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Dialogue

The compassion deficit and what to do about it: a response to Paley

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Introduction

In a recent paper published in this journal entitled *Cognition and the compassion deficit: the social psychology of helping behaviour in nursing*, John Paley analyzes the two reports by Robert Francis on the Mid Staffordshire NHS Trust (Mid Staffs) and suggests that, contrary to the findings and the general consensus both inside and outside the nursing profession, there was no 'failure of compassion', but rather 'an interlocking set of contextual factors that are known to affect social cognition'. That is to say, the appalling and sustained failure of care occurred not because the nurses lacked compassion but because they quite literally did not see that patients were suffering from a lack of the most basic care. Furthermore, and arising from this reading of the situation at Mid Staffs, he concludes that a focus on compassion and caring in the recruitment and education of students is misconceived and will be ineffective. Paley's paper is an extended version of an editorial published in *Nurse Education Today* entitled *Social psychology and the compassion deficit* (Paley, 2013), to which we wrote a response (Rolfe & Gardner, 2014). Such are the educational, professional, and political implications of Paley's arguments that we feel it necessary also to respond to this latest version.

Our critique attempts to address Paley's thesis from three perspectives. We argue that his argument is based on two studies in particular that are fundamentally flawed, that the findings are taken out of context, and that there is, in any case, a simpler account, also grounded in social psychological theory, which better explains the findings from these studies. We end with a challenge to Paley's conclusion that the problem 'cannot be corrected or compensated for by teaching ethics, empathy and compassion to student nurses' (Paley, 2014) by advocating a curriculum focused on the arts and humanities in order to help students to recognize, understand, and respond to the suffering of others.

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Inattentional blindness

Paley's claim that the failings at Mid Staffs were, in effect, failings in cognition are based predominantly on the findings from a research project carried out by social psychologists from Princeton University in the USA in the early 1970s. In this so-called 'Good Samaritan' study, trainee Catholic priests were deceived into believing that they were taking part in research into the vocational careers of seminary students, whereas the true intention of the project was to measure variables associated with helping behaviour. As part of the study, the research subjects had to move between buildings, and as they travelled from one building to the next, they passed by a man sitting slumped in an alley who coughed and groaned as they walked past. He was, of course, part of the experiment, although the students were not aware of this at the time. Most students walked by without stopping to help, and when later confronted with their behaviour by the experimenter, they tended to explain it in one of two ways. Some students claimed not to have realized that the man was in need of help, whereas others claimed that their duty to get to the next building in good time overrode their duty to stop and help the man. The only factor associated with whether or not the students stopped to help was whether they were told that they had plenty of time to get to the next building or that they were already late. From these

findings, the researchers observed that 'it is difficult not 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' (Darley & Batson, 1973, p. 107), adding that:

> It would be inaccurate to say that they realised the victim's possible distress, then chose to ignore it; instead, because of the time pressures, they did not perceive the scene in the alley as an occasion for an ethics decision. (Darley & Batson, 1973, p.108)

Paley accounts for the situation at Mid Staffs in a similar way, arguing that such 'inattentional blindness' was also a significant factor in the appalling care noted in the Francis Reports. He adds that, in the 40 years since Darley and Batson carried out their study, our understanding of the factors affecting whether or not people are likely to help others has been refined but that 'the most consistent finding is that these conditions are largely contextual: they have little to do with character traits, virtues, or compassion deficits' (Paley, 2014). In other words, when placed under sufficient pressure, nurses quite literally do not notice or perceive that patients are in distress, regardless of whether or not they are caring and compassionate individuals.

