Commentary

Character assassination? Response to John Paley, "social psychology and the compassion deficit"

Philip Darbyshire*

School of Nursing and Midwifery, Flinders University, South Australia, Australia
School of Nursing and Midwifery, Monash University, Victoria, Australia
Philip Darbyshire Consulting, Adelaide, Australia

As readers have come to expect from John Paley, his contribution to the 'crisis in care' discussions provoked by the Francis Report is thoughtful, engaging and challenging (Paley, 2013). It may also be wrong. Here's why.

Paley wants to establish a distinction between 'care' and 'compassion' being either 'motivational' or 'behavioural'. As I understand it, this suggests that a person, let's say a nurse, can have a strong caring orientation. They may want to give and know how to give compassionate, sensitive care to patients. They are (thank heavens) motivated to do this. However, something may happen at some point(s) in their world. Various "contextual factors" (home, work or both) may arise that prevent the kindly-motivated nurse from exhibiting the 'caring behaviours' that they so want to bring to their patients.

So far, so true. There can scarcely be a nurse who has never at some time berated themselves for 'not being able to do enough' or who has never gone home after a shift thinking that 'this is not what nursing and care should be like'. Almost every nurse will have been, at some time, overwhelmed by the sheer 'busyness' of a shift. They may have 'rushed things' because of the immediacy and pressure of some extraordinary emergency events. The parlous state of a staffing shortage period may have led to their overlooking some of a patient's needs. They may have been uncharacteristically brusque for a moment and might not have shown the 'caring behaviours' that are their norm. Let's file this under; 'nurses are only human, but they really are trying their best'.

* PO Box 144, Highbury, South Australia 5089, Australia. Tel.: +61 430079597.
  E-mail address: philip@philipdarbyshire.com.au.
  URL: http://www.philipdarbyshire.com.au.

Let me also assume a position that I am loathe to call 'common sense', but will anyway. Perhaps nurses' behaviours and practices are influenced by a whole gamut of factors, from individual personalities and traits, to life and professional experiences and to the cultural and organisational climate of the places they work in. In a nutshell, "Behaviour should instead be understood as the product of both person and environment" (Langdridge and Butt, 2004, p. 360).

Paley will have none of this. To determinedly try to account for the horrors described by The Patients' Association (2009), Francis (2013), the Ombudsman (The Health Service Ombudsman, 2011) and others (Clwyd and Hart, 2013) as NOT highlighting a (motivational) "compassion deficit" isn't so much a 'slide' as a ski-jump.

What takes the breath away in Paley's critique is not only that he resurrects the well worn 'person–situation' debate within ethics and social psychology (Hogan, 2009; Lucas and Donnellan, 2009; Sosa, 2009), but also that he is so keen to close it down by declaring the situationalists the clear winners. It is a stark example of what Jost and Jost wryly termed, "eliminative situationalism" (Jost and Jost, 2009, p. 253).

Such certitude is reminiscent of the situationalists' other old favourite, previously wielded by Paley in another critique, "the fundamental attribution error" (Funder, 2001; Gilovich and Eibach, 2001; Sabini et al., 2001). This is such bold linguistic puffery on social psychology's part that it could be revisioned as the 'fundamental arrogance error'. Imagine anyone so foolish and unworldly in the ways of social psychology as to fall into that basic trap. The differences of opinion between the trait/character and situation/context camps is thus semantically solidified into almost a diagnostic label, "a pervasive mistake by those seeking to account for other people's actions" — people that is, who no doubt persist with their "tendency to attribute behaviour to personality and character" (Paley, 2011, p. 252).

Some may ask of Paley's avowed distinction between motivational and behavioural "compassion lack" — who cares? I suspect that the patients and families on the receiving end of some of the well publicised care shortcomings won't be overly concerned when the end result for them was largely the same. Even if we insist that such a distinction is important, Paley may again be wrong in asserting so boldly that "there was no compassion deficit at Mid Staffs — nor is there such a deficit in the NHS more widely" (Paley, 2013, p. 1451).

Patients and families are not stupid. They understand well the difference between a) the nurse who seems genuinely concerned for them or

their relative, is clearly working hard and is doing the best that they can under difficult circumstances even when this best may not enough to prevent some lapse in care from occurring, and b) the nurse whose every attitude and action proclaims that 'I couldn't care less'.

