

Prepublication Draft

Smajdor, A. Reification and compassion in medicine: A tale of two systems. *Clinical Ethics* 1477750913502620, first published on September 18, 2013 as doi:10.1177/1477750913502620

Final published version available at:

<http://cet.sagepub.com/content/early/2013/09/11/1477750913502620.abstract>

Reification and compassion in medicine: a tale of two systems

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Introduction

Many people would agree that doctors and nurses should be compassionate.¹ Nevertheless, it is frequently lamented by patients, policy-makers and health professionals alike that compassion is under threat in modern medical practice. In February 2013, the Francis Report was published, in response to what it describes as ‘systemic failings’ at Mid Staffordshire NHS Foundation Trust. These failings brought about the deaths of many patients, and caused suffering to many others through inadequate provision for their needs. But what emerged perhaps most strikingly from the report was a background culture in which staff attitudes towards patients were rude, dismissive and neglectful.²

UK prime minister David Cameron’s response to the Francis Report was to urge that, among other things, ‘[n]urses should be hired and promoted on the basis of having compassion as a vocation and not just academic qualification’.³ This is not an entirely new development. In 2008 the then secretary of state for health, Alan Johnson, announced that the government would tackle the apparent compassion deficit by developing new metrics to assess the degree of compassion with which healthcare is delivered, alongside its measurements of safety and efficacy.⁴ Cameron’s suggestion was that nurses’ pay should be dependent on their ability to demonstrate compassion in their jobs. If these approaches worked effectively, those who lack compassion could be identified, disciplined, or perhaps even pre-emptively excluded from the healthcare professions. Alternatively, we could amend our medical education curricula to ensure that students are taught how to empathise and be compassionate right from the start of their training.

But can we be sure that the appalling events detailed in the Francis Report are linked with compassion, or its lack? And if so, is David Cameron being realistic in thinking that we simply need to choose compassionate healthcare professionals in our recruitment processes, or reward compassionate nurses with increased pay? And even if we could achieve these things, would this be enough? Gregory Pence rejects the idea that recruiting ‘better’ people is the answer. The answer lies in the system itself, he suggests. Rather than looking at individual dispositions and virtues, we should focus on the institutional structures that support or undermine compassionate behaviour.⁵ Cameron’s rhetoric, on the other hand, and that of Alan Johnson, seems to focus more specifically on individuals’ responsibility for their behaviour – especially that of nurses. (Perhaps this is indicative of an assumption that nurses are under a greater moral obligation than doctors to be compassionate. If so, it would be interesting to explore whether and why this might be the case, but that is an endeavour beyond the scope of this paper.)

David Cameron and Alan Johnson seem agreed on the need to incentivise compassion in the NHS. Their suggestions imply that we will have to find a means of quantifying compassion in order to make effective measurements. If some nurses are to receive more money than others, on the basis of their greater compassion, nurses in general will want to know on what basis this judgement has been made. They will wish to ensure that – at the next time of measurement – they can maximise their chances of a higher score, and a bigger wage packet. This is, after all, the point of linking compassion with pay: it creates a motive for demonstrating the desired attributes. Yet there is something peculiar about the idea of incentivising compassion through increased pay: isn’t virtue supposed to be its own reward? Would compassion that has been ‘bought’ be real compassion, or just a simulacrum? Anne Bradshaw, writing in the *Journal of Medical Ethics*, has argued that the endeavour to enforce compassion through metrics is doomed.⁶ She objects that such measurements must inevitably rely on proxies, and that this is likely to result in a ‘McDonald’s’ type of compassion, whereby certain stock behaviours and phrases are taken to embody compassion. For Bradshaw, true compassion is a virtue that is essential to good nursing, and the measured version is quite literally a sham, forcing health professionals to play a part in order to satisfy the artificial requirements imposed on them.

In this paper, I will explore ideas advanced by Bradshaw and Pence and others who have written on compassion in healthcare. I will attempt to see how and whether their assumptions about compassion can be justified, and seek to answer the question of what role compassion should play in a modern healthcare system. I will suggest that scepticism at the idea of attempting to incentivise compassion through metrics is justified. But the Francis Report clearly raises important questions about why patients were being harmed by the healthcare system which was supposed to be helping them. If something is failing in modern healthcare, those in charge of the service should naturally seek to remedy it. The question is, is it compassion that has disappeared, and if so, what is it that is emerging to fill its place? Do we need to rehabilitate or enforce compassion in the system, as many would argue? Or must we acknowledge that our modern healthcare systems are incompatible with compassion, and make the best of what remains?