There are several reasons why we are not convinced by Paley's account. Firstly, there are some curious anomalies in his description of the Darley and Batson study. In the *Nurse Education Today* editorial, he claimed that 'the victim was prostrate on the ground, bleeding and clearly in some distress' (Paley, 2013, p. 1451). In the *Nursing Philosophy* paper, he claims that the students 'encountered a distressed man, prostrate on the ground' and that many of them 'actually stepped over the distressed man' (Paley, 2014). Each of these descriptions is false. The man was not prostrate on the ground, he was not bleeding, and nobody stepped over him. He was described by Darley & Batson (1973, p. 104) as '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'. Thus, the actual situation was far less extreme than Paley suggests, and while a scenario in which so many of the student priests passed by a bleeding man lying face down on the ground might as Paley says, be 'almost unbelievable', and while a scenario in which many of them stepped over him might lead us to believe that they 'must be particularly callous or self-centred' (Paley, 2014), neither of these things actually happened. Furthermore, while it is perfectly feasible to imagine a situation where we might barely notice a man in a doorway who coughs twice and emits a groan, it is difficult to see how this scenario can be easily transposed to a ward full of patients *whom it is our job to notice*, whom we know are there, of whom we know in precise detail *why* they are there, and whom we constantly pass by during the course of an 8-h shift.

Outsider disbelief

However, Paley insists that it is not only possible but that it offers the best explanation for what happened at Mid Staffs. Moreover, to those of us who find such an explanation incredulous, he offers the theory of 'outsider disbelief', backed up with the 'Invisible Gorilla' phenomenon. His argument is that, in the same way that 'outsiders' would find it hard to believe that subjects in a psychological experiment failed to notice a gorilla appear on a video of people playing basketball, so those who were not working at Mid Staffs at the time simply cannot understand how the nurses involved could have behaved in such a cruel and callous way. As Paley states:

> The sense people make of a situation when it is described hypothetically from the outside, bears no relation to the sense they make of it when they are actually in it . . . From the outside, people are astonished at the failure to help and are absolutely confident that they themselves would not behave like *that*. Inside, behaving like that is exactly what they do. (Paley, 2014)

Actually, behaving like *that* is not what most nurses do. Many nurses have expressed shock and incredulity at what happened at Mid Staffs, including ourselves. Moreover, unlike Paley, we are *not* outsiders. Most nurses have, at some time or another, found themselves under immense pressure of time and resources; many will have briefly entertained the thought of perhaps cutting corners or pretending not

to notice a patient in distress; and some might even have given in to that temptation on occasion. That is only human. We are insiders, we have been in similar situations, and we do not accept Paley's assertion that the behaviours of the nurses responsible were simply misunderstood. 'Outsider disbelief' might or might not be a valid construct, but it cannot and should not be employed to excuse or explain away the inexcusable.

The cocktail party effect

Paley adds that, when staffing levels are low and when time is tight, 'It is not difficult to see how, in these circumstances, attention devoted to one seriously ill patient could prevent the distress of another being recognized' (Paley, 2014). He explains that 'it would appear that attention is a finite and severely limited cognitive resource . . . if we pay attention to one place, or object, or event, we necessarily pay less attention to others'. Thus, he concludes, 'this makes multi-tasking a bit of a myth'. Once again, most nurses whom we know and have taught have been in similar situations, and most manage perfectly well at recognizing distress in one patient while attending to another. This can be explained as a variation on the well-known 'cocktail party effect', where a guest at a party can focus their attention on an ongoing conversation yet still hear their name spoken across a noisy room. It seems that giving attention to one event does not completely preclude us from subconsciously attending to other events in the room and then suddenly switching our conscious attention when something of significance occurs.