What is so notable in many of the 'horror reports' of recent years was the preponderance of accounts of the latter. I'm going out on a limb here and hoping that Paley won't be rushing to the defence of some of the perpetrators of such travesties of 'nursing' as have recently been struck off the register by the NMC for a litany of "completely unjustifiable" and "wholly unacceptable" (not 'contextually understandable') failures of honesty, decency and care. Maybe the NMC too have no understanding of social psychology. Perhaps they mistook Sharon Turner's exhortations that patients "… can fucking wait", because "I don't give a flying fuck" (http://www.nmc-uk.org/Documents/FTPOutcomes/2013/Jul/Reasons%20Turner%20%20CCCSH%20%2027273%2020130725.pdf), as erroneously indicative of a compassion and character flaw, rather than recognising 'a narrowing of her cognitive map' (Paley, 2013, p. 1451).

Paley rightly reminds us that understanding professional ethics and behaviour is not the sole domain of the ethicist or philosopher. Knowledge from social psychology (being but one example) brings an often overlooked empirical dimension to the field. Does then social psychology and the Darley and Batson 'Good Samaritan' experiment (Darley and Batson, 1973) "plant the seeds of doubt"? Undoubtedly, but in relation to what?

Darley and Batson's work and the other landmark social psychology studies e.g. on the 'bystander effect', Milgram's 'obedience experiments' and Zimbardo's Stanford Prison Experiment have all shown what 'ordinary people' are capable of, given the existence of particular situations. Reprising these studies does not however provide the trump card that delegitimises consideration of 'personality', characteristics, dispositions, or the possibility of human agency.

Given the recent decades of systematic child abuse scandals in the Church, there may be a few "seeds of doubt" sown by relying so much on an experiment involving trainee priests in the 1970s as potential compassion exemplars, but I will set that aside.

I wonder if there may be an important distinction to be drawn between the students in the 'good samaritan' experiment and clinical nurses. These students were passing a stranger by, on the street, on their hurried way to give a presentation. We would of course like to think that people would stop to help a stranger in need but is there a moral or 'social psychological' equivalence between these students and a nurse on duty? Perhaps there is a different 'set' of expectations and obligations on the nurse because he or she is a nurse and because helping and caring for patients is their JOB. As the government's latest response to Francis, "Hard Truths" notes:

> "Ensuring compassionate care is therefore not an 'issue' for organisations providing care. It is, along with safety, the essence of the business that they are in." (Department of Health, 2013, p. 37)

Despite the near warp speed 'throughput times' in many hospitals, can we also accept that the nurse's patients and their families may not be and should not be 'strangers' but people that the nurse is involved with and has established some kind of relationship and connection with. Caring for and about patients is not an 'unusual' or exceptional act of kindness undertaken whilst 'en route' to something more important.

Paley argues that the situationalist view, derived from empirical social psychology, shows that we live in almost hermetically sealed interior and exterior worlds — the 'outside' and the 'inside'. Those standing 'outside' of a situation, it seems have no hope of grasping 'what it is like' for the person on the inside, or of understanding why they do what they do. Never the twain. This seems a particularly 'unsocial' form of social psychology, where the only ones who can possibly understand phenomena or behaviours are members of an enchanted circle of 'insiders'.

What does it mean though to be an "outsider" or "insider" in relation to the accounts of care, compassion and nursing failure described in Francis and the other reports? Are the entire 'outsider' world of 'non-nurses' to be dismissed as having no right or legitimacy when it comes to discussing or challenging 'poor care'? I would suggest that, for example, the Mid Staffs families and relatives (Bailey, 2012) were very much on the 'inside' of the "disaster of Stafford Hospital" (Francis, 2013, p. 17). Yet if I read Paley correctly, they like many others, can never have a legitimate understanding of the failures of care as they have no first hand, privileged access to the health professional's inner cognitive processes. Are nurses who happen to be managers, clinical leaders, educators, or policy makers to be ethically and psychologically 'de-nursed' and relegated to the world of looking on in "outsider disbelief"? Whose 'inside world' or 'cognitive map' will reign? Is there a polite, social psychology way of saying, "What would you know, you weren't even there at the time".

