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Organizing through compassion: The introduction of meta-virtue management in the NHS

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Abstract

This paper investigates the comprehensive compassionate care reform programme within the National Health Service (NHS) in England. Through a synoptic reading of policy documents, we show how ‘compassion’ is introduced as an overarching meta-virtue designed to govern all forms of relationships and formal positions in health care. Invoking an ‘ethics of office’ perspective, mainly drawing on the thinking of Max Weber, we evaluate the promotion of compassion as a managerial technology and argue how seemingly humanistic and value-based approaches to healthcare management might have unintended consequences for the quality of care and the conduct of health professionals that in some ways resemble and in some ways exceed those of the more traditional New Public Management measures, which the new compassion paradigm is expected to outdo. In the paper’s final sections, we turn to the original work of the nursing icon Florence Nightingale to argue that compassion and oth-

er virtues should continuously be formulated and re-formulated in relation to the role-specific skills and duties of particular offices in the healthcare sector.

Keywords: Compassion, healthcare management, Max Weber, the ethics of office, Florence Nightingale

Introduction

In recent years, we have witnessed a growing research focus on the concept of compassion¹ and a remarkable increase in publications exploring compassion in various contexts. Parallel to this growth, compassion has become a policy trope in the Anglo-Saxon world, where compassionate attitudes, leadership or governance are means to improve the quality of everything from banking (Martin and Cahan 2013) to stakeholder relationships (Hopkinson 2014), social entrepreneurship (Atkins and Parker 2012), corporate volunteering (Grant 2012) and higher education (Gibbs 2017). In healthcare management, compassion is promoted as a new managerial tool – equally a response to scandals of below-standard care and a new kind of policy invention to compensate for what are seen as the accumulated flaws of contemporary programmes of public sector reform.

The increased focus on compassion has been linked to a historical transformation of social expectations of compassionate behaviour and attitudes in organizational life, where it seems that both professional service providers and clients increasingly expect particular expressions of compassion as integral to public service (Flores and Brown 2018). In

¹ Compassion has numerous definitions and associated concepts and is difficult to delimit. Etymologically compassion comes from the Latin *compati*, which means ‘to suffer with’ or ‘to suffer together’. This original meaning is not unrelated to common definitions or everyday understandings such as ‘feeling sorry for somebody with problems’ (Clark 1997: 30) or the ability to ‘express empathy, provide emotional support and a willingness to understand and relieve another’s distress and suffering’ (Mannion 2014: 115).

healthcare, such demands and expectations have traditionally been imperative for the predominantly female care professions – such as healthcare assistants, nurses and midwives.²

In this paper, we look at what happens when the demands for compassion not only originate from patients' or public expectations of healthcare professionals in general – or of the caring professions in particular – but also become a universal means to organize and manage healthcare organizations and a policy instrument to regulate conduct on all levels of healthcare organizations. The empirical case of our paper is the comprehensive compassionate care reform programme in the National Health Service (NHS) in England, which has in recent years turned its focus towards health professionals' ethical conduct and the development of compassionate attitudes and character as the foundation for delivering high-quality care (Department of Health 2012, NHS 2014a). The compassion agenda is described as a response to what are identified as two highly interrelated problems. On one hand is the increase in healthcare scandals concerning breaches of safety or cases of below-standard care. Here the so-called Mid Staffordshire case, which resulted in a number of highly influential public inquiries conducted by Robert Francis in 2010 and 2013, is of particular importance. On the other hand, the compassion agenda is promoted as a response to an accumulated dissatisfaction with what is identified as an increasingly dominant control and target culture resulting from the large number of New Public Management (NPM) reforms that have swept British healthcare since the 1980s. Compassion scholars argue that

² The expectation of an inherent link between compassion and a caring – predominantly female – profession have found support in certain parts of gender studies, not least in the early days of feminist care ethics, where women were often understood to be of a more caring, compassionate and relational moral nature than men (Gilligan 1982, Noddings, 1984). Other parts and newer voices within the ethics of care (Reverby 1987a, 1987b; Tronto 2001; Koggel and Orme, 2010) seek to avoid this type of gendered essentialism by situating the discussions and studies of care in their historical, social and practical contexts and/or by approaching care as a potentially gender neutral activity.

these reforms have led to command-and-control leadership practices (de Zulueta 2013a, 2013b), to shifts towards ‘impersonal surveillance systems coupled with cost savings measures’ (Fotaki 2015: 201), to dysfunctional incentives associated with meeting external performance targets (Mannion 2014) and to ‘a reifying scientific ideology that make mere things of patients and staff alike’ (Smajdor 2013a: 115). Thus, the vices attributed to the NPM reform movement – which the compassion agenda is developed to outdo – are many and varied.

The policy tendency to introduce compassion as a solution to diverse challenges of organization finds support in the rising scholarly interest in compassion within management and organization studies (Simpson, *et al.* 2014) and, specifically, in newer research fields such as positive organizational scholarship (Cameron, *et al.* 2003, Dutton *et al.* 2006, Lilius, *et al.* 2011) and compassion science (Seppälä, *et al.* 2017). In these new strands of research, compassion is often promoted as all-encompassing and generalized organizing-principle (Rynes, *et al.* 2012: 505) that can help promote ‘compassion organizing’ (Dutton *et al.* 2006) or ‘caring and compassionate organizations’ (the title of a 2012 special issue of the *Academy of Management Review*) as solutions to various organizational or managerial problems. Furthermore, those engaged in the compassion agenda – whether theoretically or practically – share a high degree of enthusiasm in actively promoting it, mostly as a thoroughly positive concept, across organizational functions, positions and activities.