Several research studies of nursing situations have confirmed this ability of nurses to subconsciously monitor a room full of patients while attending to one in particular. For example, Scholes (1998) describes a series of studies in which she video recorded intensive care nurses caring for unconscious patients. She noted that they set up their monitoring equipment so that it could be seen from any location in their 'practice territory' and subconsciously scanned the visual displays at regular intervals. In this way 'they could ascertain if there were any changes to the readouts and intervene immediately to check if this was an anomaly or a cue to the patient's changing condition' (Scholes, 1998, p. 260). When they detected an altered cue, they assumed that it was by chance or through intuition, and only realized that they had been subconsciously and systematically scanning the displays when they later watched the replay on the video recorder. Scholes concluded that this enabled the nurses to 'manage complex situations and incorporate multiple activities into one apparent action or minor deviation, thus creating the time and space to manage the unpredictable' (Scholes, 1998, p. 261). Scholes points out that this is not something that just anyone can do; sustained multitasking of this kind is not a natural ability but comes with experience and 'know how'. The nurses could focus their attention on one particular aspect of patient care and yet were immediately alerted to unexpected changes on the visual displays in much the same way that we could be engrossed in a conversation at a noisy party and yet still notice our names being mentioned on the other side of a crowded room. Furthermore, it provides an interesting example of Paley's 'outsider disbelief'. To someone from outside the nursing profession who has no experience of working in this way, multitasking might well be regarded as, in Paley's words, 'a bit of a myth'. However, many experienced nurses will recognize the ability to multitask in ways similar to that described by Scholes, even if they are unaware of the precise mechanisms that enables it.

Social desirability and cognitive dissonance

Paley infers that the nurses implicated at Staffordshire Hospital in the appalling care (more correctly, in the appalling lack of care) should not be accused of lacking compassion because, for psychological reasons, they did not even notice that there were patients in distress or in need of help. This brings us to yet another objection to Paley's account. In place of the theory of 'inattentional blindness' or 'narrowing of the cognitive map' postulated by Darley and Batson and accepted uncritically by Paley, we would like to offer what we consider to be a simpler and more plausible explanation for the student priests' behaviour, also based on theories from social psychol-

ogy. The bare bones of the Darley and Batson study are as follows: trainee priests were deceived into taking part in a study to see how they would respond to a man in distress; many of them ignored the man, despite his coughs and groans; when later confronted by the experimenters about their behaviour, most claimed that they did not realize that he was in distress or else decided that it was more important to keep their appointment than to stop to help him.

At the risk of sounding naïve, our response is along the lines of 'well, they would say that, wouldn't they'. This was not the study they had signed up to, they had just been tricked into behaviour that did not sit easily with their self-image and public persona as future members of the priesthood, and they most likely had no feelings of loyalty towards the researchers or their experiment. They had just been lied to, so why not lie back by claiming that they did not realize that the man hunched in the doorway was in need of help? Furthermore, we can imagine that student nurses placed in a similar situation might respond in a similar way. If we wish to dress up this response in the language and concepts of social psychology, we might cite the well-documented phenomenon of social desirability, which is 'the tendency for participants [in research studies] to present a favourable image of themselves' either unconsciously or deliberately 'to conform to socially acceptable values, avoid criticism, or gain social approval' (van de Mortel, 2008, p. 41). In other words, we should not take responses to research questions at face value when those questions threaten the presentation of the self-image of the subjects. Or we might cite 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).

Cognitive dissonance could have been reduced in this case by the trainee priests altering their caring behaviour, by modifying their self-concept as caring individuals or by rationalizing their behaviour, perhaps by telling themselves and the researchers that they did not even notice that the man was in need of help. In this case, the first option was not available (they could not rerun the situation), the second option was undesirable as it would mean admitting that they were not the caring people that they had led themselves and others to believe, and so the only acceptable way of reducing the cognitive dissonance they were feeling was the third option. As Aronson *et al*. (2004, p. 176) conclude, 'to escape from dissonance, people will engage in quite extraordinary rationalising', including, presumably, lying to researchers. Neither Darley and Batson nor Paley entertained these alternative explanations; all accepted the accounts of the trainee priests at face value, and Darley and Batson failed to control for social desirability, despite the fact that scales to detect it were available at the time (e.g. Crown & Marlowe, 1960).

The importance of context

Let us suppose for a moment that the conclusions drawn from Darley and Batson's study are correct; that all of the respondents were telling the truth; and that their cognitive map had become so narrowed by the pressure of time that they did not recognize that the man in the doorway needed their help. Even if this is an accurate description of what was going through the minds of the priests as they walked past the man in the doorway, the question we have to ask ourselves is *to what extent can we apply this analysis to the activities of the nurses at Staffordshire Hospital?* There are two reasons why we believe that the external validity of Darley and Batson's findings is low.

