *'The most widespread way of understanding care is responsiveness to the needs of concrete individuals. The moral value of care is intimately linked to the fact that human beings are most of the time not self-sufficient, invulnerable creatures, but beings who depend on others for survival and thriving.' [6].*

For Gheaus meeting the needs of others necessitates individuals being treated in a personal way and this requires an interest in, and knowledge of, the particular circumstances of each person.

In the literature discussions about care have mainly been associated with compassion and benevolence. While noting how similar care is to other moral

emotions, authors have rarely provided an exact analysis of how they differ and according to Gheaus [6] this has precluded a full understanding of the distinctiveness of care. In attempting to delineate the boundaries between care and other moral emotions, Gheaus [6] argues that the particular meaning one attaches to the word means it can also come close to other moral emotions such as benevolence, compassion, empathy but that the scope of care is wider and involves acting on behalf of others. For Gheaus care is distinct from compassion or pity because one can be compassionate towards everybody but to qualify as care, the desire to actively help must also be present:

> *'Compared with pity, compassion or charity, the scope of care is wider. Both pity and compassion are mainly about concern with people's suffering and desire that it should be alleviated. But [...] alleviating harm is only part of the work of care. Care is as much concerned with fostering growth and happiness; it is as appropriate a reaction to cheerful situations as to distressful ones. An additional point is that one may be called compassionate or feel pity without necessarily getting too actively involved with the suffering. By contrast, to care for someone who suffers (or rejoices) requires a higher degree of commitment than that of compassion. To qualify as "care", an attitude must involve at least the desire to actively help when possible.' [6].*

Distinguishing care from altruistic motives that typically targets strangers, she develops the argument further by taking the example of benevolence:

> *'One can be truly benevolent without being committed to act extensively on behalf of those who are the objects of benevolence. Even more important, benevolence is a much less partial disposition than care. One can perhaps be benevolent towards everybody or at least towards everybody one interacts with [...] but care is more intense and engaged [and] our capacity to give it is limited to fewer people.' [6].*

In Arbuckles [10] analysis of the Good Samaritan parable, the distinction between the two concepts can be readily identified. Motivated by compassion for the victim, the Samaritan assists him at the roadside but is unable to commit to looking after the victim's long-term needs because of business commitments: unable to stay and provide the necessary care, he uses the resources at his disposal (money) to pay someone else to do the caring. That 'someone else' was the innkeeper who agreed to actively help the victim for money and in return, was rewarded for his efforts with the promise of further payment on the Samaritan's return.

In thinking of the relevance of the Good Samaritan parable to contemporary healthcare, the role of abstraction is important for without abstraction 'there is no communication with those of differing cultures [...] in short there is nothing that is universally relevant.' [17] The move to abstraction in liberal thinking is, in Onora O'Neill's view, a result of the absence of homogeneous community and culture. Abstraction has been criticised for several reasons, including the view that it idealises human agency and assumes 'various superhuman capacities such as complete transitively ordered preferences, complete knowledge of the options available and their outcomes, and unwavering powers of calculation.' [17] Other criticisms of abstraction are that it omits important or material aspects of the matter at hand. But in advancing an abstract Kantian argument that rejects 'principled indifference to others' O'Neill argues for a 'realistic account of circumstances' and says defenders of abstract rights 'have to say something about the way in which obligations [...] should be allocated to individuals, office holders and institutions.' [17] According to O'Neill a right to healthcare requires counterpart duties that must be carried out by specified persons or institutions

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that have the relevant competency and capabilities to carry out those duties [17]. Alongside the right to healthcare, individuals and institutions can have obligations but fulfilling or discharging those obligations, necessitates individuals and institutions having adequate capabilities [17].

5. Caring relationships versus institutional care

In Gheaus' view the difference between care as work and care as relationship is mainly one of focus and if we introduce a strong emotional link as the basis of care 'we are no longer able to account for some paradigmatic cases of care-giving.' [6] Rather than looking at all types of caring to see what common skills they involve, Gheaus [6] suggests proceeding the other way round and defining the activity of caring 'via the disposition of care and its employment.' Advocating for a multi-layered understanding of care, Gheaus [6] suggests that in thinking of care work within the family or within institutions, it is not necessary to say that one type of care is more valuable than another as it is reasonable to think 'that people need various types of caring relationships during life.' Institutional care may be valuable in itself if it is a complement to the loving care one gets in intimate relationships and the caregivers are enabled to meet the needs well. On this view, care received in institutions should not be seen as a replacement to intimate relationships but as complementary and valuable in their own right:

> *'As long as it is done well, we will definitely want to call their work "care" and there is no contradiction in doing so, since the criterion for judging institutions need not be identical to those for judging people.' [6].*

Clarifying the relationship between care directed towards a particular individual involved in a personal relationship and institutional care, Gheaus argues that when the work of caring for someone is not directly motivated by the personal concern of the care-giver, care is still the moral reason behind the respective practice (for example in hospitals) but the motivation may be different and that:

> *'At its best, the work of care is concerned with wanting to meet someone's needs but in caring for strangers, the motivations may be different, and can be about money or a desire to keep jobs.' [6].*

In the following paragraphs, and in Reference to the findings of the Francis Report, and the failings of care at Mid Staffordshire NHS Foundation Trust, I hope to demonstrate how compassion, understood here as an attitude one may have towards people in general, is different to the work of care because it involves acting on behalf of others and is also limited to fewer people.

6. Mid Staffordshire NHS foundation trust: the findings of the Francis Report

In the ethics of care, needs play a central role but arriving at a precise specification of what counts as needs is particularly challenging when thinking of care-giving institutions [6]. In a series of articles in *The Lancet* the dominance of the biomedical model was identified as one of the major obstacles to giving the 'right care' to patients in acute hospitals [19]. Medics are educated according to the principles of biomedicine and value acute diseases offering the prospect of successful

treatment with medical specialities demonstrating the shortest length of stay having the greatest prestige. But a growing ageing population, presenting with complex medical needs, means that older people are the major users of hospital services and often accused of 'bed blocking.' This is a term mainly used in cases where older people are deemed to be 'medically fit' but waiting for home care or alternative accommodation in a residential or nursing home setting. Nurses occupy a liminal professional space within traditional, biomedical institutions (especially hospitals) and for some, the emphasis on caring is detrimental to the profession. Paley, for example, sees care being used as a paradigm to attack the medical-scientific model of nursing that prevents its real development [4].

To be admitted to an acute hospital bed, a patient must first be suspected of having an underlying medical condition requiring treatment such as heart failure, hip replacement, pancreatitis to name but a few. In hospital settings, diagnosis and treatment are normally the responsibility of the individual physician and patients requiring medical treatment may be prescribed a range of treatments from drug therapy to surgical procedure, or both. Medical treatment is increasingly premised on evidence-based medicine (EBM), a method that typically tests traditional biomedical interventions such as drugs, devices and procedures using randomised controlled trials (RCTs) to arrive at the soundest evidence of a treatment's efficacy. Working alongside physicians treating patients, nurses use their clinical expertise and monitor a patient's progress through constant observation of vital signs such as blood pressure, bodily temperature, and administering medicines etc and assisting with basic nursing care where needed.

In the case of Mid Staffordshire NHS Foundation Trust, a distressing feature of the poor care identified by the Public Inquiry was the 'plight of patients calling for water, languishing in soiled bedding or dying neglected and confused.' [3] In her evidence to the Public Inquiry, the former Chair of Mid Staffs, Toni Brisby claimed the hospital was no different to any other and that:

> *'A reaction that I've had from quite a lot of people within the NHS, which is that actually that's the sort of thing that goes on virtually in all hospitals, and there but for the grace of God go we. Now, I'm not saying that to defend poor care, [...] but I am saying that Stafford is not a peculiar hospital.' [1].*

Concerns about nursing care highlighted by the Public Inquiry identified failures in clinical care such as completing charts, weighing patients, checking intravenous infusions, dressing wounds, and avoiding pressure sores: in several instances, patients were not helped to take their medication. Other failures involved those associated with basic nursing care including:

> *'...such matters as the supply of and help with food and drink, a timely response to call bells and buzzers, attention to the hygiene needs of patients, and respecting the dignity and privacy of patients [1].*

In an article responding to the findings of the Francis Report, Anna Smajdor dismisses the claim that a lack of compassion particularly among nursing staff is to blame for poor care and argues the root cause of poor care is a lack of time and a lack of resources in the NHS but fails to specify where the scarcity lies. On Smajdor's view compassion is not necessary when caring for patients and one can:

> *'[R]emove an appendix without caring about the person from whose body it is taken, empty a bedpan without caring about the patient who filled it, or provide food without caring about the person who will eat it.' [3].*

Conflating different types of healthcare tasks (removing an appendix versus emptying a bedpan) and the roles performed by different healthcare professionals (surgeons compared to nurses or healthcare assistants) Smajdor dismisses the need for compassion and suggests 'reminders, routines, and checklists,' can do the same job as compassion [3].