In this paper, we critically engage with both the enthusiasm and the all-purpose approach that accompany current understandings of compassion. We argue that although the turn to compassion is often understood as a noble attempt to create more humanistic public sector organizations by overcoming the failures of earlier reform programmes, the attempts to make compassion a key policy concern have important unintended consequences. Through a synoptic reading of health policy documents, and by drawing on an ‘ethics of office’ tradition

represented by Max Weber (1978, 2004a, 2004b) among others, we explore how and with what consequences compassion as an overarching moral virtue (Maritain 1951) – or what we term a *meta-virtue* – is cultivated in current reform programmes to signal a new area of management by identifying, developing and rewarding compassionate attitudes in staff – from front-line student nurses to hospital managers and board members – independently of differences between professional roles, tasks and contexts.

In the paper's final sections, we turn to the original work of the nursing icon Florence Nightingale (1860) to discuss how the virtues of care work in general and in nursing specifically have traditionally been approached as thoroughly task- and role-specific. On the basis of this, we point to the possibility of offering an office-based perspective on virtues such as compassion which is devoid equally of the abstractions of large-scale policy agendas or the expectation of compassion as a natural character trait of – often female – care workers.

Background: Care scandals and failures of policy in the NHS

Of the scandals that have paved the way for the compassion agenda in the NHS, the Mid Staffordshire case has been most important for its intense after-play of public outcry, inquiries and political promises of betterment. The compassionate care programme has been described as a direct result of what is termed the Francis effect, named after the two public inquiries into the scandal in 2010 and 2013 (Francis 2010, 2013a). The Francis inquiries told an uncomfortable story about appalling incidents of suffering by large numbers of patients at Stafford Hospital between 2005 and 2009. The inquiries showed in detail how the Mid Staffordshire NHS hospital trust, which ran the hospital, had for years failed in its primary duty to protect its patients and to maintain confidence in the healthcare system. Staff morale was reported as low, and although many did their best under difficult circumstances (unmanageable workloads; lack of training; dysfunctional teamwork, collaboration and

leadership), the failures were said to signify a low point in the quality of care. One concurrently noted cause of the scandal was a shortage of nursing staff, which had resulted in the use of a large group of low-paid, unregistered and often unsupervised healthcare assistants. Additional reported causes of the scandal included staff burnout and emotional stress and a work culture of defensiveness, secrecy and tolerance of poor standard care. Such cultures were predominantly described as a result of the system, and it was argued that, for instance, ‘the emergence of such attitudes in otherwise caring and conscientious people may be a mechanism to cope with immense difficulties and challenges thrown up by their working lives’ (Francis 2013a: k1351).

Despite this systemic perspective of the inquiries, the scandal was quickly linked to the moral conduct and character of the health professionals, the managers and the board members in question. The link between moral character and the scandal was partly supported by some of the Francis inquiries’ 290 recommendations which included, for instance, the introduction of aptitude tests to secure compassionate character traits in future nurses, or the much-discussed suggestion to let aspiring nurses work as healthcare assistants before joining nursing college in order to develop compassionate behaviour. The report also recommended the introduction of mandatory performance appraisals for all nurses and clinicians based on feedback and satisfaction surveys from patients, relatives and colleagues (Francis 2013a). Such suggestions paved the way for a wider call for compassion in the NHS whereby standards of compassionate care should be adopted and implemented widely in healthcare organizations. Although the policy programme was initially directed primarily at nurses, midwives and care staff and their management, the compassion agenda has increasingly become a policy trope that includes the whole of the NHS.

In support of this turn to compassion as a new policy trope, the apparent character flaws that had led to what was politically deemed a lack of compassion were linked to

critiques of dominant ways of organizing healthcare, in which, it was argued, NPM had led to a ‘hard’ culture focused on performance targets, economy and measurement. The compassionate care programme was therefore ‘to replace tick-box targets as the major focus on boards and wards’ (NHS 2014a) and should accordingly be understood as a challenge to and replacement of dominant elements of the NPM agenda (Department of Health 2012). This argument sat well with a rising critique by practitioners and scholars alike about NPM and the introduction of market-type mechanisms’ unintended and often unwanted effects on professions, work systems, management and the relationships between patients and professional expertise (see, for instance, Dent 1993, Fitzgerald and Ferlie 2000, Doolin 2002, Bevan and Hood 2006, Harrison and McDonald 2008, Waring, *et al.* 2010). Many of these critiques have focused particularly on the underlying rationalities and unintended effects of new kinds of externally imposed accountability and audit measures, including the widespread use of performance indicators, target setting, benchmarking and performance management (Power 1997, 2007). Thus, with a view to larger policy trends, the compassion agenda can be understood as part of a larger public reform landscape in which ‘softer’ and more value-based approaches to public management are increasingly introduced as corrections to the dominance of more market-based managerial ideologies (Pollitt and Bouckaert 2017, Moore 1995, O’Flynn 2007).

An office-based approach to the compassion agenda

In this paper, we encourage an office-based approach to understand and contextualize the current compassion agenda. In applying this approach, we draw attention to some of the practical and normative consequences for the organization of healthcare and the conduct of healthcare professionals that follows from this new layer of policy. More specifically, we turn to literature on office and office-holding and to a particular tradition of ethical thought: the

ethics of office, or what is more commonly known as role-morality (Condren 2006, du Gay 2009, 2017, Hennis 2000, Lopdrup-Hjorth and Roelsgaard Obling 2018). This is a tradition of ethical thought that is often sidestepped in the current landscape of the dominant ethical theories of consequentialism, deontology and virtue ethics, but which has a long and influential history, from Cicero's *De officiis* (44BC/2014) to Pufendorf (1673/1991) to Max Weber (1978, 2004a, 2004b) and to sociologist Paul du Gay's (2007, 2013) more recent work. In what follows, we turn especially to Max Weber, who has been placed in the continuous tradition of the ethics of office through his theorisation of bureaucracy as *officium* and the office-holder as a *persona* (Condren 2006: 24, 347).

