
Brid Hehir
Do Good Charity, UK; Battle of Ideas Committee Member, UK

Introduction

This is a summary of a conference session that was conceived in recognition of the fact that real problems have been identified in regard to the poor quality of health and social care that vulnerable people – sick, elderly and disabled people – receive in the United Kingdom. It is an issue that has been in the news pretty much constantly over the past year.

This crisis began very publicly in 2009 when Margaret Haywood was struck off the UK Nursing Register for secretly filming neglect and mistreatment of elderly patients in a Brighton Hospital. She had resorted to this underhand approach because she had not had a positive response when she tried to draw attention to the poor care she was witnessing (see debate between Paul Wainwright and Chris Belshaw in Nursing Ethics 2009; 16(5)).

Moreover, in 2009, in Stafford Hospital, appalling standards of care and chaotic systems were revealed. The fall-out from that still reverberates. Then, there was the horrific Panorama exposé about Winterbourne View where vulnerable people were teased, taunted, kicked, poked, slapped, doused with cold water, had mouthwash poured into eyes, wet wipes forced into a mouth, head butting led to a broken nose and so on. Eleven members of staff have pleaded guilty to abusing vulnerable patients and have now been sentenced (http://www.bbc.co.uk/news/uk-england-bristol-20092894). Christina Patterson’s articles in the Independent about her poor care added fuel to the fire, horrified readers and embarrassed the nursing profession sending the leadership scurrying for excuses and solutions.

And we have had the dehydration scandal. A 22-year-old diabetic patient was so desperate for a drink of water that he phoned the police from his hospital bed. The Office of National Statistics reported that 43 hospital patients starved to death last year and 111 died of thirst. Another 8 people starved to death and 21 people died of thirst in care homes.

So, nursing and care in general has been tried and found wanting. We have been accused of being uncaring and too posh to wash. Whistle-blowing, undercover reporting and filming are consequently now commonplace in care settings. All types of solutions – technical, educational and regulatory – have been suggested or are being implemented in an attempt to address this crisis of care.

This week, the government announced that it is to spend £46m training 10,000 National Health Service (NHS) workers, half of whom will be nurses and midwives, to develop skills, knowledge and competence in leadership so that they will then provide exceptional care and act as role models and inspirational leaders for future caregivers. A whistle-blowing charter ‘Speaking Up’ has also just been launched. Twenty-eight

Corresponding author: Brid Hehir, Do Good Charity, 52 Kenneth Crescent, London NW2 4PN, UK.
Email: bhehir@hotmail.com
organisations, including the Nursing and Midwifery Council, the royal colleges of nursing and midwives, UNISON and Unite, have committed to support staff when raising concerns.

Nurse recruitment is to be reviewed. Nurse education experts are to look at how universities can improve the selection process for preregistration nursing students and will examine the effectiveness of existing methods, for example, psychometric testing, emotional intelligence tests and propensity to be compassionate.

In work practice, initiatives like hourly rounds are being developed at the Prime Minister’s behest. Nurses will have to have conversations with patients and discuss their specific needs covering aspects such as pain management, positioning and personal care. And the Care Quality Commission is determined not to be caught short again as it was over Winterbourne View and is flexing its regulatory muscles.

But will any of this make a difference? The panel explored the crisis of compassion. Then, we invited the audience to comment, contribute, challenge, disagree with or question what they had heard. Here, I include three of the four commentaries from panel members. The fourth panellist, Professor Raymond Tallis, has published his views elsewhere.

**Christina Patterson, writer and columnist, columnist at the Independent**

When I was diagnosed with breast cancer nine years ago, I was pretty worried. I was worried about the treatment, and worried that I’d have to lose a breast, and worried that I was going to die. But I wasn’t worried about the care I’d get.

Actually, I should have been. When I woke up from my first operation, and had drips and drains hanging off me, a nurse told me I had to get up and get my own breakfast. Someone showed me how to clip the drips and drains to a kind of trolley thing, and how to use the trolley to propel myself to the room with the breakfast. I’d just had all the lymph nodes out from under one arm and I couldn’t lift the giant teapot, and that was when I realised that no one cared whether I got a cup of tea or not.