Firstly, we have to decide whether the settings are comparable. Can we assume that young male students studying for the priesthood in an American university in the early 1970s would respond in the same way as possibly older, mostly female qualified and experienced nurses in a UK hospital 40 years later? Can we assume that an unexpected encounter with a man coughing in a doorway when those students were on their way to a prior appointment is similar enough to the day-to-day clinical encounters between trained professionals and their patients to ascribe similar reasons for not stopping to help them? In the former case, the students were not expecting to see the man coughing and groaning in the doorway and could reasonably have argued that they were not skilled or informed enough to make a decision about whether

or not he needed help. Indeed, that is exactly what many of them did say. In the latter case, sick patients were precisely what the nurses were expecting to see, and they were certainly skilled and informed enough to decide whether or not those patients required help. Paley makes the point that context is all-important; that the Francis report 'seriously underestimates the power of contextual factors'; and that the behaviour of the nurses at Staffordshire Hospital can be almost entirely accounted for by the situation they found themselves in rather than by any personal shortcomings. Indeed, he argues that there *were* no shortcomings and no compassion deficit. However, he rather naively assumes that the findings noted by Darley and Batson are completely context free and make no attempt to discuss whether or not they are applicable to other, quite different settings. Our analysis of the situation is that the differences in these cases are so great that it would be reckless to assume, as Paley does, that 'it was not a failure of compassion that led to the events in Mid Staffs but an interlocking set of contextual factors that are known to affect social cognition'. Moreover, even if contextual factors did, in fact, play some part in the behaviour of those nurses, there are no grounds and no evidence for the claim that there was not *also* a failure of compassion. A lack of evidence is not the same as evidence of a lack.

Secondly, Paley suggests that we might widen the external validity of the 'social cognition' thesis to include 'any other hospital where too many examples of appalling care are reported'. However, some of the examples of appalling care across the UK have not simply been cases of neglect but shocking accounts of wilful cruelty. These are not cases where nurses and other healthcare workers merely failed to spot patients in need of help but where they went out of their way to inflict pain and suffering on helpless individuals, often elderly or suffering from intellectual disabilities. However, Paley also has an explanation for 'institutions, such as prisons or hospitals, in which one group of people is responsible for another'. Once again, his intention is to demonstrate that '*situations* produce institutional behaviour. People's attitudes and values, shared or not, are peripheral'. In other words, good people can be coerced into doing bad things through social and psychological mechanisms that are largely out of their control and therefore no blame should be attached: these people were in the grip of forces which they found extremely difficult to resist.

In order to support his thesis, Paley cites the (in)famous Stanford Prison Experiment conducted by Phillip Zimbardo and colleagues in the basement of the psychology department at Stanford University in 1971. The Stanford Prison Experiment is very well known and is described in detail by Paley in his paper. Briefly, 24 young male college graduates were assigned to play the role of either prisoner or guard in a simulation of an American prison. The guards very quickly began to behave in a brutal and inhuman fashion, and the prisoners initially rebelled but rapidly became submissive, compliant, disoriented, and distressed.

Paley draws a number of conclusions about the behaviour of the nurses at Mid Staffs and elsewhere based on the findings from the Stanford Prison Experiment; the first and most fundamental of which is, quoting Zimbardo, that 'situations matter. Social situations can have more profound effects on the behaviour and mental functioning of individuals . . . than we might believe possible'. As a general statement, this certainly has a ring of truth. However, as a general statement, it also limits any conclusions we may infer from one situation to another. If situations matter, then we might suspect that different situations matter in different ways. Paley outlines the cruelty of the guards, the degradation rituals that the prisoners were forced to perform, and the fact that the guards quickly began to treat the prisoners 'like cattle', in order to draw comparisons with details described in the Francis Report. However, if the social situation is the most important determinant of behaviour, then we might expect that very different situations are likely to produce quite different patterns of behaviour. Moreover, as with the 'Good Samaritan' experiment, the situation in the basement at Stanford University was very different from Staffordshire Hospital in almost every respect. We have already made the point that any generalizations from a group of young male college students taking part in a role play exercise in 1970s America, to a group of older, mostly female healthcare professionals in 21st century