The Weberian ethics-of-office perspective is relevant for the discussion of the compassion agenda in two important ways. Firstly, in Weber's understanding, office-holding is tied to a specific office which cannot be organized by the values of another office. To understand this conception of office, one must turn to Weber's idea of life-orders (*Lebensordnung*), which refers to different spheres of life, each existing independently with its own identifiable moralities, norms, responsibilities and expected life-conduct (*Lebensführung*; Weber 2004a, 2004b). According to Weber, offices are irreducible to one another and there are no overarching virtues that cover, so to speak, all of these. Instead, each office places certain office-specific demands and expectations on the people who are educated to occupy it. Furthermore, an office is manifested not in an individual but in a 'persona'. The distinction between an individual, understood as a reflective and autonomous self (du Gay 2008: 338, see also Condren 2006: 29), and a persona, understood as specific to an office, is important. Thus, to give a short example from healthcare, it is the professional and procedural character of medical conduct that makes up a distinctive medical ethos, and not any personal attitude or individual conviction. Thus, substantive ethical goals and what we recognize as ethical conduct accompany the office and not the individual occupying it.

This takes us to the second point. With his account of office and the expectation that people must behave according to the requirements of their respective offices, Weber delivers an important antidote to the call for subjective responsiveness and enthusiasm in current public sector reform programmes (du Gay 2008). According to Weber, what characterizes bureaucratic organization broadly understood³ was the strict separation of the office-holder's personal preferences and beliefs from the moral and functional content of offices. Thus, Weber writes in *Economy and Society* (1978: 975): 'Bureaucracy develops the more perfectly, the more it is "dehumanized", the more completely it succeeds in eliminating from official business love, hatred, and all purely personal, irrational, and emotional elements which escape calculation'. Weber (1978: 600) further states that the public servant as an office-holder must act 'without regard to the person in question, sine ira et studio, without hate and without love (...) but sheerly in accordance with the impersonal duty imposed by his calling, and not as a result of any concrete personal relationships'. The German word for 'impersonal' in the quote is *sachlich*, which means 'attending to the matter at hand'. A caring nurse is thus *sachlich*, but not a machine-like automaton devoid of human qualities (understood as impersonal). For du Gay (2000: 75), the stress on impersonality as a crucial feature of bureaucratic rationality in Weber's descriptive analyses is not tantamount to an elimination of emotional elements, as long as 'these do not undermine the ethos governing the conduct of that office, through for example, opening the doors to corruption or

³ Within the sociology of professions, it is common to identify a conflict between professionalism and bureaucracy (Freidson 2001). Weber, however, never distinguished between the authority of office and the authority of expertise or professionalism, and it is often argued that healthcare organizations, and especially hospitals, should be approached as 'professional bureaucracies' (Mintzberg 1979) in which clear lines of command and the delineated and well-defined distribution of responsibilities and obligations through a system of offices are the preconditions for the exercise of clinical discretion and professionalism (Perrow 1972/2014).

encouraging inappropriate forms of patronage’. A clinician can be expected to be impersonal in order to process patients, provide services and apply rules evenly. Here, the conception of impersonality also refers to the professional capacity to treat everyone impartially, without paying attention to patients’ status or individual attributes. For healthcare professionals impartiality entails a duty to decide on cases and care for patients unbiased by personal relations or feelings. This also includes the ability to strike sensible promises between various demands, and to decide when and in what situations to apply a professionalized ‘compassionate attitude’ as an integrated part of the official duties and obligations of office-holding (Zacka 2017)⁴.

It is with these two Weberian tropes in mind – the irreducibility of a system of offices to any kind of meta-virtue and the impersonality or *sachlichkeit* of public offices in bureaucratic organizations broadly understood – that we now return to the compassion agenda in the NHS.

Meta-virtue management

In the process of introducing compassion as a key policy concern in the NHS, the concept has come to be defined in many ways to answer particular policy problems, to continue existing managerial practices, to develop new types of control mechanisms and to support a rhetorical

⁴ Bureaucratic forms have been subject to intense scrutiny in the last decades. One dominant strand of literature has argued that we have entered the ‘era of total bureaucratization’ (Graeber 2015) and that bureaucracies in practice are often both corrupt and dysfunctional, partly because the idea of separation between the person in private and public functions can be hard to maintain in practice (Jørgensen 2012, Hodson, *et al.* 2012, McCabe 2015, Clegg, *et al.* 2016). At the same time, another strand of literature have sought to revitalize bureaucracy. While acknowledging that in practice bureaucratic organization can fail, as can any organizational form, this is a strand of literature that shows how undermining bureaucratic virtues of, for instance, formality, impersonality and office-based responsibility structures, statuses and hierarchies in state bureaus as well as in public service organizations can have fatal consequences (see for instance, du Gay 2000, Perrow 1972/2014, Goodsell 2004, Zacka 2017).

strategy of change, innovation and improvement (The Kings Fund 2017). In the Compassion in Practice strategy (Department of Health 2012), compassion covers everything from care to competence, communication, courage and commitment. In other policies, compassion has been promoted as a generic virtue or personally trait comprising all the characteristics that a healthcare leader must aspire to, including emotional intelligence, resilience, integrity, authenticity, balance and motivation (NHS 2014a). Thus, as an overarching policy trope, strategy or solution, compassion tends to mean everything and nothing. Then Chief Executive of NHS Employers Dean Royles (2014), in his blog ‘Compassion is one of our few infinite resources’, defined compassion thus:

Compassion can be innate and it can be taught and learned. It can be central to who we are and what we stand for, but far more importantly it can come in small doses and those small things can make a huge difference to the way people experience care. That positive experience can also help build values, it is a truly virtual circle of good (...) compassion is so close to love.

Apart from being highly abstracted, this quote also shows how compassion is promoted as a thoroughly positive concept: who can be critical of something ‘so close to love’?

