Nurse Education Today xxx (2014) xxx–xxx

Contents lists available at ScienceDirect

Nurse Education Today

journal homepage: www.elsevier.com/nedt

Editorial

# Invisible gorillas and red herrings: A response to Paley (2013)

## Cognitive Blindness and the 'Compassion Deficit'

John Paley began a recent editorial for this journal (Paley, 2013) with the assertion that the 'compassion deficit' identified by the Francis Report and elsewhere was due *not* to a lack of compassionate motivation, but because the nurses and other care providers implicated in the report quite literally *failed to understand* that there was a problem. Drawing on a forty-year-old social psychology study, Paley added: 'the failure to help was not the result of a compassion deficit. It was rather the consequence of how the situation was *cognitively processed*' (Paley, 2013, p.1451, his emphasis). Paley's conclusion turns on its head the received wisdom and general consensus about how educationalists might respond to the events at Mid Staffordshire NHS Foundation Trust (Mid Staffs) and other so-called 'failures in compassion'. He argued:

> If this is right, the project to 'grow and develop compassion' is misconceived. It was not a 'failure of compassion' that led to the incidents of appalling care in Mid Staffs, but a series of contextual factors that are known to affect social cognition. These factors cannot be corrected or compensated for by teaching ethics, empathy and compassion to student nurses (Paley, 2013, p.1452).

Paley provided evidence for his argument that, under certain circumstances, people can experience 'cognitive blindness' towards suffering and distress, with reference to a research study conducted by psychologists from Princeton University in the early 1970s. The study, which Paley described as 'a classic', deceived students at Princeton Theological Seminary who were training for the priesthood into believing that they were 'participating in a study of the vocational careers of seminary students' (Darley and Batson, 1973, p.103), whereas its true purpose was to measure variables associated with helping behaviour. As part of the experiment, the subjects walked past a man sitting slumped in an alley. If they stopped and asked if he needed help, he replied that he had just taken a pill and that he would be O.K. If they persisted with their offers of help, he consented to being taken inside the building. The subjects subsequently completed a 'helping behaviour questionnaire' which asked when they had last seen and responded to a person in need. This was followed by a debriefing interview in which it was revealed that the encounter with the man in the alley was part of the experiment, and where the subjects' behaviour during the encounter was discussed.

Interestingly, Paley provides an inaccurate and exaggerated account of the encounter in the alley in which the victim is 'prostrate on the ground, bleeding and clearly in some distress', adding that it is 'tempting to assume that someone who failed to help must be particularly callous or self-centred' (p.1451). This is in contrast and contradiction to Darley and Batson's original description in which:

> The victim was sitting slumped in a doorway, head down, eyes closed, not moving. As the subject went by, the victim coughed twice and groaned, keeping his head down (Darley and Batson, 1973, p.104).

Furthermore, Darley and Batson do not describe the man as in distress, but refer to 'a situation possibly calling for a helping response' (p.101). Indeed, they later point out that the 'victim' was generally *not* perceived as being in distress by the research subjects. We suggest that there is a world of difference between walking past a man sitting in a doorway coughing and one lying face down (the dictionary definition of 'prostrate') on the ground bleeding and 'clearly in distress'. It is not clear why Paley would wish to embellish his account in this way, other than to make it seem even more incredible that anyone could possibly not stop to help.

The findings of the study indicated that, in fact, only 40% of the subjects stopped to offer some form of help whilst the remaining 60% did not. The only variable associated with whether they stopped to help was the amount of time which the subjects had been led to believe they had before the next phase of the experiment. It appears, then, that people in a hurry are less likely to stop and offer help to a stranger than people who are not. However, we hardly need such an elaborately deceptive study to tell us this, and as the researchers themselves pointed out, 'it is not difficult to conclude from this that the frequently cited explanation that ethics becomes a luxury as the speed of our daily lives increases is at least an accurate description' (p.107). However, they caution that we should not jump to the obvious conclusion that the subjects consciously chose to leave the 'victim' in distress. Rather:

> Our seminarians in a hurry noticed the victim in that in the postexperimental interview, almost all mentioned him as, on reflection, possibly in need of help. But it seems that they often had not worked this out when they were near the victim. Either the interpretation of their visual picture as a person in distress or the empathic reactions usually associated with that interpretation had been deferred because they were hurrying (Darley and Batson, 1973, pp.107–108).