Compassion is neither necessary nor sufficient for the provision of good healthcare

The following assumptions are commonly made about compassion in healthcare:

1. Compassion is intrinsically, rather than instrumentally valuable
2. Compassion is incommensurable
3. Compassion is a necessary attribute for healthcare professionals

In this paper, I do not question the first two assumptions, though it seems plausible that they could be challenged. Rather, I want to suggest that if we accept the first two assumptions, the third cannot follow as a matter of course.

Bradshaw argues that the Judaeo-Christian virtues such as compassion that used to play a significant though often unstated part in medicine and nursing in the Western world have been undermined by the encroachment of utilitarian values. This is a fundamental problem since Bradshaw, and many other commentators, such as Gregory Pence, take compassion to be intrinsically valuable, not just instrumentally so.^{5,6} It is very common to conflate, as Bradshaw does, compassion or other virtues such as empathy, with being a good healthcare professional.^{7,8} For those who hold these views, no-one can be a good doctor or nurse without compassion or empathy. The idea that healthcare workers do not – and perhaps need not – feel compassion for patients is unacceptable. These are the caring professions: how can a doctor care for a patient, if he or she does *not* care?

The terminology here is unhelpful. To care can be either to feel a certain way, or to carry out certain activities. Because the words are identical, and the meanings may overlap, we may forget that feeling and doing can be two very different things. But the difficulties associated with the word ‘care’ go beyond simply its ambiguity in this context. The approach to ethics advocated by Gilligan⁹ and others¹⁰ suggests that care *is* necessarily entwined with feelings, attitudes and emotions. This is often construed as part of a broader ‘female’ ethic, where loving relationships and interdependence supercede traditional moral concerns for justice and duty. Advocates of care ethics might believe that to separate the actions involved in caring from the feelings, is not only a debased sort of ethics, but perhaps a pathologically male approach. Although Bradshaw does not link caring with specifically female characteristics, she does claim that ‘conceptions of care divorced from virtue are ... incoherent and artificial’.⁶

Yet one *can* remove an appendix without caring about the person from whose body it is taken, empty a bedpan without caring about the patient who has filled it, or provide food without caring about the person who will eat it. The first concern of an institutional health service is that tasks are carried out effectively. The question here is whether compassion has a role to play in ensuring that this happens. The Francis Report set out the many ways in which patients can be damaged, even fatally, when their needs go unnoticed or unmet. Were the failures identified by the Francis Report due to the healthcare staff’s failure to *feel* in appropriate ways?

Most averagely compassionate individuals would expect to be moved by the plight of patients calling for water, languishing in soiled bedding, or dying neglected and confused. If this is true then, compassion might be seen as a safety valve, a way of compelling healthcare staff to intervene if things are slipping, or patients are suffering. On this view, those who feel no compulsion to intervene when patients are neglected and dying are dangerous in the health service. And if compassion is the means by which such compulsion can be generated, then compassion is what is required in order to forestall similar situations in future.

But if we ascribe the failings in mid Staffordshire wholly or partly to a lack of compassion, this raises some very difficult questions. The problems at mid Staffordshire were systemic, permeating the entire institution and its culture. It would be bizarre if that particular hospital had come to be staffed entirely by individuals who lacked compassion. Such a thing *could* happen through chance – or even through deliberate choice - but it seems extraordinarily unlikely.

Aside from the improbability of either chance or deliberate recruitment of uniformly uncompassionate staff, it makes no sense to suppose that the failings in mid Staffordshire were caused by lack of compassion, given the findings of the France Report. The Report contains many accounts of healthcare professionals' distress; their feelings of depression and helplessness; their frustrations at findings their concerns dismissed. Not every staff member's views are included, of course. But the overwhelming impression is that Mid-Staffordshire NHS Trust was not a happy place to work. Yet if lack of compassion were the root cause of the Trust's failings, there would be no reason for the un-caring staff to be suffering *as well as* the patients from these problems. Given the low morale among staff detailed in the Francis Report and elsewhere, it is more plausible to suppose that the failings in mid-Staffordshire came about *despite* the healthcare staff being no less than averagely compassionate.