This very broad and positive definition makes it possible to understand compassion as an overarching virtue required for the performance of any of the tasks and obligations facing an NHS employee, whether nurse, midwife, physician, surgeon, chief executive or financial manager. The bolstering of compassion in the NHS is formulated as an urgent need even ‘amongst commissioners and throughout arm’s length bodies, assurance and oversight bodies’, reaching far beyond the healthcare institutions themselves (NHS 2014c: 2). Thus, resembling what Maritain has described as ‘hypermoralism’, the NHS policies can be said to hold a moral position that applies ethical norms – what we here term *meta-virtues* – to

everything from interpersonal relations to group activities and political situations (Maritain 1951; see also Rohr 1998: 19–22).

Although compassion is understood as a guiding value for the whole of NHS, most of the policies particularly address either nursing, midwifery and care personnel or their managers. But also here, the compassion agenda remains mostly unrelated to particular roles, tasks and care practices. The follow-up strategy to *Compassion in Practice* (Department of Health 2012), *Leading Change, Adding Value* (NHS 2016: 1), is defined as ‘a framework for all nursing, midwifery and care staff. It can be used by everyone, wherever you work and whatever your role’. Likewise, the meta-virtue approach of the compassion programme is particularly evident in the NHS policy on compassionate leadership (NHS 2014b). A main finding of the public inquiries following the Mid Staffordshire case was that the care scandal arose because of NHS leaders’ poor decision-making and their prioritizing of financial health and performance targets above safe and appropriate care (Francis 2010, 2013a). Within the compassionate care agenda, these findings are used to develop policies particularly targeting leaders, as the leaders – through the building of a compassionate character – are understood as the change agents who can make possible a radical transformation of the NHS culture and environment. Thus a compassionate leadership programme has been introduced, built on the assumption ‘that greater compassion within and through leadership has the potential to (re) align the NHS to its core purpose and truly transform patient care’ (NHS 2014b: 10).

But what are the consequences of promoting compassion as a meta-virtue across contexts and roles in the healthcare system? The distinctiveness of offices and the personae occupying them, and the associated problems of assuming that compassion can guide all of these, can be illustrated in relation to clinical work. Often, for instance, compassion seems to be a more relevant virtue for a nurse involved in direct care activities than for a surgeon who spends most of her time in the operating theatre. This difference is evident in our social

expectations for the emotional behaviour and attitudes of healthcare professionals. Nurses, midwives and healthcare assistants are expected to be compassionate, empathic and caring in their meetings with patients to such an extent that the concept of compassion fatigue has gained prominence to describe stress, burnout and an inability to nurture related to ‘the continuous offering or giving of self’ (Harris and Griffin 2015; see also Nolte *et al.* 2017; Peate 2015). And vice versa, we often associate surgeons with a cultivated emotional distance and dispassion that is understood to be necessary if they are to ‘inoculate themselves against the dispositional contagion of suffering and death’ (Brown 2016: 28). So, notwithstanding the calls for clinical empathy from research environments and policymakers, the public perception of surgeons is often one of detachment rather than compassion (Brown 2016, Bloom 2016).

Although these ideas of the dominating virtues of the different professions already question the applicability of compassion as a meta-virtue across offices, it is evident that the requirement with respect to a compassionate attitude is highly situation-based and therefore also unequally relevant within each office. Thus, for instance, compassion might well be a virtue also for the surgeon, for instance in the medical encounter where she is disclosing a serious diagnosis to a patient. Here exhibiting kindness, empathy and compassion is an important part of the role. But compassion could well be a vice in the operating theatre, where a surgeon’s compassion towards and ‘suffering with’ a patient might interfere with delivering the best possible surgical result. Rather, the conduct of the surgeon is here to be guided by the mastery of sophisticated skills of surgery, a strict adherence to rules and protocols and ‘a professional posture of calm rationality’ (Brown 2016: 28) to secure the necessary discretionary abilities in instances where critical decision-making or swift action is needed. Abilities that, one might suspect, will not be optimized by overly compassionate

feelings for the patient. As noted polemically by Paul Bloom (2016), it is not meaningful to insist that the surgeon empathise with the cancer as she cuts out a tumour.

If we look to the NHS leadership programme for another example, it is here equally evident that in relation to some – perhaps most – administrative and managerial functions and tasks, compassion can easily be a vice rather than a virtue. For a patient-flow manager, for example, it is essential to practice the office with a developed sense of justice, treating everyone equal independent of kith, kin or class. Here it is ethically – and often also legally – required that the flow manager prioritize and act with cultivated indifference to the particular patient in question, looking only to distinctive criteria (such as need, illness stage and legal frames) when deciding, for instance, who is to have the earliest available time slot for surgery. When main virtues imply securing fairness and equality through impartiality, the demand for compassion becomes problematic, as this would make possible situations in which the patient-flow manager is likely to prioritize patients for whom he or she had the most compassionate feelings. In this particular situation, a compassionate ethos is therefore likely to conflict with the values of equality, equity and justice traditionally so central to the NHS.

Thus, whether compassion is to be understood as a virtue or a vice is not only office-based but also highly situation-based and, as such, dependent on the discretionary abilities, practical rationality and casuistic skills of the health professional to decide – based on the traits of the particular situation – whether a compassionate attitude is required or not. It might even be argued that deployment of a compassionate attitude is to be based on a prior *sachlich* (Weber 1978, du Gay 2000) evaluation of the particular needs of the situation at hand.