During that first hospital stay, and the two operations that followed, I learnt that it was perfectly normal for nurses to give the impression that they didn’t like the patients, or their job. But when my cancer came back, three years ago, I thought things would be better. When my cancer came back, three years ago, I thought things would be better. I’d heard that you could, because of something called ‘patient choice’ go a hospital where you thought they might be. The morning after the operation, I realised they wouldn’t. I’d just had a breast removed, and a big chunk of flesh, and blood vessels, from my stomach, put in the gap. Someone’s meant to check the blood vessels are still alive every 15 minutes, but after the nurse who’d been allocated to me finished their shift, no one came for two hours. When one finally did, she was rude and cross and didn’t even know what operation I’d had.

When she made some serious mistakes, and I complained, no one seemed to know who was in charge. Afterwards, I heard two nurses bitching about me at the end of my bed. For the next few days, I felt abandoned and alone. I was in serious pain, and worried that the chunk of flesh that was now where my breast had been might, as the doctor said it might, go black and die. But I was also terrified of the nurses. The surgeon had told me that I had to dry my bandages with a hairdryer very quickly if they ever got wet. When I asked a nurse for one, she told me she didn’t have time to go to the cupboard. When a friend came to visit me, and the tea trolley didn’t stop at my bed, and she asked a nurse if I could have a cup of tea, she was told off.

I didn’t necessarily expect kindness in hospital, but I didn’t expect cruelty. I didn’t expect the women around me, who were all in pain after operations, and all had cancer, to ring the buzzers and find that no one answered. I didn’t expect that the patients would be polite, and the nurses would be rude. But they were. And when I wrote about my experiences, in the *Independent*, and made a programme about nursing for Radio 4, I had hundreds and hundreds of letters and emails from people saying that they’ve had terrible experiences of nursing care too. We’ve all heard about the terrible reports into the care of the elderly, and, of course, Mid Staffordshire. When we hear these
reports, there’s a tendency to think that these are just a few bad apples. I don’t think they are. I’ve talked to many nurses, and many patients, and many healthcare managers, for a special week-long report on nursing in the Independent, and a programme I’m making for Radio 4, and I think there’s a very serious problem with it in this country. And I think it’s not just about nursing. I think, as the title of this panel indicates, that there is a real crisis of compassion.

And I think what it comes down to is culture. It can be the culture of an NHS trust, the culture of a hospital, or the culture of a ward. It can also be the culture of a society.

Cultures are set from the top. If you have leaders who aren’t compassionate, and who don’t care about the people they employ, you’re very unlikely to see compassion anywhere in the organisation they run.

It is, of course, a complicated issue. There are other people on this panel who have spent their entire professional lives addressing it, and I don’t know how much headway we’re going to make in an hour and a quarter. But I do believe there are many things that can be done. I think people who want to work in caring roles can and should be assessed for their compassion. I think healthcare managers need to make sure that compassionate care is at the heart of what they’re trying to do, and that all staff are held to account when the compassion isn’t there. I think there are ways of assessing staff for this, which aren’t just about ticking boxes. And I do think compassion can be taught. I’ve met people who are doing it, and doing it very well. If John Lewis can train their staff in empathy, then hospitals and care homes can too.

It isn’t easy to do this stuff in a culture which has increasingly emphasised the individual. I think it’s hard to turn a tide, but I think it can be done. But if we want it to be done we’ll have to decide that we want to be a society that cares more, and play our part in making sure we do.

Ann Gallagher, Reader in Nursing Ethics, University of Surrey

The late Claire Rayner, herself a nurse, said that ‘bad, cruel nurses’ should be struck off the professional register. Everyone concerned with patient care should agree. The possible causes and cure of, what some have characterised as, an epidemic of unethical practice does need to engage with the behaviour and attitudes of individuals but also with the culture of organisations and political and societal contexts.

I would like to begin with examples of some of the individuals I know and with some of the initiatives in nurse education and research that are directed towards understanding unethical care practices and sustaining ethical practice. Let’s start with Owen.

