Nurse Education Today 39 (2016) 12–15

Contents lists available at ScienceDirect

Nurse Education Today

journal homepage: www.elsevier.com/nedt

Review

Exploring the compassion deficit debate

Rosie Stenhouse [a], Robin Ion [b,*], Michelle Roxburgh [c], Patric ffrench Devitt [d], Stephen D.M. Smith [e]

[a] School of Health in Social Science, University of Edinburgh, Medical School, Teviot Place, Edinburgh EH8 9AG, UK
[b] Abertay University, Division of Mental Health Nursing and Counselling, Bell St, Dundee DD1 1NG
[c] School of Nursing, Midwifery & Health, University of Stirling, Stirling, Scotland
[d] Leeds Teaching Hospitals Trust, Leeds
[e] Edinburgh Napier University Sighthill Court, Edinburgh EH11 4BN

ARTICLE INFO

Keywords:
Compassion
Poor care
Accountability
Care failure
Nursing

SUMMARY

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% in 2014—the second highest level since the British Social Attitudes survey began in 1983. Dissatisfaction fell to an all-time low of 15%' (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, 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

* Corresponding author.
E-mail addresses: Rosie.Stenhouse@ed.ac.uk (R. Stenhouse), r.ion@abertay.ac.uk (R. Ion), c.m.roxburgh@stir.ac.uk (M. Roxburgh), patricdevitt@gmail.com (P. Devitt), ste.smith@napier.ac.uk (S.D.M. Smith).

http://dx.doi.org/10.1016/j.nedt.2016.01.019
0260-6917/

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, 2014, 2015a, 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 Darley and Bateson's (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.

Paley 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 be 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-optimal' 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?

Discussion

- ➢ What can individuals and teams do in the workplace to prevent lowering of standards?

A critique of Paley's position is provided by Rolfe and Gardner (2013) who argue that while the participants in Darley and Bateson's (1973) study were not expecting to see a person in distress, in the healthcare environment this is exactly what nurses should expect to see—failure to notice, when a key aspect of your role requires it, therefore becomes less persuasive as an account for inaction. Furthermore, unlike the participants in the experiment, the primary role of the nurse is to alleviate distress. They note that at Mid 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?