Selecting and fostering compassionate identities

Apart from being highly abstracted, the NHS's approach to compassion is characterised by being not so much about conduct, skill or training as about identity. The underlying assumption of policy is often that to deliver compassionate care, one must *be* compassionate. Because of this assumption, the compassionate care programme becomes partly about selecting for already compassionate characters and partly about fostering compassion in the selves of health professionals in the NHS. As for the selecting process, the Francis Inquiry recommended various means to identify such compassionate character traits in, for instance, aspirant nurses (Francis 2013a). One idea was that the Nursing and Midwifery Council should consider the introduction of an aptitude test to be 'taken by aspirant registered nurses prior to entering into the profession to explore the candidate's attitude towards caring, compassion and other necessary professional values' (Francis 2013b: 77). This was a somewhat counter-intuitive recommendation of the report that had otherwise taken a systemic stance on the conduct of health professionals, stating continuously that the tolerance of poor practice was a cultural and systemic problem that affected otherwise caring people in a negative way (see, for instance, Francis 2013a: 1368). However, the subsequent introduction of a new national value-based recruitment framework to ensure 'that the NHS is recruiting the right people with the right values and behaviours to be compassionate and caring' (NHS 2013: 42; see also NHS 2016) supported this idea of compassion as an inbuilt character trait of individuals and includes an increased use of personality and aptitude tests.

Other initiatives are based on the idea that compassion can be stimulated in NHS employees. To this purpose, the compassion agenda developed, promoted and to some extent implemented new types of virtue-developing, -accessing and -rewarding technologies to foster compassionate selves. A virtue-developing suggestion is, for instance, the much-discussed recommendation from the Francis (2013a) report that student nurses complete a

period of healthcare work, in the role as untrained healthcare assistants, before applying for nursing college. Here the assumption is that such work can help develop a caring and compassionate attitude in the nursing students. Other virtue-developing techniques include more therapeutic tools such as the Scottish NHS's Valuing Feedback programme, which focuses on supporting compassionate care practice through feedback processes and appreciative listening techniques to help patients, relatives or staff recall 'being touched' (Smith 2017). Also, the NHS Compassion in Practice e-Learning programme supports 'compassionate care through a model of the compassionate mind' and in so doing, 'identify[ing] the core attributes and skills' needed to deliver compassionate care (Shropshire Community Health 2017).

As for virtue assessment, NHS has experienced an increased focus on incentive structures that support compassionate behaviour, such as employee rewards and bonus systems linked to quality-of-care measures. This development was initiated by former prime minister David Cameron, who, in the wake of the Mid Staffordshire case, declared that 'we need a style of leadership from nurses which means poor practice is not tolerated and is driven off the wards' and that one way of achieving this was that 'nurses should be hired and promoted on the basis of having compassion as a vocation' and not just training, skills or academic qualifications (Campbell 2013). The focus on developing 'valid and realisable measures and methods to assess and reward compassionate care' (Lown 2014: 200) has led to an increase in the attempts to measure compassion in ways that are not essentially different from much of the NPM measures that the compassion agenda is understood to outdo. In the vision and strategy for nursing, midwifery and care staff, *Compassion in Practice* (Department of Health 2012), 'measurement of impact' was explicitly identified as one of six action areas. Further, in the follow-up plans (NHS 2014a: 2016), it was evident that most action areas involve a steady focus on measuring, not least with the use of patient experience

and patient feedback as new dominant control mechanisms. With new and more ‘soft’ headlines, the measuring schemes include, for instance, the Friend and Family initiative, which is a ranking of hospitals based on a patient-survey question about whether patients would recommend the hospital to family and friends. The test is said to measure ‘how successfully health and care services treat people with respect, dignity and compassion, so that we can make changes, where necessary’ (Department of Health 2015). Another technology to assess and reward compassion includes the ‘Leading with Compassion Recognition Scheme’ whereby patients and relatives can ‘show their appreciation’ by nominating NHS staff for compassionate behaviour (see what nhscompassion.org lists on their homepage). In the same vein, the ‘Open and Honest Care: Driving Improvement’ initiative ‘aims to support NHS organizations be more transparent and consistent in the measurement and publication of their safety, experience and improvement data; with the aim of improving practice and creating a culture of compassion’ (NHS 2014a: 28).

The technologies and programmes promoted to select, develop, measure and reward compassionate character are largely focused on the individualities of the healthcare professionals in question. In the NHS (2014b) implementation plan *Building and Strengthening Leadership: Leading with Compassion*, compassion is described as the ‘self-awareness, resilience, mindfulness and emotional intelligence that allows you to be present and available to the needs of others’ (p. 12) and further that ‘each individual needs to: develop routine habits to stay balanced; keep rooted to core purpose; plan ahead for situations where work is personally depleting or restorative; and notice the signs and activate plans when off-balance’ (p. 5). Thus, managers are encouraged to bolster compassion in the self, and various strategies are advocated for developing personal leadership in contrast to office-specific leadership. One of these concerns how to improve self-mastery through the development of ‘routine habits to stay balanced’ (NHS 2014b: 7). Here compassion is an

identity, a character trait or a psychological state that either comes naturally or needs to be fostered – less a practical skill or virtue that must be trained and used with discretion when particular clinical situations demand so but more as part of the self.

It is further argued that exercises on the self – for instance through the use of a coach to promote ‘personal feelings’, developing a ‘personal mission’ and ‘ensuring a psychosocially rich life and opportunities to refresh, e.g., walking the dog; living fully in and out of work’ (NHS 2014b: 6) – provide a gateway to character development with the goal of enabling ‘one to be present and available to the needs of others’. ‘Others’ seem here to include both personal relationships and relationships with patients, colleagues, co-managers and so on.

This idea of compassion as somehow transferable to the surroundings can perhaps explain the somewhat peculiar premise that if, for instance as a manager, one of your key responsibilities is to ensure the compassionate care of patients, and the compassionate character of your employees, then one of your own main virtues must also be to embody compassion. As an implementation plan for building and strengthening leadership puts it, it is important that any NHS leader ‘distil the essential leadership behaviours, attributes and characteristics that embody a compassionate leader’ (NHS 2014c: 2). The reason for this, the NHS (2014c: 22) plan states, is that ‘a leader displaying compassion will win the respect of staff and allow them to deliver good quality care and feel more aligned with the organization’s objectives. The leader will be more credible, more authentic, and more likely to be followed’.