Owen is now a third year student nurse who had a previous career as an engineer. He was working with a staff nurse, Sarah, in the emergency department when an elderly patient, Lily, was admitted. After investigations, it became clear that her care would be palliative. When asked what she would like to eat or drink, Lily reminisced about holidays at the seaside and said she would really like a soft ice cream. The hospital ice cream machine had broken down and Owen agreed with Sarah that he would drive to the local McDonalds at the end of his shift. He returned with the ice cream and Lily’s friend helped her to have this. Lily died some hours later. Such small acts of kindness are not unusual in our NHS and need to be acknowledged [See Nursing Ethics Editorial at http://www.surrey.ac.uk/healthandsocialcare/Files/PDF/ActsOfKindness_Editorial_NEJ19%203.pdf]

Martha is a senior nurse and an exemplary role model for ethical practice at a local hospital. We had been talking about a piece I had written on the theme of ‘slow ethics’. She emailed me later with the following message:

‘We are all so bombarded every day, all day, with information, with demands upon our time, that the opportunity for quiet reflection becomes eroded [. . . ]. Coupled with the quantity of information comes demand to get everything done quickly and finesse is lost, because we are sadly looking for a quick fix, the quick reply, the short cut. And everyone is under so much pressure, so taking time is a luxury’. 
There are many colleagues whose work in professional education and nursing ethics research I would like to tell you about. One colleague has initiated a process to support students when the concerns they raise about care practices need to be escalated. Another colleague, who teaches physical assessment skills, reminded me of the high level of knowledge, skill and ethical sensitivity required to engage in what an observer might consider a mundane task, such as taking an older person to the toilet. Yet another teacher colleague brings together students from our drama school and student nurses to role play and reflect on practice situations and to rehearse ethical responses.

Teachers, including myself, also use accounts and reports of unethical practice, such as Christina’s Radio 4 programme ‘Care to be a nurse?’ and reports from the Patients Association, the Health Service Ombudsman and the Care Quality Commission to keep students close to the patient and family experience, enabling them to recognise the impact of their actions and omissions and to consider how such practices can be avoided.

The journal Nursing Ethics is now in its 19th year and, as Editor, I am privileged to have the perspectives of nurse researchers and teachers from around the world. There were 200 participants at our recent nursing ethics conference from 28 countries. The conference theme was ‘Overcoming Challenges to Ethical Caring’. Researchers in our field examine the experiences of older people in care, their relatives and the staff who work with them and also analyse concepts such as dignity, respect, compassion, wisdom and courage. Other research relates to staff experience of moral distress in circumstances where they know the right thing to do but feel unable to do it, generally due to organisational constraints. Some have examined the relationship between moral distress and the ethical climate of the healthcare organisation. Unsurprisingly, the better the ethical climate the less moral distress is experienced by nurses.

The title of this event refers to a crisis of compassion. One definition of ‘crisis’ refers to ‘a turning point of a disease when an important change takes place’ and my hope is that by working together this change will be towards recovery. By way of conclusion, I will make three main points:

First, care work is complex, challenging and ever-changing – Nurses and other professionals need to hold firm to professional values when these are challenged by organisational values that prioritise financial targets over patient dignity and societal values that diminish older people and those with disabilities.

Second, I can confirm that we are on our case – Explanations for uncaring practices require an understanding of individuals, organisations and the wider societal and political context – single concepts and simple solutions will not do. We do not need additional ethical guidelines, pledges or manifestos but rather bottom up approaches with values-based leadership to sustain ethical practices from the boardroom to the bedside and beyond. Nursing research, education and UK initiatives by the Royal College of Nursing and the Department of Health are actively engaged with understanding and responding to unethical practices.

Finally, it is a both a privilege and a responsibility to be a nurse caring for people when they are at their most vulnerable. But in a culture where care is devalued and care work is considered low status – perhaps seen as women’s work that anyone can do – and where there is little reporting of the value of nursing, it seems unlikely that the brightest and the best of our young (and older) people will consider this as career options. It is in all of our interests that they do.

Alka Sehgal Cuthbert, English teacher, PhD researcher, education, University of Cambridge

We need to look at, and have a deeper think about the nature of the problem we face, which is less of horrific but rare misdeeds and more of an everyday casual callousness. Otherwise we propose solutions based upon the ‘wrong diagnosis’, which often make matters worse. So it’s worth considering the nature of liberal professions – namely (for this discussion) the medical and educational professions.
These professions developed at a particular period in history where they have been afforded a high degree of autonomy. Their institutions, procedures, rules and codes have by and large been implemented and regulated by autonomous bodies. In this framework professional relationships were formed. The underpinning level of privacy and autonomy was compatible with professionals in general acting in a professionally moral way. Whilst there could be problems such as automatic deference and corruption, the liberal humanist professions also encompassed respect for humane learning and knowledge. During the 1980s a political reconfiguring between government and existing professional institutions took place and existing relationships and centres of authority were displaced. This partly accounts for the contemporary trend to devalue past knowledge and experience – this has to be devalued for new centres of authority to be established. Those with loyalties to a traditional concept of professionalism are often seen as ‘sclerosis at the point of implementation’ in the words of one health manager at a recent conference I attended.