Britain should be made with extreme caution. And yet making such a generalization is exactly what Paley does. Thus, the fact that the 'guards' in the Stanford Prison Experiment behaved as they did, despite all of them scoring within the normal range on a series of personality tests, leads him to the conclusion that:

> It is quite futile to propose 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'. (Paley, 2014)

Firstly, we believe that this is a rash and very assertive overgeneralization of the findings from the Stanford Prison Experiment to a very dissimilar group in a quite different setting, with quite profound consequences were Paley's recommendations to be taken seriously. Secondly, the Stanford Prison Experiment participants were not tested for their attitudes towards 'caring, compassion and other necessary professional values'. Zimbardo merely states that the applicants completed an extensive questionnaire concerning their family background, physical and mental health history, prior experience, and attitudinal propensities with respect to sources of psychopathology (including their involvement in crime) (Haney *et al*., 1973, p. 73). Moreover, despite Paley's assertion that 'the participants were all in the middle of the normal curve on traits such as trustworthiness, conformity, stability, masculinity, and empathy', there were notable individual differences in the behaviours of the 'guards'. The original report of the study explains that:

> Some guards were tough but fair ('played by the rules'), some went far beyond their roles to engage in creative cruelty and harassment, while a few were passive and rarely instigated any coercive control over the prisoners. (Haney *et al*., 1973, p. 81)

Clearly, something other than situational factors was at play; there would appear to be differences between the 'guards' that were not detected by the battery of tests administered before the experiment. We have no idea from the report whether the 'tough but fair' guards would have scored high on caring and compassion and whether those who engaged in 'creative cruelty' would have scored low on those traits. We do not know whether those with what Paley calls 'necessary professional values' would have withdrawn from the experiment at the first signs of abuse, or whether they would have 'whistle-blown', because those variables were not measured. However, neither can we be so certain, as Paley appears to be, in ruling it out. Although the report favoured a situational explanation for what happened at Stanford, it concluded that 'We cannot say that personality differences do not have an important effect on behavior in situations such as the one reported here' (Haney *et al*., 1973, p. 90). Perhaps Paley is correct in his assertion that situation is the most important factor, or perhaps character plays a greater role in directing the behaviour of trained healthcare professionals than in college students; the Stanford Prison Experiment does not inform us either way. Moreover, even if situation does outweigh character, a ward in a UK hospital is a very different situation from a simulation of a prison in an American university basement.

However, there is more to it than this. As with the 'Good Samaritan' experiment, the Stanford Prison Experiment suffers from internal validity as well as external validity problems, and once again social desirability plays a significant role. As several critics have noted, Zimbardo participated in the experiment by taking the role of Prison Superintendent and exerted a strong influence over what was expected of the students (i.e. to act according to their stereotyped views of what prisoners and guards in American prisons do) and the 'guards' were briefed beforehand by an ex-prisoner on ways of psychologically humiliating and harassing the 'prisoners'. Furthermore, as Zimbardo (2007) later admitted, he also briefed them with suggestions of how they might behave towards the 'prisoners', including creating a sense of boredom, frustration and fear, taking away any sense of individuality and volition, and creating a sense of powerlessness. It is probable, then, that social desirability played a part in shaping the behaviour of the students and that they were acting in ways intended to please the experimenter rather than according to their natural inclinations. Other criticisms of the experiment include serious ethical concerns about the very real stress caused to many of the participants; that the conclusions and observations were largely anecdotal and subjective; and the presentation of counter-arguments

drawn from real-life examples about the extent of the role played by individual personality traits.