In other words, most of these trainee priests claimed not to have realised at the time that the 'victim' was in need of help. Darley and Batson suggested that some subjects reported that 'they did not perceive the scene in the alley as an occasion for an ethical decision', whereas others claimed that they considered the ethical duty to be on time for their appointment with the experimenter over-rode the duty to help the victim. Thus, 'conflict, rather than callousness, can explain their failure to stop' (p.108).

0260-6917/$ – see front matter © 2014 Published by Elsevier Ltd.
http://dx.doi.org/10.1016/j.nedt.2014.01.005

Please cite this article as: Rolfe, G., Gardner, L., Invisible gorillas and red herrings: A response to Paley (2013), Nurse Educ. Today (2014), http://dx.doi.org/10.1016/j.nedt.2014.01.005

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In addition to this study, Paley also cites the 'invisible gorilla' experiment (Chabris and Simons, 2011) in relation to his contention that nurses at Mid Staffs simply failed to see the suffering going on around them. In this study, subjects were asked to watch a 24-second video of six people passing a basketball and to count how many passes were made by the team in white shirts. During the video, a person dressed as a gorilla walks into shot, beats its chest, and walks off again. According to the researchers:

> half of the people who watched the video and counted the passes missed the gorilla. It was as though the gorilla was invisible. This experiment reveals two things: that we are missing a lot of what goes on around us, and that we have no idea that we are missing so much (Chabris and Simons, 2010).

Paley's conclusion is that social psychology experiments such as these can explain why nurses who are 'hurried, stressed and preoccupied' might have 'a severely impaired ability to cognitively process situations which (to anyone outside) self-evidently require intervention' (p.1452) in the same way that, to anyone outside, the gorilla would self-evidently be visible. Thus, 'there was no compassion deficit at Mid Staffs – nor is there such a deficit in the NHS more widely – and that, for this reason, the project of "growing and developing" compassion is misconceived' (p.1451). This is a bold claim with important consequences for the profession of nursing in general, and nurse education in particular. However, we hope to demonstrate that it is based on flawed research and dubious generalisations. In particular, it is subject to errors of internal and external validity which call into question its application to nursing and nurse education.

## Problems of Internal Validity

Paley laments the fact that 'there have been few if any references to social psychology in attempts to understand what happened at Mid Staffs' (p.1452), but he appears to overlook the point that social psychological theories can also offer some important insights into problems of validity in the Darley and Batson study on which so much of his claim rests. The bare bones of the study are as follows:

- Trainee priests were deceived into believing that they were taking part in a study of the vocational careers of seminary students, whereas in fact they were unwittingly involved in a study of helping behaviour;
- Many of them chose to ignore a 'victim' who was slumped in a doorway and who groaned and coughed as they walked past (not, as Paley described it, 'prostrate on the ground, bleeding and clearly in some distress');
- When later interviewed about the incident, some claimed that they did not realise at the time that the man needed help, whist others said that their duty to help him was over-ridden by their duty not to be late for their meeting with the researcher.

The naive response to these claims might be along the lines of 'well, they would say that, wouldn't they'. Not only had the subjects been 'set up' by the researchers, but they also had been set up in such a way as to call into question their self-image as caring and compassionate trainee theologians. We would imagine that student nurses would have responded with much the same explanations for much the same behaviour; indeed, it is likely that these were the very reasons given by many of the nurses for their 'compassion deficit' at Mid Staffs and in other recent cases of gross dereliction of care. This is not to say that the subjects were necessarily lying about their motivations for failing to stop and help the 'victim'. It might be that in some cases, as Paley suggests, the subjects simply did not perceive the 'victim' as in need of help. It might even be the case that, as with the 'invisible gorilla' experiment, some of the subjects did not see the 'victim' at all. However, we would like to offer some more feasible alternative explanations, also based on social psychological theory.