If I am right about the points argued above, there are two key issues to consider here. Firstly, compassion is not a necessary component of healthcare, since the crucial tasks associated with healthcare can be carried out in the absence of compassion. Secondly, compassion is not sufficient to prevent catastrophic failures in healthcare, of the sort described in the Francis Report. Undoubtedly, compassion is one means by which a person can be motivated to perform the tasks involved in caring. When we see that a loved one is thirsty, hungry, in pain, or lying in soiled bedding, our compassion may be the primary cause for our intervention. This kind of relational care ethic is all very well when a mother cares for her child, or a wife her husband.

But healthcare professionals are *not* necessarily treating loved ones. They are responsible for many individuals, working to fulfil many tasks as efficiently as possible often in situations where time and resources are limited. For this reason, it is dangerous to rely on compassion as the motivation that ensures the necessary tasks are carried out. Reminders, routines, checklists, are also ways of ensuring that crucial healthcare tasks are undertaken - without relying on compassion. Of course, these systems are not infallible. They require intelligent management, and an ability to foresee and forestall potential problems. And however careful and conscientious healthcare staff may be, however rigorous their systems of reminders and checklists, if they are fundamentally under-resourced, they will fail to deliver the care that is required. Pence observes that compassion requires 'the time and willingness to listen'.⁵ Likewise, the fulfilment of the tasks involved in healthcare requires time; if this is not available, the willingness avails nothing...

Compassion causes suffering

Healthcare professionals who feel compassion may be deeply distressed by some of the things they see and do, though they may feel powerless to change the circumstances that lead to incidents such as those described in the Francis Report. To the extent that compassion causes distress, it may even be a factor in worsening outcomes in institutions where there are serious problems, and where compassionate healthcarers are affected by a sense of guilt and shame at their inability to improve things. It is known that emotional and psychological

damage can affect people who are working in situations that challenge moral norms, or make them feel powerless to act in accordance with what they believe to be right.^{11,12} For this reason, the compassionate healthcare worker may be at risk of suffering burnout, fatigue, becoming de-sensitised, damaged and ultimately dangerous in the healthcare system.

To understand this, it is necessary to recognise the double-edged nature of compassion and its relationship with love and suffering. Compassion is often associated with religious belief, as Bradshaw notes, especially Christianity. The ‘passion’ in compassion derives from the Latin ‘pati’ – to suffer. Love and suffering go together. When you love someone, you suffer when they suffer. A mother whose child undergoes surgery worries about the outcome; and suffers, knowing that her child is experiencing fear and pain. Compassion thus *multiplies* pain and suffering. Perhaps this is why our capacity to love and to feel compassion is so circumscribed. Imagine feeling that pain of compassion for every child suffering in the world. We cannot do it, and if we tried, it would probably kill us. The image of Christ on the cross is an illustration of this – perhaps this is the closest we can get to understanding the pain and suffering of someone who feels compassion for the whole world. It is literally excruciating.

Unless we regard healthcare professionals as saints, we cannot demand that they guarantee an unlimited flow of compassion for each patient. Indeed, it is not only unfair, but dangerous to do so. Medical professionals need to protect themselves as well as performing their medical duties, and if we demand compassion in addition to medical expertise and knowledge, we are setting our healthcare professionals up for failure. But perhaps part of the problem here arises from the quasi religious connotations of compassion. While Bradshaw explicitly links her understanding of compassion with a Judaeo-Christian religious perspective, even a secular understanding of compassion, such as the cognitive version advanced by Martha Nussbaum, seems excessively demanding as a sine qua non for all healthcare encounters. Nussbaum argues that compassion has three cognitive components:

- 1) the thought that another person is afflicted by a predicament that is serious and not merely trivial
- 2) the thought that this predicament was not on the whole caused by the person’s own fault
- 3) the thought that this person is part of my circle of concern, one of those whose happiness is an element in my conception of a flourishing life.¹³

Nussbaum suggests that compassion can be embedded in institutions as well as experienced by individuals – and this is something that is clearly relevant for healthcare institutions. However, for the moment, I want to focus on healthcare workers as individuals. In a healthcare setting there are likely to be many people who are as Nussbaum says, afflicted by serious predicaments. Indeed, depending on one’s sphere of work *all* one’s patients might meet this criterion. Nussbaum’s second point raises some interesting questions: would it be impossible to feel compassion for a murderer condemned to death? Or a smoker dying of lung cancer...? But these are not within the scope of this paper. It is Nussbaum’s third point that is crucial here. Because if we expect compassion on an individual level from healthcare professionals we must expect each of them to be able to describe each of their patients as being ‘one of those whose happiness is an element in my conception of a flourishing life’, as Nussbaum puts it.