Carnham & McFarland (2007) also found from their own study that students who responded to a replica advertisement for a prison study were higher in traits such as social dominance, aggression, and authoritarianism, and lower in empathy and altruism than a control group, suggesting that Zimbardo's sample might have been skewed from the outset. They also failed to recruit adequate numbers when advertising for a similar study into 'helping behaviours', suggesting perhaps that students with an orientation towards helping others might not have been adequately represented in Zimbardo's study. It is probably fair to conclude that situation and disposition both played a role in the Stanford Prison Experiment, such that people with aggressive and authoritarian tendencies are attracted to situations where those traits are further nurtured and allowed to develop in a vicious circle of abuse.

This analysis does not necessarily detract from Paley's thesis that social pressures play a large part in determining individual behaviour, and to some extent, it supports the idea that good people sometimes do bad things in order to please other powerful or charismatic bad people, but it fails adequately to account for the events in Mid Staffs. It also raises questions about the extent to which the Stanford Prison Experiment (and, indeed, the 'Good Samaritan' experiment) should be considered as credible and reliable evidence on which to draw such far-reaching conclusions and recommendations for nurse recruitment and education.

Compassion and the recognition of suffering

Paley's fundamental argument against a 'compassion deficit' in nursing draws heavily from the theory of 'inattentional blindness' and the 'Good Samaritan' experiment with trainee priests. Thus, he argues that 'the failure to help was not the result of a compassion deficit. Rather, it was the outcome of a cognitive constraint', which rendered individual personality differences irrelevant. In making this argument, we suggest that Paley is confusing two different phenomena: failure to *notice* and failure to *recognize*. He conflates examples such as experimental research subjects failing to *notice* a gorilla beating its chest on a video of a basketball game, commercial airline pilots failing to *notice* a large jet turning on the runway right in front of them; an American policeman failing to *notice* white colleagues beating up a black suspect (or perhaps failing to *recognize* that they were doing anything wrong or out of the ordinary); and the trainee priests who failed to *recognize* that the man in the doorway was in need of help. As an explanation for the latter case, Paley explains that the trainee priests:

> Simply did not interpret the situation as one requiring an intervention. They may have *noticed* the man, but they did not *recognise* the situation as one to which the description 'requiring my help' applied. It was a case of 'Now you mention it, yes . . .' rather than a case of 'I saw his distress but decided to ignore it'. (Paley, 2014, our emphasis)

It was not that they failed to notice the man; according to Paley, they simply did not recognize that he needed help. This is clearly a different situation from either the 'invisible gorilla' experiment or the airline pilots' situations. We doubt that any of the subjects who failed to spot the gorilla said 'Now you mention it, yes, there *was* a gorilla in the video'; it is unlikely that the airline pilots would have said 'Now you mention it, yes, a large jet *was* turning on a runway right in my path'. In fact, many of the subjects in the Invisible Gorilla experiment were so convinced that there was no gorilla that they suspected trickery on the part of the experimenters. These were not cases of a failure to recognize the significance of the gorilla or the jet, they were cases of not even noticing it.

However, in the case of the trainee priests, they all recalled noticing the man in the doorway and offered various reasons why they did not stop to offer help, mostly centred on not recognizing that help was required. Except, of course, that some of them (albeit a minority) *did* stop. Paley can offer no explanation for this. He points out that:

> It turns out that there are no individual difference – no variations in socio-demographic characteristics or in character traits – between those who notice extraneous objects and those who do not. (Paley, 2014)

It seems that some of us simply have the ability to notice people in need of help and some of us do not.