The first and perhaps most likely explanation for the reasons given by the subjects in the research study for not stopping to help is the well-documented psychological phenomenon of social desirability bias. Put simply, 'social desirable responding is the tendency for participants to present a favourable image of themselves' (Van de Mortel, 2008, p.41), either unconsciously through self-deception or else deliberately 'to conform to socially acceptable values, avoid criticism, or gain social approval' (p.41). In other words, we should not take responses from research subjects at face value, particularly when questioned about sensitive issues which threaten the presentation of their self-image. It is important to note that not all social desirability bias involves deliberately lying to the researcher. However, in cases where it does, we could surmise that some of the respondents might well have felt justified in their wilful deceit, given that they had themselves been lied to by the researchers. Clearly, social desirability can have a significant effect on the internal validity of the research study, with Nederhof (1985) estimating that up to 75% of variance in responses could be attributable to this form of bias. Whilst scales to detect social desirability bias were available at the time of Darley and Batson's study (e.g. Crowne and Marlowe, 1960), there is no indication that any consideration was given to this issue, either by the researchers or by Paley in his account of the study.

A second explanation for the reasons given by the subjects for not stopping to help is the psychological theory of cognitive dissonance, which is defined as 'the feeling of discomfort caused by performing an action that runs counter to one's customary (typically positive) conception of oneself' (Aronson et al., 2004, p.174). This feeling of discomfort can only be dissipated by reducing the dissonance between behaviour and self concept; that is, either by changing the behaviour or by attempting to justify the behaviour by changing the dissonant cognition. In the case of the Darley and Batson study, there was no opportunity for the subjects to return to the scene and offer help to the 'victim'. It is therefore feasible to suppose that some of them might have reduced the dissonance between their conception of themselves as good and charitable Christians and their action of ignoring a needy person by convincing themselves that the person was not, in fact, in need of help, despite signs to the contrary. As Aronson et al. (2004) conclude, 'to escape from dissonance, people will engage in quite extraordinary rationalizing' (p.176).

## Problems of External Validity

Paley employs the theory of 'cognitive blindness' to argue that 'there was no compassion deficit at Mid Staffs' (p.1451), and that the dereliction of care was due to compassionately motivated nurses simply not perceiving the situation as one requiring an intervention. As we have seen, his evidence for this assertion is based on a study in which trainee theologians were confronted with the fact that they ignored a man in need of help, and whose justifications tended to be, in Paley's words, that 'they simply did not interpret the situation as one requiring an intervention. It was a case of "Now you mention it, yes …" rather than "I saw his distress but chose to ignore it"' (p.1451). In contrast, we are suggesting what we consider to be the more plausible explanation, also based on psychological theory, that the trainee theologians were fully aware of the need to help the man, and that they consciously and deliberately chose not to, perhaps because they were in a hurry, or perhaps because they simply did not care enough. When confronted by the researcher with their behaviour, they either consciously or unconsciously came up with excuses that usually entailed the claim that they did not realise that he needed help. If our explanation is accepted, Darley and Batson's study suffers from problems of internal validity and does not provide sound and compelling evidence for Paley's conclusion that there is no compassion deficit and that 'the project of growing and developing compassion is misconceived' (p.1451).