Nussbaum's conception of compassion as a personal response seems to suggest that it arises when people's lives are so deeply entwined that the happiness of one individual is dependent on that of the other. Similar points have been made about empathy: Martin Buber regards empathy as being intrinsically personal, and subjective; it is not something that can be enforced or systematised. Rather, it springs from intimacy – the 'I/thou' rather than the 'I/you' relationship.¹⁴ Pence likewise suggests that trust and intimacy are necessary for compassion to flourish, and that compassion is a response to the particular rather than the general: it is based on personal relationships, rather than abstract ideals, or generalised roles.⁵ But can we expect healthcare professionals to have this kind of intimate relationship with all of their patients in modern hospital environments?

Of course, helping patients *in general* will be part of a flourishing life for someone who has chosen to become a doctor or nurse. Just as educating people will be part of a flourishing life for a teacher, or pleasing diners will be part of a flourishing life for a chef. To flourish in any profession, one needs to believe that the role is worthwhile. Often, that will imply that it benefits the particular class of people whose interests form the focus of one's professional concern. But these broad benefits are not associated with the intimate, deeply entwined sort of compassion that Nussbaum describes. Nor do they fit with the accounts of compassion given by Bradshaw or Pence.

Perhaps in the past when people had very personal relationships with their doctors or teachers, compassion could have been an integral part of these vocations. Historically, these were relationships in which love was not rigorously sought out and excluded, as it is in modern medicine and teaching, for example. There are many reasons for the deliberate exclusion of love from our schools and hospitals. Love is very powerful and it can be dangerous, especially where there are significant power imbalances. But perhaps more crucially here, love is incompatible with modern values attached to education or healthcare because it cannot readily be controlled and quantified in order to integrate it with our institutions. If compassion were part of each student's or patient's due, how could we control and systematise it to ensure everyone would receive his/her fair share? If we accept the idea that compassion is incommensurable, we simply cannot systematise it in this way.

Left to themselves, averagely compassionate healthcare workers *will* form compassionate relationships with some of their patients. Resilient healthcare workers will ensure that the presence or absence of compassion does not interfere with their care, or draw them away from their obligations to patients in general. But David Cameron's plan is *not* to leave healthcare workers to themselves to develop compassionate relationships naturally, but to incentivise or enforce individual healthcare workers to display compassion, and ensure that it plays a part in every healthcare interaction.

This poses some serious epistemological challenges for the healthcare system. How will we know whether the doctor or nurse is compassionate? What measures can we implement, and can we be certain that they are reliable? How can we eradicate the variable, human nature of compassion as a response to individuals, and ensure that there is an even, controlled flow of compassion from each healthcare professional, to each patient? The answer seems to be that we must commodify compassion: we must control and manage it, and parcel it out in equal portions. Compassion cannot be allowed to be wayward or variable: it must be made to fit into our evidence-based, scientific, efficiency-driven healthcare system.

Commensurable compassion

A scientific approach to healthcare seems to require that we have something to measure if we expect to demonstrate the existence and degree of compassion in healthcare professionals - and medicine is overwhelmingly regarded as a science. This was not always the case: in the past, the division between sciences and other branches of human endeavour were far less pronounced. Medicine used to be allied with the arts, with religion and magic.¹⁵ As Hayek has observed, since the sciences and arts started to be seen as separate disciplines, the appeal of scientific methodology and terminology has been immensely powerful. The language and methods of science suggest credibility.¹⁶

This reverence for science leads us to force all kinds of concepts, activities and fields of endeavour into a scientific paradigm however ill-fitted they may be for such treatment. Hayek terms this ‘scientism’ and characterises it as a scramble for status through the uncritical appropriation of scientific jargon or methods. We can see this in medicine, as in other fields of human activity. Science has many benefits for modern medicine: we can discover the properties through which an intervention works; establish the likelihood of adverse reactions; measure efficacy and track outcomes. Patients are no longer expected to place blind faith in their doctors: they can do their own research, check their doctors’ knowledge and participate in interpreting the facts that science makes available.