At the risk of stating the obvious, isn't this ability that some people have of recognizing suffering in others and wanting to do something about it precisely what we mean by compassion? The dictionary definition of compassion is 'sympathetic consciousness of others' distress together with a desire to alleviate it' (*The New Penguin English Dictionary*). Thus, the trainee priests who recognized that the man was in distress and who stopped to offer help were, *by definition*, more compassionate than those who noticed him but did not stop. Similarly, the prison guards who were 'tough but fair' could be said to be more compassionate than those who went out of their way to be cruel. What each of these experiments teaches us is not, as Paley wants us to believe, that our behaviour in social settings is determined almost entirely by the situation to the extent that individual differences in personality, attitudes, and values have no effect, but rather that these extreme situations help us to distinguish and differentiate between the Good Samaritans and the decent prison guards on the one hand and those who fail to recognize suffering (or worse, those who recognize it and do nothing) on the other.

Zimbardo later acknowledged that individual difference played a significant role in the Stanford Prison Experiment. In a summary of Zimbardo's retrospective account of the experiment, Krueger wrote:

> Situations do not 'overpower' people but rather reveal latent possibilities. Even if everyone becomes more aggressive in an aggression-inducing environment, individuals differ in the degree to which they respond. Hence, person and situation do not compete for a fixed amount of behavioral variance. Behavior is not a zero-sum game. Instead, *situations can bring out individual differences that would otherwise never be seen*. (Krueger, 2008, p. 338, our emphasis)

Just because the experiments cited by Paley did not measure or control for compassion does not mean that it does not exist or that it was not an active variable in determining behaviour. Indeed, the fact that it was not controlled for allowed it to emerge as an important construct in understanding the difference between those trainee priests who stopped to help and those who did not, and between the 'tough but fair' guards and those who treated the prisoners 'like cattle'. In any case, it is possible that compassion is impossible to control for because it cannot be quantified. Compassion might turn out to be one of those things that you just know when you see it; something that manifests in what we do rather than in which boxes we tick on a questionnaire.

If this is the case, then the lesson for the nursing profession is not, as Paley would have it, that care and compassion are irrelevant in the face of situations such as those found at Mid Staffs but that some nurses possess a sympathetic consciousness of others' distress and some do not; that some nurses have a desire to alleviate that distress and some do not; and that some behave with honour and integrity in the face of extreme social pressure and some do not. In other words, there *is* a compassion deficit and something needs to be done about it. Explaining it away as a problem of social cognition will not make it disappear. On the contrary, it will draw attention away from it at a time when it desperately needs to be confronted head-on.

Educating for compassion

The question that is begged by our analysis, then, is *What is to be done?* We are suggesting that the failure of care at Mid Staffs and elsewhere was not a failure of cognition; it was not a failure to *notice* patient suffering brought on by lack of time and pressure of work. Rather, it was a failure to *recognize* the suffering *as suffering* or, in the words of the dictionary definition of compassion, a failure of sympathetic consciousness of suffering, which was in some of the more extreme cases coupled with a lack of desire to alleviate it. It might be objected that we are splitting hairs in making this distinction between failing to notice and failing to recognize. However, whereas Paley's argument that nurses sometimes do not even notice patients in need of help leads him to the conclusion that the problem 'cannot be corrected or compensated for by teaching ethics, empathy, and compassion to student nurses', our formulation leads us in the opposite direction. We believe that there *is* a compassion deficit in some nurses, but it is not a cognitive deficit; it is *not* brought about by external circum-

stances, and it *can* be remedied through education. Put simply, it is a deficit of imagination; of the ability to imagine ourselves in the position of those who are suffering and, in extreme cases, to imagine them as human beings like ourselves.

In order to consider an educational response to this deficit, let us return to Darley and Batson's Good Samaritan experiment. Let us imagine that, instead of trainee priests, it was conducted with student nurses. Let us also imagine that Darley and Batson's findings were more or less replicated with our nurses; that is, roughly 60% stopped to help when under no pressure of time and 10% stopped when they were already late for their appointment. This suggests that, under normal circumstances, the majority of our student nurses would have met both conditions for compassion: they possessed a sympathetic consciousness of others' distress *and* a desire to alleviate it. When pressed for time, these students still noticed the man and arguably still recognized that he was in need of help but weighed up their priorities and decided that their obligation to the experimenters (who were, after all, paying them to take part in the study) was greater that their impulse to stop and help. This hypothesis fits with the findings from Darley and Batson's study, where some of the trainee priests expressed a 'conflict between stopping to help the victim and continuing on [their] way to help the experimenter . . . Conflict, rather than callousness, can explain their failure to stop' (Darley & Batson, 1973, p. 108).