The theory of obligations advocated by Onora O'Neill suggests that those who reject 'indifference and neglect' must meet demanding standards: 'but what those standards demand is inevitably variable and selective.' [18] In the context of a ward setting, patients have many different needs, including medical and surgical needs (requiring many years of speciality training) and needs associated with basic nursing care, such as wiping bottoms, emptying bedpans, changing soiled bedsheets, or dressing seeping bed sores. The tasks associated with these latter needs are usually performed by a nurse or healthcare assistant and conflating different types of healthcare needs and the roles performed by different healthcare professionals, fails to do justice to patient suffering and of the harms inflicted through neglect, that was so much a feature of Mid Staffs NHS Foundation Trust.

Furthermore, Smajdor's analysis fails to recognise a key concept in healthcare which is the prevention of suffering and harm. The current COVID-19 pandemic has triggered debate about the right for all to access healthcare and the scarcity of resources: Mannelli [20] argues that in the present crisis 'as in other circumstances in which there is a scarcity of resources, it is unfortunately not possible to avoid harm at all. The effort is to reduce it.' At Mid Staffs such efforts were not always apparent, as patients were denied water not because water was scarce, but because ill and frail patients were neglected. Care work or 'basic' nursing as it is often referred to, is integral to the work of the nurse and if a nurse or health care assistant fails to respond to the patient who says: 'I need the toilet now' or: 'I cannot hold a knife or fork but can chew and swallow' then it is hard to see how the distressing situation of Mid Staffs can be avoided in the future.

A shift in healthcare away from one in which the doctor and patient knew each other, to healthcare provided in complex institutional settings, necessitated a refocus on medical ethics. In an effort to avoid paternalism and to protect patients, more formal relationships and procedures were instigated between the two [17]. This was achieved partly through the mechanism of *informed consent* that aimed to avoid imposing medical treatment or action on patients without being fully informed. But in O'Neill's view, there are other ethically important concerns in healthcare such as 'unnecessary surgery, clinical negligence, or unwarranted risky treatment' aside from informed consent and most ethical positions do not consider informed consent as sufficient for respecting patient autonomy:

> *'Contemporary accounts of autonomy have lost touch with their Kantian origins in which the links between autonomy and respect for persons are well argued; most reduce autonomy to some form of individual independence and show little about its ethical importance.' [21].*

Other emerging trends in healthcare include the concept of *patient-centred care* in which the ideals of independence and self-care are promulgated. The phrase 'patient-centred care' originated in the United States but has gained prominence in the UK [22]. Linked to the shift in healthcare from paternalism to autonomy, patient-centre care (or person-centred care as it is more frequently known) is intended to represent the shifting of power and control from the healthcare provider or practitioner, to the patient. With patient autonomy taking precedence over paternalism or 'best interests' Jonathan Evans argues that advocating independence

for patients who are dependent upon others for help may be worthless without the necessary power needed to secure the care and attention they require [23].

Up until the late 1970s, Anne Bradshaw [4] notes that nearly every survey into nursing care contained unsolicited comments on the kindness and helpfulness of nursing staff but that patient perceptions changed in the 1990s. Under Tony Blair's government, attempts at measuring compassion using patient surveys, was proposed by then Secretary of State for Health, Alan Johnson who said patients had a right to be treated with 'dignity, respect and compassion' – a move that was supported by the Royal College of Nursing [4]. Dismissive of such moves Anne Bradshaw [4] claims it is inherently false to measure and reward the appearance of compassionate care (such as encouraging nurses in the art of smiling or the saying of warm words) for the purposes of data collection. For Anna Smajdor the 'insidious' need to measure all we touch, including compassion, is part of a broader trend that is in awe of the evidence-based structure of our health service:

> *'Some – perhaps much – of the suffering experienced by patients and healthcare professionals in today's healthcare systems, is the result of a clash between incompatible values. On one side, there is a scientistic ideology which holds that everything which is meaningful must be measurable and controllable. On the other, there is the conviction that some of the most valuable things in life are intrinsically so; […] It is not compassion per se, that is at issue here, but a far broader and more insidious need to measure all we touch.' [3].*