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There is no definitive way of settling this difference in interpretation, although we would suggest that Occam's Razor (the principle of minimum assumption) cuts in our favour. However, even if we give Paley the benefit of the doubt on the internal validity of his evidence, there remains the issue of external validity, the extent to which Darley and Batson's findings can be applied to the situation at Mid Staffs and elsewhere in the health service. Let us suppose for a moment that each one of the 24 trainee theologians who walked past the coughing and groaning man, head down, eyes closed and motionless, were telling the truth and really did fail to register that he required help. After all, they were not expecting to find him there, it was not their job as seminary students to offer care to him, and perhaps if he was still there on subsequent occasions they might have realised that he was in need of help. In other words, it was an unexpected one-off situation that they were not obliged to respond to. Now consider the situation at Mid Staffs. As nurses, coming across patients in need of help is neither unexpected nor one-off, and responding to needy patients is the very essence of their job. It is conceivable that a nurse might pass by a patient on a particular occasion and not notice that they needed help. It is conceivable that the same nurse might pass by the same patient on a second occasion, or that a second nurse might also pass by without realising that they needed help. But every nurse, on every occasion, every day for weeks and months? We simply cannot agree with Paley that this is a situation in which the nurse might say 'Now you mention it, yes …'. This can only be a case of 'I saw his distress but chose to ignore it', regardless of how the nurse might justify her or his actions afterwards.

And what of the 'invisible gorilla' experiment in which subjects who were concentrating on a particular task simply failed to see a person dressed in a gorilla costume pass before their eyes? At the risk of mixing our metaphors, the invisible gorilla is a giant red herring that has no bearing whatsoever on what happened at Mid Staffs. As the experiment shows, it is perfectly possible to fail to notice a gorilla on a video screen when you are concentrating on counting the number of passes made by basketball players. In discussing how this might be possible, the authors of the study state that 'this error of perception results from a lack of attention to an unexpected object' (Chabris and Simons, 2011, p.6). The subjects do not see the gorilla because it is the last thing they expect to see. As in the experiment with the student theologians, the appearance of the gorilla is out of context, it is on the screen for merely a few seconds, and the experiment is only conducted on a single occasion. However, patients in need of help are precisely what nurses expect to see, and they are there, all the time, lying in beds exactly where they are expected to be. Paley uses the example of the invisible gorilla to demonstrate how 'outsider' disbelief that anyone could fail to spot something so obvious can be unfounded. However, failure to see the gorilla is quite different from failure to see the patient, and the outsider's incredulity that the gorilla could pass unnoticed cannot be equated with the justified disbelief of the general public that nurses could, in Paley's words, 'fail to recognise such obvious examples of bad care'.

And, lest we forget, we are not merely confronted here with sins of omission. By no means all of the issues reported by whistleblowers within the profession, by patients and carers and by investigative journalists are cases of passive neglect or misconceptions that can be explained away by theories of cognitive psychology. It is not just a case of failing to *recognise* bad care: nurses at Mid Staffs and elsewhere were responsible for *giving* bad care, and in extreme cases, of inflicting the very opposite of care. There are numerous well-documented cases of cruelty and wilful negligence that beggar belief, not because 'the outsider finds it impossible to comprehend the insider's cognitive narrowing' (Paley, 2013, p.1452) but because no excuse can or should be acceptable.

## Compassion, Courage and Commitment

Perhaps we have laboured these points somewhat, but all of this is of vital importance. It is important first and foremost that members of the nursing profession should not be perceived as attempting to explain away the current crisis of public confidence in nurses and nursing in terms of what Paley calls 'a series of contextual factors' such as ambiguous distress cues, unconcerned bystanders or diffuse responsibility. We may well be, as Paley suggests, 'post-Francis', but even in the unlikely event that he has got it right with his interpretation of the motivation of the nurses implicated at Mid Staffs and elsewhere, this is neither the time nor the place to be saying so. It is of vital importance that we as a profession are not seen to be excusing or rationalising the appalling behaviour of (hopefully) a small minority of our colleagues. But it is also vitally important that, as nurse educators, we respond sensitively and appropriately to the situation. On the one hand, we must continue to resist the knee-jerk 'too posh to wash' rhetoric from certain sections of the national press that nurses are over-educated. On the other hand, we believe also that we must challenge Paley's assertion that 'the project to grow and develop compassion is misconceived' (p.1452). We hope that we have demonstrated that there are absolutely no grounds for his assertion that 'it was not a "failure of compassion" that led to the incidents of appalling care in Mid Staffs, but a series of contextual factors that are known to affect social cognition' (p.1452). And if we reject this assertion, then we must also question his conclusion that matters will not be improved by focussing our attention as educators on growing and developing compassion.