How will clinicians', close colleagues and fellow nurses' fare and what world will they be deemed to inhabit? In what sense could, for example, Mid Staffs Staff Nurse and whistleblower, Helené Donnelly be said to be an "outsider"? Her telling account, presented to the Francis Inquiry, of the thuggery, poor practice and woeful standards exhibited by some of her 'colleagues' is so revealing, precisely because she was there at the time, as "inside" as it must surely be possible to be. In Paley's fatalistic world where we seem doomed to be little more than cultural dupes and moral prisoners of our "situation", Helené Donnelly and many other good nurses like her would simply have caved in to their context on the basis that, "From outside, people are absolutely confident that they would not behave like that. Inside, behaving like that is exactly what they do" (Paley, 2013, p. 1451). Yet despite the intense difficulty of her 'situation' and the powerful pressures exerted on her, "behaving like that" is exactly what she did NOT do. I wonder why? Perhaps Hogan is correct in his assessment that "the conceptual status of 'situations' is a mess" and that paradoxically, "situations are defined by the personalities that they are supposed to influence" (Hogan, 2009, p. 249).

The situation or context for many nurses is similar. They may work in the same wards of the same hospital with the same colleagues and the same management. They can be under the same deadlines, pressures and strictures, yet they do not all behave and respond identically. Helené Donnelly explained her refusal not to 'walk on by' but to speak out and do the 'right thing' thus: "My own moral code told me that the standards of care were not right" (http://www.patientsfirst.org.uk/wp-content/uploads/2011/10/Helen_Donnelly_-_witness_statement.pdf) (p. 4). At the risk of precipitating a cardiac arrest among 'eliminative situationalists', I suggest that Helené Donnelly has *character*.

I won't attribute intention here but the impression I gained reading John Paley's editorial was that social psychology and in particular some of its more "gee-whiz" experiments were presented as a massive 'get out of jail card' that will absolve poor or negligent practice from any hint of personal responsibility and accountability. "It wasn't me gov, it was the situation what made me do it".

Perhaps the person–situation battle is just a collection of windmills tilting at each other. Many of those most active in this area of scholarship seem to agree that both situational and personal factors are important in determining human behaviour and the kinds of moral and professional choices that people make. Fleeson and Noftle (2008) have recently proposed that the person–situation debate can be resolved by accepting a synthesis that:

> "takes into account the important contributions of both the trait and social–cognitive approaches to personality." (Fleeson and Noftle, 2009, p. 150)

Similarly, Jost & Jost explain that:

> "The real lesson from empirical studies is not that character traits fail to exist, but that behavior is the product of a complex interaction between the person and the situation." (Jost and Jost, 2009, p .253)

All of this seems so eminently reasonable. People are not collections of template personality traits that predetermine their every waking

action. Nor are people automatons devoid of agency and shaped unwittingly by an all-powerful external 'context'. There are some nurses who should never be nurses and no amount of 'ethics training' will redeem them. There are toxic, malevolent cultures and environments that would test the caring and compassion of the most saintly and dedicated nurse. We have agency (not unlimited), we make nursing choices and we make professional and personal decisions. I would worry for the basic purpose and future of nursing and nurse education if we could not or did not. Education absolutely has a role to play in fostering and nurturing skilled, thoughtful, intelligent, life-changing compassionate care (see eg, Ballatt and Campling, 2011; Cole-King and Gilbert, 2011; Firth-Cozens and Cornwell, 2009; Sellman, 2011).

The nurse as an individual is inescapably part of a wider context, whether that be society as a whole or the more immediate organisational context of the workplace. There are certainly political and ideological biases that will seek to frame Francis and the crisis of care as resolutely one-dimensional, where the blame is laid exclusively at the door of either a few 'bad egg' individuals and their personal failings OR of an unchangeable monolith called 'the system'/'the culture'.

We cannot afford such a Cyclopean view of the crisis in care. Both individual people and organisational and wider contexts are assuredly implicated and we need to understand how and to stop the rot. 'Contexts' and 'situations' are not people-free zones. To a significant extent, WE are that culture, WE shape that context. The situationalism that Paley champions has a definite role to play in this understanding. It should not blind us to human flaws and character failings, rather, it should highlight how contexts and environments contribute to such a malaise. A good example here is the recent focus on "wicked problems" in health service provision. These are the seemingly intractable problems in care provision that are known to be complex, poorly formulated and multiply entwined so that seeming to 'solve' one problem can unintentionally worsen others (Burns et al., 2013). If situationalism teaches us anything it is the valuable practical and organisational lesson that there are a range of professional, social, organisational and workplace culture conditions that, if unchecked, "typically lead to moral failures" (Russell, 2009, p. 446). The good people in nursing and health care should not pass by on the other side of that obligation.