But the scientific impulse to identify, isolate, or even create ‘objects’ that can be controlled and measured has an impact on modern medicine that goes far beyond the production of better and more reliable interventions. The German philosopher Axel Honneth advises that our capacity to reify should be viewed with suspicion. Reification is characterised by Honneth as a habit or disposition which leads us to “... perceive ... things in a merely objectively identifying way, without being aware that these objects possess a multiplicity of existential meanings for the people around us.” In short, reification is the tendency to regard other entities as mere things. The status of medicine as a science is clearly problematic here: arguably, it is precisely the job of science to perceive things objectively, separately from the values they may have in other contexts. But this is where the difference between science and scientism is important. Science – and medicine, to a degree – *have* to adopt certain dispositions towards their subjects. This becomes scientific when the objectifying or reifying disposition becomes embedded or valued in itself.

Honneth’s account of reification has a resonance with Kant’s formula of humanity: that it is wrong to treat human beings as mere means to one’s own ends. Reifying others is one way in which we might fall foul of Kant’s injunction. Thinking back to the Francis Report, it seems clear that patients *were* at least sometimes being treated as mere things. This might lead one to suppose that by forcing or enabling healthcare professionals to ‘recognise’ or to treat patients as ends in themselves, we could avoid the kind of problems set out in the Francis Report. But this is to miss the complexity and embeddedness of the reifying tendency in the healthcare system. This is not just about relationships between human beings, but something much broader.

Kant is of course concerned with human interactions, and with the question of whether any particular act accords with, or transgresses, the moral law. In contrast, for Honneth, reification is pathological whether it is directed towards other human beings or other entities. Thus, the concept of reification goes far beyond Kant’s formula of humanity: a reifying tendency may be turned upon people, animals, objects, even to attributes such as compassion.

Moreover, a reifying tendency may be exemplified not just between two people, but may become systematised. I have argued it is implausible that the kind of problems discussed in the Francis Report were due to individual failures of compassion on a large scale. However, it *is* plausible that they were due at least in part to a healthcare system that is in thrall to a reifying, scientific ideology, which makes mere things of patients *and* staff alike.

The irony here is that compassion itself must be reified if it is to be accommodated in a scientific healthcare system. It becomes an object to be examined, measured and produced in uniform quantities. But as suggested, the link between scientism and reification seems to be an implicit part of what proponents of compassion in healthcare regard as being pathological. Arguably, this concern forms the background to the more specific complaint about the dwindling of compassion in the health service. On this view, Bradshaw's scepticism seems justified. The health system itself is reifying and scientific. It has no place for intrinsic or incommensurable values. If we operationalise incentives for compassion, we will not necessarily solve the problems in our health service, but simply offer up another sacrificial victim to be reified.

Some – perhaps much – of the suffering experienced by patients *and* healthcare professionals in today's healthcare systems, is the result of a clash between incompatible values. On one side, there is a scientific ideology which holds that everything which is meaningful must be measurable and controllable. On the other, there is the conviction that some of the most valuable things in life are *intrinsically* so; that they are incommensurable and not answerable to our attempts to control them. It is not compassion per se, that is at issue here, but a far broader and more insidious need to measure all we touch.

Honneth emphasises the importance of understanding reification as a *social pathology*, not just a matter of individual moral responsibility. Institutions themselves support and encourage the tendency to reify as they identify and measure outcomes in order to justify their existence, and prove their effectiveness. The NHS is no exception to this. It exists in a society where measures, outcomes, costs and evidence are fundamental prerequisites of governmental support. Our society cannot account for, or justify expenditure whose effects cannot be measured, controlled or defined. Although we may value things that are incommensurable, such as compassion, it seems that we value commensurability still more!

Our healthcare systems have been constructed in ways that encourage and reinforce reification. Crucially, this applies not just to patients, but to healthcare staff too, who are measured, monitored and controlled. Indeed, incentivising, monitoring and measuring healthcare professionals's compassion might in itself be seen as another example of reification. One might hope that if reification is part of the problem, its antithesis – recognition – should be the solution. For Honneth, recognition is the capacity to perceive and respond to others as though they are *more* than mere things. Honneth's account of recognition is complex, and any attempt to suggest it as a solution to problems in modern healthcare may lead to some of the same difficulties as compassion. For this reason, I do not advocate a focus on recognition as an alternative to compassion. Rather, I suggest we turn a critical eye on the scientific element of our healthcare service, and especially its relationship with reification. We may not be able to eradicate scientism and reification from the health service, but at the very least, we should try to remember that these are powerful forces, whose influence and effects are not always straightforwardly benign, and look for places where it may be possible to limit their exercise and effects.