Compassion is one of the Chief Nurse for England's '5 Cs of caring', along with competence, communication, courage and commitment (Cummings, 2012). Of these, competence and communication are skills which can be taught, whereas compassion, courage and commitment are qualities or (perhaps) virtues which cannot. This begs the question of exactly what compassion is and how, in Paley's words, it might be grown and developed. Paley is no doubt correct in his assessment of an ambiguity surrounding the term. However, we believe that he is mistaken in his analysis of a split between compassionate behaviour and compassionate motivation. The Penguin English Dictionary defines it as neither; rather, compassion is 'sympathetic consciousness of others' distress together with a desire to alleviate it'. The key words here are 'together with'; compassion is *both* a sympathetic consciousness of distress *and* a desire to do something about it. Neither alone will do. There can be no compassionate desire to intervene without a consciousness of suffering, whereas a consciousness of suffering without a desire to intervene is monstrous. Paley's argument that the nurses embroiled in the Mid Staffs case did not lack the motivation to be compassionate even though, for reasons of 'cognitive narrowing', they lacked the sympathetic consciousness of others' distress is, by this account, simply wrong. If there is no sympathetic consciousness in the face of obvious suffering, then there is no compassion. If we fail to recognise that a man slumped over in the street is in need of care, there has been a failure of compassion on our part, regardless of whether we were in a hurry, had other things on our mind or whatever other rationalisations we might provide. And if as nurses we witness a failure of compassion in our colleagues without the desire to do something about it, then we too have failed to be compassionate. We know from accounts of whistleblowers at Mid Staffs and elsewhere that speaking out in the name of compassion is difficult, dangerous and that it often entails a personal cost, which is why compassion alone is sometimes not enough, but must be accompanied by the virtues of courage and commitment in order to translate desire into action.

The project to grow and develop compassion must, almost by definition, lie at the heart of all the caring professions. Whereas some people come into nursing with a fully developed sense of compassion, others do not. Some might never develop compassion, and it would be extremely useful if we could discover ways of identifying these people early on and point them towards more appropriate careers. Others have the potential for compassion but need to be sensitised to the suffering of others *and* encouraged and supported in their desire to alleviate it. Each is desperately important and one is of no use without the other; it is this failure to 'join the dots' between sensitivity to the pain

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of others and acting on these feelings which has resulted in 'too posh to wash' syndrome. Paley is right insofar as the solution does not lie in teaching compassion to student nurses, but that is because compassion is not a skill or a competence; *compassion cannot be taught*. In Richard Rorty's words, compassion (or what he calls solidarity) 'is to be achieved not by inquiry but by imagination, the imaginative ability to see strange people as fellow sufferers' (Rorty, 1989, p.xvi). Our challenge as educators is to help nurses to imagine and identify with the suffering of others to the extent that they are motivated to respond to that suffering, and the solution is not to exclude them from our universities but to integrate them more fully. What our students need is less teaching and more education.

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Gary Rolfe
Lyn Gardner
*College of Human and Health Sciences, Swansea University, UK*
*E-mail address:* g.rolfe@swan.ac.uk.


Available online xxxx

Please cite this article as: Rolfe, G., Gardner, L., Invisible gorillas and red herrings: A response to Paley (2013), Nurse Educ. Today (2014), http://dx.doi.org/10.1016/j.nedt.2014.01.005