



## Editorial

## Wisdom, prudence and academic freedom



John Paley recently wrote an editorial for this journal in which he stated:

In my own view 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. (Paley 2013, p.1451).

In a response to this editorial, Lyn Gardner and I challenged the research findings underpinning Paley's conclusion (Rolfe and Gardner 2014). In particular, we called into question his assertion that the nurses implicated in the neglect and cruelty at Mid Staffs were not lacking in compassionate motivation but were subject to ‘a narrowing of the cognitive map’ which meant that they quite literally did not see the neglect and distress occurring under their noses. We further challenged his view of the general public as ‘outsiders’ who could not possibly understand the ‘cognitive narrowing’ experienced by the Mid Staffs nurses which led to such appalling cases of neglect. In other words, for Paley, there was no compassion deficit at Mid Staffs, educational initiatives to develop compassion are misconceived, and any attempt by members of the public, by relatives and by other nurses to argue otherwise can be dismissed simply as ‘outsider disbelief’.

It was our contention that Paley based his arguments on the findings of psychological experiments which lacked validity, generalisability and credibility, but that even if his conclusions were justified, this was neither the time nor the place to be making such claims. As nurses, we had been troubled and dismayed by the way in which our profession was being increasingly demonised by certain sections of the national and local press, and we were concerned that the perception (whether accurate or not) that nurses and nurse academics were in denial over the root causes of so many recent ‘failures of care’ would only fuel the flames. In his reply to our paper, Paley accused us of wishing to suppress debate about the possible causes and responses to the current crisis of confidence in nurses and nursing and of advocating ‘education for compassion on political grounds’ (Paley 2014). Inherent in Paley's critique is the question of academic freedom, of whether academics should be free to state their views regardless of social, political or personal consequences.

Academic freedom is sometimes portrayed as an absolute value, a shared concept and an inviolable right. However, like democracy and freedom of speech, it is a contested construct and has been interpreted differently at different times and in different countries. Furthermore, it cannot be divorced from disputes about the nature of evidence, truth and scientific method. Academic freedom does not give us the right to say whatever we choose; for example, it cannot and should not be invoked to justify unsupported claims about race, sexuality and gender.

Whilst it allows us to follow our own lines of thought in whatever direction they lead us, it is generally accepted that the dissemination of the findings of our inquiries, whether through teaching or writing, should be supported by an evidence-base or justified through rigorous argument. Apart from any political, philosophical or scientific considerations, then, the limits and boundaries of academic freedom are determined by our subjective decisions about what constitutes sufficient evidence for our assertions.

However, the purpose of this editorial is not simply to debate the merits and limits of academic freedom, but to raise awareness of some of the moral, ethical and practical dilemmas faced by nurses when their professional values come into conflict with their academic roles as writers and scholars. These are issues that do not directly affect all contributors to scholarly debate in nursing. Some writers, including Paley, are not nurses and are not subject to these particular obligations and demands. And for those of us who are both nurses and academics, the issue is wider than simply deciding what and what not to publish; it affects also our decisions about what and how we should be teaching and researching, and about our wider extramural activities. In short, we are required to balance the agenda, mission and goals of the university in which we work with the demands and obligations placed on us as members of the nursing profession.

For example, the Standards of conduct, performance and ethics for nurses and midwives (NMC 2008) instructs nurses to ‘make the care of people [patients] your first concern’ and ‘act with integrity and uphold the reputation of your profession’. The majority of what we do as academics does not contravene these moral imperatives; indeed, most of our research, teaching and writing is patient-focussed and enhances the standing of the nursing profession. However, many of us will have had to make choices in our academic careers where the care of patients might not be our first or primary concern. There will be occasions where, as researchers, we are faced with choosing between (say) taking on a small-scale developmental project of direct local benefit to specific patients or becoming involved in a large-scale nationally-funded research study which might be of only limited practical use. It is, of course, debatable which of these hypothetical projects will contribute most to the care of patients, but how many of us can honestly say that our first concern in making such a decision is always ‘the care of people [patients]’ rather than our own career prospects. And in making these decisions, can we always claim to be concerned primarily with the benefits to our profession rather than with the benefits to our university, our department, or ourselves?

For ‘pure’ academics, those colleagues with no professional affiliations and no practical obligations outside of the academy, life is presumably more straightforward. The missions of most universities are quite similar, and usually include a commitment to ‘research excellence’, as

measured by the size and source of external grants and the publication of papers in high impact journals; and to 'teaching excellence', as measured by student retention rates, degree classifications and scores on student satisfaction surveys. I have suggested, however, that nurse academics are also bound by the ethos and values of our professional discipline, which may at times conflict with the academic mission of our employers. I suggest that the large externally funded research projects are not always of greater benefit to the profession than small, local action research and practice development projects; that publishing our findings in high impact journals that are only read by other researchers is not always a better way of improving nursing practice than publishing them in professional journals with little or no academic status; that doing everything we can to retain struggling nursing students for the sake of raising retention rates is not always in the best interest of patients; and that striving to ensure high scores in student satisfaction surveys does not always result in the optimum educational experience for practice.

I have suggested, then, that the values of academia sometimes clash with the values of the nursing profession, and that in these cases nurse academics are faced with tough choices. It was in recognition of these recurring dilemmas that we said of Paley's paper that:

... 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. (Rolfé and Gardner 2014, p.956).

This is, perhaps, one of those (thankfully rare) situations where the values of the academy (in this case the freedom to comment on a professionally sensitive ongoing situation without fear of external censorship and regardless of the wider political fallout and possible distress to patients and their families) conflict with the best interests of the nursing profession, of practitioners and of patients. So what is to be done? Paley (2015) claims that I was calling for his views to be suppressed 'in the interests of a PR exercise'. I was not. What I am suggesting is that, when faced with dilemmas of this kind, nurse academics should respond with wisdom and (if necessary) restraint by carefully considering all of the competing values, obligations and demands placed on us as educators and nurses. As nurses, we are skilled at weighing up costs and benefits, pros and cons, and with making clinical judgments based on critical reflection. As academics, we can draw on the same expertise in deciding when, where and in what form to publish our thoughts, theories, essays, research and polemic. Academic

freedom is a huge privilege that should be exercised wisely and prudently rather than asserted in all cases and at any cost. It is not an imperative; it represents one value amongst many, and just because we can publish more or less whatever we choose does not mean that we must. Paley is, of course, free to publish what he likes when he likes, and I am free to express the view as a nurse that, in my opinion, a little wisdom and restraint would not have gone amiss on this particular occasion. Paley is free to respond to my position and label it as suppression, and I am free to object to his label and to try to explain my position more fully. This is not, as far as I can see, a process of closing down or suppressing debate but of opening it out; it is academic freedom in action.

I accept that questioning the hard-won principle of academic freedom might be viewed as reactionary and counter to the values of the liberal university. It is important to conclude, therefore, with a positive endorsement of the academic right to pursue our own chosen fields of study and lines of inquiry. In pursuit of a high standing in academic league tables, research assessment exercises and patient satisfaction surveys, our universities are prescribing more and more what research we should be conducting, which grants we should be applying for and where we should be publishing our 'outputs'. The introduction of key performance indicators means that, in many cases, goals are being set on our behalf and measured by crude numerical indicators. If ever there was a time to stand up and assert our rights to research what we consider to be in the best interests of patients and to publish our work where we think it will be read and acted upon by practising nurses, it is now, and the privilege of academic freedom offers us the best hope of doing so.

## References

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