McDonald's style compassion

The proposal to measure and enforce compassion, to discipline certain individuals, or exclude them from practising medicine, might be problematic – if it worked – since we might lose, penalise or persecute many excellent healthcare workers. However, if Bradshaw is right, it would *not* work for precisely the reasons that she identifies: compassion would slip between the measurements. We would be measuring and incentivising something else. Yet if ‘compassion’ measures or incentives do in fact improve outcomes, should we worry about what exactly it is that is being incentivised, and whether it is ‘authentic’?

Whatever is captured in efforts to measure compassion is – on Bradshaw’s view – necessarily a proxy. Relying on these measures may lead to stereotypical routines. This further undermines the integrity of what is being achieved. Healthcare professionals may be told that they have been compassionate when they use certain phrases, or achieve certain scores on a standardised measure – *regardless of what they really felt*. This is the essence of Bradshaw’s objection: she believes it is inherently false to measure, systematise and reward compassion in this way. If we focus on actions or outcomes without the feeling, we are creating what she regards as a trite McDonalds type of compassion, a travesty of the real thing. Pence’s approach seems to harmonise with Bradshaw’s here. He rejects the idea of role-modelling as a way of teaching compassion, since those who imitate certain behaviours are trying to please those in authority, or pass their exams, rather than being compassionate for its own sake.⁵

If outcomes and behaviours are the primary focus of compassion measures, it is easy to imagine that healthcare workers who have compassion targets to meet will adapt and mould their responses in order to do so. In fact, this is already clearly observable to anyone involved in medical education. Students are encouraged to utter certain phrases, and display certain behaviours, in order to ‘show empathy’.¹⁵ Some students may approach these tests with the pragmatic aim of simply satisfying the requirements. But many of them will come to feel that this is indeed empathy, and that they have mastered it. In this way, empirical measures of virtue may ultimately subsume the ‘real’ thing, as Honneth has noted:

“There are innumerable investigations in the domain of cultural sociology or social psychology that have discerned an increasingly strong tendency on the part of subjects to feign certain feelings or desires for opportunistic reasons, until they eventually come to experience these very same feelings and desires as genuine elements of their own personality.”¹⁷

If Honneth is correct that when someone simulates feelings, he may come genuinely to *feel* them, perhaps this ought to appease those such as Bradshaw who wish to see greater compassion in the healthcare service. However, it seems unlikely that Bradshaw would accept this. Neither does Honneth’s remark above, suggest that he regards the transition from opportunistic feigning to genuine feeling, as benign. The problem of initial falseness still remains, as does the reifying tendency to commodify one’s dispositions and characteristics.

If the government’s system of metrics and control *does* improve appearances and outcomes, perhaps we need not worry about what lies beneath. Or that the ‘compassion’ being produced is not authentic. A system which is focussed on outcomes has no need for introspection, provided the outcomes are as desired. One way of avoiding the problem of falsity would be to ditch the term compassion entirely. An outcome-focussed approach could then apply itself

more honestly to identifying, measuring and rewarding ‘measurable outcome-improving behaviours’. Of course, there is a possibility that the endeavour would *not* improve outcomes – but the beauty of the measurable system is that it can be tested. If the putative outcome-improving behaviours do *not* prove to have the desired effect, they can be tweaked and recalibrated until they do.

Conclusion

There is no minor adjustment that we can undertake in our existing health service that would allow compassion to flow back in, unmeasured and uninterrogated. In a world where proof and evidence are valued intrinsically, nothing can be taken on faith. This seems to be at the root of much of Bradshaw’s argument: we need to take more on faith, to acknowledge intrinsic values, rather than chasing after instrumental ones. But we cannot have our cake and eat it. If we are only satisfied that we know whether our hospitals are clean, our drugs effective, our surgeons competent, on the basis of demonstrable evidence, we must identify outcomes and measure them to establish this. If we think individual doctors and nurses should be compassionate and we value the evidence-based structure of our health-service, compassion is going to have to be served up in measurable ways.

I would suggest that Bradshaw is right to note the competing ideologies that inform our healthcare system. Until the conflicts between different ideologies are recognised, there is a great deal of incoherence in the system. She is also right to note that individual doctors and nurses tend to be held to account for their failure to exemplify a quasi Christian ideal of care and compassion, while working in systems that do not support the expression and development of such virtues. Nevertheless, I think many of those who abjure the attempt to subsume compassion into a scientific framework, as Bradshaw does, do not recognise how deep the ideological conflict is.

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