Following concerns about variability in medical practice and rising costs, efforts were made to make such systems more quantifiable by introducing a range of initiatives including compulsory clinical audit, quality assurance (QA) and evidence-based medicine (EBM.) [5, 19] The Department of Health in Britain in 1994 embraced the notion of knowledge-based medicine and assumed that science could identify non-effective treatments or procedures thereby creating uniformity in the delivery of services to various patients [5]. This 'scientistic ideology' according to Smajdor has contributed to much of the suffering experienced by today's patients and healthcare staff alike and has stifled our ability to care. But given evidence-based medicine is primarily concerned with the effectiveness of drugs, devices and procedures and not tasks associated with assisting patients on and off the commode, or helping with food and drink, Smajdor's claim is somewhat puzzling. This is particularly so as such tasks are typically exempt from the scientific impulses driving evidence-based medicine. And, as effectiveness and outcomes represent values and not scientific universals [5], outcomes that may be seen as good from the doctor's perspective (the patient is medically fit to go home) are not necessarily good from the patient's perspective (the medically fit patient awaiting discharge is left to languish in soiled bedding).

Furthermore, Smajdor's suggestion that 'reminders, routines, and checklists,' can do the job of compassion may only further inhibit 'human interaction and thinking, lead[ing] to an increasingly rationalised world.' [24] Such tools may be superfluous to the basic task at hand and potentially damaging to its performance. Plus, the utility of such tools when compared to the potent 'reminder' of a patient calling out for help, or the pungency of a bedpan that needs emptying remains questionable. The NHS is a much criticised and much loved organisation that some argue has taken the place of religion [25]. Misdiagnosing all that ails the NHS, coupled with gratuitous sentimentality can only prove fatal to its proper functioning in the long run.

7. Care of the self

As the capacity to care and respond to an individual's needs is one of the defining characteristics of being human, losing our ability to care can be harmful. Caring *about* something constitutes a need in itself as it can bring meaning into our lives because life perceived to be meaningless can lead to depression [6]. In the Francis Report there were many accounts in which healthcare professionals employed at Mid Staffs, expressed their distress and feelings of depression and helplessness at finding their concerns dismissed [3]. In looking to identify the causes of the Trust's failings, the Public Inquiry investigated the effectiveness of the Trust's whistleblowing policies that were 'intended to empower employees to raise concerns.' From its review of the Trust's actions in the case of an A&E nurse, the Inquiry concluded Mid Staffs did not follow its stated whistleblowing policy of supporting and protecting those who raised concerns:

> *'Ms Donnelly was offered no adequate support. She had to endure harassment from colleagues and eventually left for other employment. Clearly such treatment was likely to deter others from following her example and she was aware of colleagues on whom this had an effect.' [1].*

It was also revealed that Ms. Donnelly was failed by her professional organisation, the Royal College of Nursing (RCN). The Inquiry also noted that doctors who sought to raise concerns fared little better than nurses. In evidence given to the Inquiry by Dr. Pradip Singh, the doctor admitted he was not 'brave enough.' He told the Inquiry raising concerns would have had a detrimental effect on his health and he also feared losing his job: 'I would have then ended up becoming either a stroke or a heart attack, and being on the road.' [1].

One difficulty with care-giving institutions is the number of people needing care at any one time. This can have implications for the quality of care and can lead to the overburdening of care-givers. Unlike a utilitarian or Kantian perspective on morality, which states that one must not place the requirements of self above the requirements of others, the ethics of care makes allowances for the better care of the self and recognises the moral importance of ensuring one's own needs are met [6]. This is a view also articulated by Mary Wollstonecraft; writing in the eighteenth century on women's human rights, she advised her female readership - often deprived of opportunities for self-development - that their 'first duty is to themselves as rational creatures.' [26] In conversation with a former psychiatric nurse, she described how she was distressed at the manner in which patients were treated on the ward she worked, and explained she liked to treat patients in the same way she would treat a relative, or how she herself would like to be treated. On referral to a counsellor (provided by her employer) she was told it was unrealistic to expect her colleagues to care for patients in the same way she did, and having such expectations, would only be detrimental to her own well-being. She has since left the profession and now does odd jobs to earn a living.