If our hypothetical sample of student nurses behaved in the same way as the student priests, we might conclude that around 60% of them were naturally compassionate, although perhaps they would need to work on their skills of prioritization of tasks. But what of the remaining 40%? This is the point at which our analysis differs significantly from Paley's. He suggests that these are equally compassionate people who, as a result of what he calls 'inattentional blindness', failed to notice that the man was in need of help. In Paley's words, they 'did not recognize the situation as one to which the description "requiring my help" applied'. This might well be what they said when interviewed by the experimenter, but we have argued above that there are good reasons why they might not have been completely honest in their responses. Furthermore, Paley argues that inattentional blindness is almost entirely situational and can only be resolved by changing the social and psychological conditions that caused it.

Our interpretation is more nuanced than Paley's; we suggest that of the 40% who did not stop, some walked on because they had no desire to alleviate the man's suffering, while others lacked the sympathetic awareness to recognize a fellow human being in distress. Of those in the former category, some would never stop to assist others regardless of the situation. This has nothing to do with cognitive blindness; they are simply lacking in compassion. Others might stop in more extreme situations than to assist a man sat coughing in a doorway, and others might have stopped if they had been better educated about the ethics and morals of helping others. In other words, at least some of these people could, with the right educational input, become more compassionate individuals and better nurses.

Regarding those who walked on because of a lack of sympathetic awareness, we again suggest that we are not dealing with a problem of cognition, but with a deficit of imagination. Whether on the street or in a hospital ward, nurses sometimes fail to respond fully to people who are in need of help *not* because they do not see the situation as one requiring an intervention, but because that is *all* they see. They see a situation rather than a suffering person; they see the 'stroke in bed four' rather than Mr Smith who is frightened, in pain, and unable to communicate; they see tasks to be performed rather than people to care for. So, for example, these nurses are likely to approach giving a bed-bath to Mr Smith in the same way that they would go about washing a car, as a task to be performed and an object to be cleaned. Not only does this depersonalize the nursing intervention, but it makes it easy to justify cutting corners when time is pressing, or even putting off the task until another day.

These nurses are, by definition, lacking in compassion, but again it is a lack that can be addressed through education. One of the difficulties with educating nurses for technical rational, evidence-based practice is that nursing is presented as a series of rational problems to be solved through technical

interventions, with little attempt to address the human element of the situation. It is understandable that some nurses, particularly younger ones, might have little first-hand experience of the kinds of suffering that their patients are undergoing, but that is not to say that they cannot be helped to *imagine* what they might be experiencing and how they might be feeling. Richard Rorty refers to this ability to imagine the suffering of others as 'solidarity' and claims that it can be enhanced through studying the arts and humanities:

> This process of coming to see other human beings as 'one of us' rather than as 'them' is a matter of detailed description of what unfamiliar people are like and of redescription of what we ourselves are like. This is a task not for theory but for genres such as ethnography, the journalist's report, the comic book, the docudrama, and, especially, the novel. (Rorty, 1989, p. xvi)

Education can therefore play a significant role in developing compassion and offers the best hope for the future of nursing, but it requires us to take a much broader view of what should be included in the nursing curriculum. While it might be tempting for the profession to accept Paley's argument that the appalling lack of care found at Mid Staffs was due almost entirely to staffing shortages and other situational factors, we consider that the conclusion that this failure of care has nothing to do with 'character, attitudes and values' and that it will not be addressed by promoting a 'culture of compassion and caring in nurse recruitment, training and education' is dangerously misplaced.

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