References

Bailey, J., 2012. From Ward to Whitehall: The Disaster at Mid Staffs Hospital. Cure The NHS, Stafford.
Ballatt, J., Campling, P., 2011. Intelligent Kindness: Reforming the Culture of Healthcare. RCPsych Publications, London.
Burns, D., Hyde, P., Killett, A., 2013. Wicked problems or wicked people? Reconceptualising institutional abuse. Sociol. Health Illn. 35 (4), 514–528.
Clwyd, A., Hart, T., 2013. A review of the NHS hospitals complaints system: putting patients back in the picture. Final Report (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255615/NHS_complaints_accessible.pdf).
Cole-King, A., Gilbert, P., 2011. Compassionate care: the theory and the reality. J. Holist. Healthc. 8 (3), 29–37.
Darley, J.M., Batson, C.D., 1973. "From Jerusalem to Jericho": a study of situational and dispositional variables in helping behavior. J. Pers. Soc. Psychol. 27 (1), 100–108.
Department of Health, 2013. Hard truths: the journey to putting patients first. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/259648/34658_Cm_8754_Vol_1_accessible.pdf.
Firth-Cozens, J., Cornwell, J., 2009. The point of care: enabling compassionate care in acute hospital settings. http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/poc-enabling-compassionate-care-hospital-settings-apr09.pdf.
Fleeson, W., Noftle, E., 2008. The end of the person–situation debate: an emerging synthesis in the answer to the consistency question. Soc. Personal. Psychol. Compass 2 (4), 1667–1684.
Fleeson, W., Noftle, E.E., 2009. In favor of the synthetic resolution to the person–situation debate. J. Res. Pers. 43 (2), 150–154.
Francis, R., 2013. Report of the Mid Staffordshire NHS Foundation Trust public inquiry. Executive Summary (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113018).
Funder, D.C., 2001. The really, really fundamental attribution error. Psychol. Inq. 12 (1), 21–23.
Gilovich, T., Eibach, R., 2001. The fundamental attribution error where it really counts. Psychol. Inq. 12 (1), 23–26.
Hogan, R., 2009. Much ado about nothing: the person–situation debate. J. Res. Pers. 43 (2), 249.
Jost, J.T., Jost, L.J., 2009. Virtue ethics and the social psychology of character: philosophical lessons from the person–situation debate. J. Res. Pers. 43 (2), 253–254.
Langdridge, D., Butt, T., 2004. The fundamental attribution error: a phenomenological critique. Br. J. Soc. Psychol. 43 (3), 357–369.
Lucas, R.E., Donnellan, M.B., 2009. If the person–situation debate is really over, why does it still generate so much negative affect? J. Res. Pers. 43 (2), 146–149.
Paley, J., 2011. Commentary: care tactics arguments, absences and assumptions in relational ethics. Nurs. Ethics 18 (2), 243–254 (discussion 262).
Paley, J., 2013. Social psychology and the compassion deficit. Nurse Educ. Today 33 (12), 1451–1452.
Russell, L., 2009. Is situationism all bad news? Utilitas 21 (04), 443–463.
Sabini, J., Siepmann, M., Stein, J., 2001. The really fundamental attribution error in social psychological research. Psychol. Inq. 12 (1), 1–15.
Sellman, D., 2011. What Makes a Good Nurse: Why the Virtues are Important for Nurses. Jessica Kingsley Publishers, London.
Sosa, E., 2009. 'Situations against virtues': the situationist attack on virtue theory. In: Mantzavinos, C. (Ed.), Philosophy of the Social Sciences: Philosophical Theory and Scientific Practice. Cambridge University Press, Cambridge, pp. 274–290.
The Health Service Ombudsman, 2011. Care and compassion? Report of the Health Service Ombudsman on Ten Investigations Into NHS Care of Older People (http://www.ombudsman.org.uk/__data/assets/pdf_file/0016/7216/Care-and-Compassion-PHSO-0114web.pdf).
The Patients' Association, U.K., 2009. People not numbers, patients not statistics. http://www.patients-association.com/Portals/0/Public/Files/Research%20Publications/Patients%20not%20numbers,%20people%20not%20statistics.pdf.