At its best, the work of care is concerned with wanting to meet someone's needs and with compassion one of the six values of the NHS Constitution, staff are expected to demonstrate compassion and kindness as part of their work. Staff placed under unremitting pressure can however become estranged from each other and those 'coerced by circumstances become coercers.' [11] Michael West writing for the NHS Leadership Academy maintains NHS leaders need to embody the virtue of compassion because in an environment that is:

> *'directive, controlling, punitive, threatening or uncaring, […] compassion dries up and […] bullying becomes dominant [27].*

And in the context of care-giving institutions, care-givers need to be able to rely on people and institutional structures to support them because:

> *'For those invested with institutional power, though the responses will be different from the requirements that apply to non-institutional interaction there is no reason to believe that a citizen who wishes to live in a caring society would not have any more reason to tolerate institutional abuse than the one who wishes to live in a just society.' [6].*

The NHS Constitution lists compassion as one of six values that is central to the work of the organisation that is realised through the expression of humanity and kindness to both patients and fellow staff members. In their book *On Kindness*[11], Phillips and Taylor write that the pleasures of kindness are fundamental to our sense of well-being, a view also shared by the Mental Health Foundation in the UK that chose kindness as its 2020 theme:

> *'[kindness] Has the singular ability to unlock our shared humanity. Kindness strengthens relationships, develops communities and deepens solidarity. It is a cornerstone of our individual and collective health.' [22].*

But unkindness is now the norm in our society, according to Philips and Taylor and overcoming our current attitude towards kindness, requires a form of 'ordinary, unsentimental kindness' because:

> *'Real kindness is not a magic trick, a conjuring away of every hateful or aggressive impulse in favour of a selfless dedication to others. It is an opening up to others that [...] enlarges us and so gratifies our profoundly social natures.' [11].*

Following Freud and Winnicott, both Phillips and Taylor argue that sentimentality and nostalgia, and not hatred, are the enemies of kindness with too much kindness seen as a saboteur of fully formed independence. Gaita [28] agrees we often struggle against a disposition to sentimentality that prevents us from seeing things as they are, rather than as they appear:

> *'When concepts such as sentimentality, pathos are causes of the false, they are psychological states that can cause thought to go astray more or less as tiredness, drunkenness, fearfulness or recklessness can.' [28].*

Seeing things as they are and not as they appear, requires a form of understanding in which head and heart are inseparably combined and says Gaita 'is neither a Kantian nor a Humean thought, but one which acknowledges what is important to both of these traditional oppositions.' [28].

8. Conclusion

Drawing on the parable of the Good Samaritan and the work of Anca Gheaus and the ethics of care, this paper has explored how the concepts of compassion and care differ. The distinctiveness of care according to Gheaus lies in the desire to actively help when possible and is a more intense and engaged activity compared to compassion. In the parable of the Good Samaritan, the difference between compassion and care is best illustrated by the differing levels of involvement of the Samaritan who had the resources to pay someone to do the caring, and the

innkeeper who agreed to care for the victim in return for money. As the work of care is concerned with wanting to meet someone's needs, the motives for caring may be different depending on context, and for those in care-giving institutions, their relationship with patients remains largely instrumental and can be about money and staying employed. In extrapolating from the parable of the Good Samaritan to contemporary healthcare, the paper follows O'Neill and her arguments on the utility of abstraction and the need to take a realistic account of circumstances.

Bureaucratisation and rationalisation have been blamed for usurping the value of care with the traditional approach to care as 'my brother's keeper' falling apart in the face of such efforts. With utilitarianism now considered to be a major influencer in the practice of medicine, its influence has also seeped into UK nursing. Unlike compassion - here understood as an attitude one may have towards people in general - the work of care is concerned with wanting to meet someone's needs. The ethics of care is opposed to a utilitarian approach to care and argues for care to retain its special moral significance, a vivid sense of particular situations and concrete individuals is necessary.

In the context of healthcare, meeting the needs of concrete individuals, remains a challenge to the NHS. As care is a more intense and engaged activity according to the ethics of care, defining what counts as needs, and determining how such needs are met, particularly among patients who are most vulnerable, requires a form of thought in which head and heart are intertwined. The dangers to a healthcare system that encourages staff to rely on 'reminders, routines and checklists' rather than thinking and human interaction along with ordinary, unsentimental, everyday kindness, can only give cause for concern, and may do little to avoid the harms previously experienced by patients and staff at the Mid Staffordshire NHS Foundation Trust.

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