In this way, compassion increasingly becomes a question of individuals looking inwards by focusing on balance, mindfulness, resilience and restoration in order to live up to the external demands and expectations to build a compassionate character. Rather than first and foremost paying attention to others, and especially other peoples’ suffering, bolstering

self-compassion becomes a key concern. Therefore, healthcare managers are told to ‘find those things you personally need to attend to, to ensure you are grounded and balanced, connected to what matters to you personally’ (NHS 2014b: 22). Since feeling grounded and balanced are regarded here as virtues, and since such feelings are understood to transfer naturally to the surroundings, forms of behaviour that invite the individual to attend to the needs of the self are highly valued.

In this way, the compassionate care policy not only signals the introduction of a more moral and value-based NHS, as a mean of challenging some of the downsides of the NPM regime and its tick-box mentality, but also brings with it new, all-encompassing sets of rationalities and methodologies that demand an internalization of compassion to guide the conduct of people hired by the NHS.

A task-specific conception of compassion: Revisiting Nightingale

To investigate the possibilities of rethinking compassion in healthcare from an office-based perspective, we turn in the last part of this paper to the founder of modern nursing, Florence Nightingale (1820–1910). The current close connection between the compassion agenda and care work finds traction historically, where compassion has often been understood as a main virtue in studies of and perspectives on nursing especially. Here, Florence Nightingale is depicted as *the* leading figure in the establishment of compassion as the impetus for care and for promoting the development of a compassionate character as the ethos of the nursing profession (Maben, *et al.* 2009, Bradshaw 2011, Bivins, *et al.* 2017). It is therefore somewhat surprising to find that words such as *compassion* or *empathy* are nowhere to be found in Nightingale’s influential *Notes on Nursing* (1860). Neither are any of the other humanistic or feminine virtues that are often attributed to the compassionate healthcare worker such as genuineness, openness, honesty, authenticity, tolerance and kindness, to name some (Sinclair,

et al. 2016). Rather, Nightingale's *Notes* constitutes a detailed description of the duties and tasks of the nurse, none of which are abstracted in terms of meta-virtues but rather are formulated as specific guidelines on how to never speak to the invalid patient from behind, how to air the room of the patient without chilling her, how to reduce noise in the sickroom, or how not to rush or hurry when with a patient. Consequently, for Nightingale good nursing was only to be defined in task-specific terms as 'the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet – all at the least expense of vital power to the patient' (Nightingale 1860: 8). And ensuring such 'proper use' was a question of training, not least of the important skill of observation:

The most important practical lesson that can be given to nurses is to teach them what to observe – how to observe – what symptoms indicate improvement – what the reverse – which are of importance – which are of none – which are the evidence of neglect – and of what kind of neglect. All this is what ought to make part, and an essential part, of the training of every nurse. (Nightingale 1860: 105)

Thus, Nightingale (1860: 108) argues, it is often the trained skill of observation that normatively distinguishes the good nurse from the bad nurse. The good nurse is she who meticulously observes her patient's dieting habits at every meal, for instance. And the good nurse is she who, instead of asking vague, loose or leading questions such as 'Did you have a good night?', asks direct and informative questions such as 'How many hours did you sleep?' It is perhaps not wrong to assert that Nightingale's *Notes* concern the training and nurturing of the compassionate character of the nurse. This is, however, a meaningful claim only if we link compassion to the specific life-order of nursing and its related practical work tasks and trained abilities, or even define compassion *as* these highly specialized practices of care – and not as an inner feeling or an abstracted attitude of kindness or empathy (Greenhalgh 2013). Rather, the ethos of nursing concerns the trained abilities and skills of the nurses, not least the

skill of observation, and, she adds, ‘if you cannot get the habit of observation one way or other, you had better give up the being a nurse, for it is not your calling, however kind and anxious you may be’ (Nightingale 1860: 113).

The Nightingalian mission was to establish nursing as a recognized profession that was not subordinated to medicine, or a mere technical skill, but a vocation and a professional calling with its own normative and practical standards and training programmes (Nelson and Rafferty 2010; Riverby 1987b). This call for professionalism has given Nightingale a mixed reception in feminist and gender studies. On one hand, her definition of nursing as a distinct profession has made her a front figure in the promotion of women’s social status and transition into the labour market (Holliday and Parker 1997). On the other hand, her stance on feminism and the women’s movement was cautious. She did not identify with women as a group – neither did she believe in promoting female gender issues or female values particularly. Rather, Nightingale supported women ‘as individuals rather than from a gender perspective’ (Selanders 2010: 70). This also meant that she was not as interested in the gender of the nurse as she was in the roles, statuses, duties and tasks of nurses, who – because of historical and social circumstances – happened to be female. Being a good nurse had nothing to do with inhabiting any naturally given or socially fostered feminine virtues; instead, Nightingale’s understanding of nursing was thoroughly office-based. Her promotion of nursing as an educated, secular profession was never disconnected from the remaining hospital organization understood as a complex system of relations between the official roles, obligations and duties needed to supply proper treatment and care of patients. This also had consequences for the way Nightingale understood leadership; namely as the responsibility to ensure that everyone fulfils his or her appointed office:

To be ‘in charge’ is certainly not only to carry out the proper measures yourself but to see that everyone else does so too; to see that no one either wilfully or ignorantly

thwarts or prevents such measures. It is neither to do everything yourself nor to appoint a number of people to each duty, but to ensure that each does that duty to which he is appointed. (Nightingale 1860: 42)

Thus, in sharp contrast to the argument that compassionate leadership results in compassionate employees, Nightingale defines clinical management as the task of ensuring that each person follows the task-specific duties linked to the formal roles of their particular office.