The responses of individual professionals to this situation tend to fall into three categories: conversion to new managerial, target driven culture, burn out, or amotivation. The last of these is probably the most common response. It is when an individual feels no connection between his/her inner volition and their external acts, irrespective of whether the acts are praised or criticised. So the sticks of being ‘last in the league tables’ or the carrots of coming first in competition for ‘nurse or teacher of the year’ are meaningless in terms of a traditional idea of professional commitment. Where once people entered such professions with the hope of incorporating a large part of their personality and volition in their work, they now feel more like they have to reduce their personal commitment for self-preservation. For example, qualifying medics who point out they are working far longer than their scheduled hours are likely to be told they need more time management training rather than to be thanked for their effort and commitment.

The outwardly negative effects of this technical or instrumental managerialism are well documented. It diverts important time and energy needed for what is often emotionally demanding work. This much is clearly visible. Less visible is how this tends to also reduce our moral imagination. That is our capacity to include many strangers in our imagined circle of concern. We do not have to personally love every patient or pupil that stands before us. We do need to be able to envisage them within what Nussbaum has called ‘an imagined circle of care’ and have autonomy enough to make our inherent moral inclinations manifest. Everyday moral acts cannot be engineered mechanically but we can create conditions favourable to moral behaviour to flourish; and we can also create the reverse, as we seem to be doing today.

While the intellectual/cognitive aspects of any profession can be subjected to scrutiny and intervention, and professional procedures can be improved (for example, stipulating that all patients are asked if they need the toilet on a regular basis) the space in which professional knowledge combines with individual commitment and morality – the space of practice – needs a high level of autonomy. This is because a moral act, by nature, has to be chosen and offered freely; it has to be inner-directed and orientated towards establishing a relationship between the individual professional and the patient or class (not some intervening quality control mechanism).

Problems of casual callousness in the nursing and care services indicate a broader cultural shift of our conception of individuals. Basically, if we understand individuals to be essentially spontaneously moral beings, then autonomy is not a problem, because moral acts will tend to happen if people have the ‘space’ in which to enact such acts. But if we understand individuals as being essentially amoral or immoral, then moral behaviour can only emerge by controlling or curbing more and more of our behaviour via external techniques and controls. This reduces our space for autonomous choice and acts; and the more we try and manufacture certainty, the more we undermine the very need for moral choice and action. In other words an element of uncertainty or risk is an intrinsic element of any moral act – bad and good. Checklists and new monitoring schemes may result in greater compliance, which feeds into, and intensifies a climate of mistrust of others and ourselves, lest we fall short of some externally imposed measure. But compliance is antithetical to true moral behaviour.
Discussion

During a lively discussion, differences among the panellists’ views became more apparent, particularly over the issue of whether compassion can be taught. In conclusion, Christina supported motivational talks and teaching empathy; Ray thought a shift from covenant to contract was detrimental to genuine caring; Ann reminded us that our concern needs to extend to nurses and medical staff whose work is often costly in emotional terms and Alka stressed that the unique qualities of a moral act such as caring are antithetical to template teaching that really treats people like Pavlov’s dogs.

As is common in Battle of Ideas (BOI) discussions, more questions were raised than were possible to pursue in depth, but the audience were encouraged to carry on the conversation informally afterwards. Feedback about the session was overwhelmingly positive, many saying that it had begun to help them understand the basis for the crisis. That for us at the BOI is what it is all about – not assuming that solutions can be found without first interrogating the issue from a number of perspectives. If you have enjoyed this review, consider attending the ninth BOI in October 2013. Information can be accessed from http://www.battleofideas.org.uk/ or contact Bríd Hehir on 02072699224.

If you would like to comment on this or any other item in Nursing Ethics, please contact the Editor on nursing-ethics@surrey.ac.uk.