There can be no doubt that since Nightingale's writings, the nursing profession has changed in significant ways. Importantly, the office of nursing has become more differentiated, and a range of new roles and positions have been introduced. In the UK, this differentiation has been part of government's modernization agenda, which has reinforced occupational boundary disputes between separate professions (Bach, *et al.* 2008). Qualified nurses are increasingly being asked to adopt advanced practice roles, and it is expected that a greater amount of what belongs to basic care work is handed over to other healthcare workers (Sturgeon 2008). This includes what are often defined as lower status occupations, such as healthcare assistants and support workers, whose roles, authorization and educational level have been explored and heavily debated in recent years (Hasson and McKenna 2011, Traynor, *et al.* 2015). As earlier described, it also seems the public demands to nurses have changed to become more expectant of emotional expressive behaviour, emotional labour, and compassionate attitudes (Smith 1992; Peate 2015 – see also Flores and Brown 2018). And often to such an extent that 'compassion fatigue' is the result (Harris and Griffin 2015; Nolte, *et al.* 2017).

An occupational blurring of boundaries, a more complex division of labour, an increased differentiation of the nursing role, and increased emotional labour, however, do not make Nightingale's stance less relevant. On the contrary, it seems that the Nightingalian

focus on training and practice, on task specificity and definition, on the importance of professional status and on the relations between and the need for clearly defined offices, duties and obligations in the organization of healthcare is only becoming more pertinent. Moreover, with her office-based definition of the nursing role – and with the specific focus to nursing and caring as particular practices and trained skills – Nightingale delivers a distinct approach to discussions of care work that escapes the tendency to universalise “caring as an element in female identity, or as a human quality, separate from the cultural and structural circumstances that create it” (Reverby, 1987b: 5).

Compassion in perspective

When returning to the Francis Inquiry (2013a, 2013b), which in many ways – as we described earlier – set the scene for the compassion agenda in the NHS, it is noticeable how a great part of the report’s 290 recommendations align neatly with a Nightingalian stance. In accounting for the scandal, the report pointed to inadequate staffing levels and poor leadership, recruitment and training, which in turn had led to ‘a declining professionalism and a tolerance of poor standards’ (Francis 2013b: 45). More specifically, the report pointed to the large group of uneducated and unregistered care staff in the hospital, to a lack of proper training of nurses and to problems in the professional organs (such as the Royal College of Nursing) where, it was stated ‘[l]ittle was done to uphold professional standards among nursing staff or to address concerns and problems being faced by its members’ (Francis 2013b: 61). Consequently, recommendations were given to secure registration and authorization, well-functioning professional organizations and an adequate level of training. It was, for instance, recommended that all healthcare assistants be registered and receive a minimum standard of education and training; that uniforms make it possible for patients to distinguish between different roles (such as nurses and healthcare assistants); that key nurses

be made responsible for each patient at the beginning of each shift; that nurses attend all ward rounds; and in general that ‘training and continual professional development for nurses should apply at all levels, from student to director, and commissioning arrangements should reflect the need for healthcare services to be delivered by those who are suitably trained’ (Francis 2013b: 76).⁵

While the Inquiry clearly supports a distinct Nightingalian stance, it also became an important stepping-stone for the subsequent abstracted policy rhetoric on compassionate care and a basis for the development of technologies and control mechanisms to ensure compassionate behaviour in the NHS. As described, the report promoted ideas of compassion as a natural or inner state of individuals by suggesting, for instance, ‘aptitude tests’ to be taken by aspirant nurses prior to entering the profession (Francis 2013b: 77).

That the Francis Inquiry’s recommendations sought not only to secure the training, authorization, professionalism, clearness of roles, leadership and oversight but also the selection and development of compassionate selves via suggesting, for instance, aptitude tests and performance appraisals, can perhaps be explained by an increase in social expectations for compassion in care relations (Flores and Brown 2018). Thus, apart from an increased differentiation and role diffusion, it seems that also public demands of care professions have changed considerably since Nightingale’s visions. Compassion has increasingly become an expected ‘emotional style’ – here understood as ‘a combination of the ways a culture becomes “preoccupied” with certain emotions and devises specific “techniques” – linguistic, scientific, ritual – to apprehend them’ (Illouz 2008: 14; see also Stearns 1994). So, while ‘brisk, reassuring behaviour and advice of the “stiff upper lip”, “pull yourself together” variety’ were described as characteristic emotional styles in Menzies Lyth’s teaching hospital in London in the 1950s (Menzies 1960: 54), the behavioural standards of today have changed

⁵ The report also criticized the quality of medical training – and especially that medical training had been taking place in an environment of below-standard care and patient safety.

towards more informal and emotionally expressive ways of interacting with others (Roelsgaard Obling 2013; 2012), manifested for instance in an ‘upbeat, smiling, agreeable attitude’ (Illouz 2008: 81; see also Furedi 2004).

Alongside these changed expectations of care work, the current compassion agenda’s success can be linked to its being part of a number of emergent reform movements that are – despite fragmentation and variation across contexts and countries – unified by a strong focus on human values and more ‘soft’ measures in public management. As we have described, the compassion policies in some ways continue and extend existent managerial technologies in clinical practice, while also new types of virtue-assessing, -developing and -selecting technologies have been introduced. Although this new focus on the fostering of compassionate selves is promoted as a correction of earlier reform agendas’ ‘harder’ types of managerialism, it seems that upon closer look the new compassion measures and mechanisms are not radically different from other reform agendas, where an increased focus on performance, measurement and control systems is often coupled with increased expectations of public servants about bringing their personalities, enthusiasms and emotions to bear in their relations with the policy programmes as well as the service users (Stoker 2006, du Gay 2008). This should not come as a surprise, as it has often been argued that public management reforms – despite rhetoric of radical newness – rarely suspend earlier approaches but rather add to and built another layer onto them (Pollitt and Bouckaert 2017, Greve 2010). Take, for instance, dominant policy agendas of quality improvement, patient safety and patient-centredness in healthcare. As modes of governance, the emphasis on quality, safety and patient experience involve both regulation, measurement and control of instrumental aspects of clinical work *and* a cultivation of what Brown and Hesketh (2004) call ‘non-bureaucratic soft currencies’, that is, control of the social and psychological

attributes of individuals, such as interpersonal skills, humanism, charisma, appearance and language (see also Pedersen 2018).

On the basis of the discussions of this paper, the call for compassion as an abstracted policy goal in current public management reforms needs to be treated with the same kind of cautiousness and critical reflexivity as any other new policy trend. And especially so, because the compassion agenda comes with normative connotations that make it almost impossible to criticise. As we have argued by drawing on an ‘ethics of office’ tradition represented by Max Weber, the compassion agenda risks introducing abstracted and generalized notions of compassion that are not tailored to the demands of a limited role. As an instance of what we determine as meta-virtue management, attending to compassion as a generalized virtue risks neglecting how public servants are morally accountable in dissimilar ways for different aspects of their professional work situations. In returning to questions of ‘office’, we get to see how current management reforms in health care organizations have much to say about managing individual conduct and performance, but very little to say about how this relates to tasks, functions, and responsibilities pertaining to the conduct of public office (du Gay 2017).

What is more, the new policy regime instils new types of demands that can have unintended consequences. As Smajdor (2013b) points out, the compassion agenda seems at worst ‘a rhetorical flourish that may feed into further sets of targets and priorities that detract from the central purpose of our health service’. Such new demands and priorities not only consist in the redistribution of time, attention and focus caused by new types of compassionate care control systems and performance measures but are also visible in the efforts directed at assessing or changing the manner in which health professionals positively and eagerly engage in developing a moral character based on personal preferences and private moral beliefs. Such increased expectations of internationalization, work on the self and emotional labour

might, on the one hand, affect what Weber determined as the necessary impersonality or *sachlichkeit* of the public servant in order to ensure an ability to – for instance – apply rules and treat patients evenly without paying attention to status or individual attributes. On the other hand, it might well build up pressures on the healthcare worker by decreasing the possibility for detachment, reinforcing emotional stress and increasing the possibility of ‘compassion fatigue’ (Peate 2015). Following this line of argument, it might even be that the current compassion agenda, rather than preventing future scandals, provides a platform for new ones to emerge.

On a positive note, our analysis of Nightingale’s *Notes* and the review of the Francis Inquiries from an office-based perspective indicate that it is both possible and meaningful to understand compassion in healthcare not only as an abstract, all-encompassing virtue or as an inner state or feeling, but rather as a bundle of role-specific and trained skills and rules of conduct, such as, the appreciative and informative ways of communicating with patients or the attentive observational routines that Nightingale described in her *Notes on Nursing* (1860). From this perspective, compassion is linked directly to specific tasks, skills and roles and is only meaningfully applied to clinical situations as an instance of case-based or practical reasoning, where the health professional judges the appropriate attitudes and virtues needed in each care situation as it happens (Pedersen 2018; Schei 2006). Thus, our critical engagement with the current compassion agenda is not an argument for *not* attending to the virtues of healthcare professionals or for *not* arguing for compassion as an important, integrated part of professionals’ work. Nor is it an argument against compassion-based therapies or similar tools to train compassionate behaviour or communication in concrete situations. Rather, we wish to highlight that any policy agenda should treat compassion, and any other virtue, as a pattern of conduct to be trained and habituated and as role-specific skills and duties tailored to particular offices in the healthcare system and used with

discretion and prudence in particular care situations rather than expanded as a meta-virtue to guide all conduct unrelated to task, situation, role and obligation. Moreover, important structural and systemic underpinnings need to be addressed politically, especially given that healthcare workers today work under extreme workloads and are often caught between different value regimes. Placing pressure solely on healthcare workers and their level of compassion signals a shift of responsibility away from the organization and the larger funding policy system of which it is part.

Conclusion

The problems that the current preoccupation with compassion in the NHS is understood to resolve are indeed real. Medical negligence, poor standards of care and a widespread tick-box mentality in healthcare should be both a research and a policy concern. However, as we have argued in this paper, the current understanding of compassion in the NHS is largely blind to differences in roles, relationships and tasks in the delivery of healthcare and to the situatedness of clinical practice in which virtues can easily become vices. Moreover, compassion is asserted and evaluated as rooted largely within the selves of individual health professionals, who are asked to bring generalized practices of self-reflection and inner scrutiny into their professional work and relationships.

With the abstractedness and internalization demands of the current policy discourse – and with the support this discourse finds in current research traditions on humanistic, compassionate and holistic understandings of care – we not only risk promoting an idea of ethical conduct in healthcare practices that overlooks the immense amounts of hard work, education, training, experience, and professional organization, regulation and authorization that goes into the continuous formulation and securing of the virtues, professional skills and duties needed for specific purposes in the delivery of care. We also risk supporting a

damaging idea of compassion as a naturally or culturally given – often feminine – characteristic that is somehow deeply rooted in the selves of (some) individuals and that is effortlessly transferred from ‘the compassionate souls’ to their surroundings.

Thus, in approaching the compassion agenda through an office-based perspective, we are not rejecting the importance of ethical conduct or compassion in the area of health service delivery but arguing that attending to such conduct must necessarily be a role-based and task-specific exercise. A revitalization of what could be termed role-morality combined with a turn to classic perspectives on care work, such as that presented by Nightingale, offers a much-needed research agenda within sociological healthcare research. Drawing attention to the tradition of the ethics of office, and more specifically to Max Weber’s work, allows us to develop a stance towards healthcare delivery that assumes ethical and appropriate conduct to be related specifically to particular roles or offices. This stance is often ignored in ethical theorizing; and even within Weberian-inspired scholarship, it seems to have fallen out of fashion. A more focused attentiveness to the relations between particular types of conduct and life-orders could open up novel research avenues and inform healthcare policymaking at a time when healthcare institutions are struggling to handle role diffusion, increased differentiation, complex coordination issues, endless reforms and restructurings and, as a result, concrete challenges of securing professional standards and proper training.

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