INTRODUCTION

Nursing has always been supposed to be founded on compassion, care and respect for those who are weak and suffering. Patients’ vulnerability and their dependency on health professionals imposes on nurses a moral obligation to take care of them, an obligation that is very clearly summed up by the word “compassion”. This might sound obvious and unproblematic. But in nursing circles in Scandinavia a debate is currently taking place on whether compassion and care should occupy a central place in nursing and if so, to what extent. The compilers of the most recent version of the Norwegian code of ethics for nurses (2001) have chosen to include the word “compassion”.

ABSTRACT

The Norwegian Nurses’ Association recently (2001) approved a new code of ethics that included compassion as one of the basic values in nursing care. This paper examines the idea of compassion in the context of the Bible story of the Good Samaritan using an analysis of qualitative data from nurses’ clinical work with psychiatric patients. The aim is to show how the idea of compassion challenges nursing practice. Thereafter, the paper discusses the benefits of and premises for compassion in care work. The results show that nurses tend not to be guided by compassion in their work with patients. The organisation of the day-to-day work in the hospital ward, the division of labour between nurses and doctors, and the nurses’ approach to nursing were identified as influencing this tendency. The study shows that compassion is a radical concept with a potential to promote greater respect for patients’ dignity.

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caring; code of ethics; compassion; dignity; psychiatric nursing; The Good Samaritan

Is compassion essential to nursing practice?
The question at issue, however, is whether a professional approach based on compassion might lead to a quasi-religious, idealised view of nursing as a vocation, which in turn might lead to a low-paid profession becoming romanticised. Compassion alludes to the individual nurse’s character and manner in a fairly explicit way, and this can reinforce feelings of guilt and inadequacy in nurses who do not feel they are living up to their professional ideals. Another issue in the debate is whether a focus on compassion might obscure the objectivity that must be expected of a professional nurse.

**PURPOSE**

The present article is intended to be a contribution to the debate based on the analysis of empirical material from nursing practice. A case drawn from an acute psychiatric ward is examined in relation to the idea of compassion. The aim is to examine specific nursing practices in the context of compassion, and to show how the content of this concept challenges such practices. We then discuss whether the idea of compassion has general relevance for the practice of nursing.

**THEORETICAL CONTEXT**

The idea of compassion has played an important role in nursing as well as medicine, and it has been a cornerstone of western hospital tradition since 400 CE. The ideal expresses the duty to love and care for the weak and the sick regardless of their social rank or status (Nortvedt, 2002). In theoretical medicine it has been argued and regretted that compassion has weakened it’s position in favour of the prevailing view of medicine as applied biology. Pellegrino (1979), Pellegrino and Thomasma (1981), Toombs (2001), Kleinman (1988) and Zaner (1993) are among the significant medical theorists who explore medicine as moral enterprise. Kleinman (ibid., p. 54), for instance, argues that the moral core in medicine is an existential commitment to be with the sick person. Likewise, compassion has been a central concept when discussing how nursing is to be understood. Is nursing applied science or first and foremost a healing relationship and a form of dialogue with the sick person (Nortvedt 1998)? A lot of clinicians and researchers in nursing seem to agree on the importance of establishing a nurse–patient relationship in which nurses use themselves as therapeutic tools. Influential researchers and textbook authors as Travelbee (1971), Mereness & Taylor (1982), Stuart & Sundeen (1991), Peplau (1992), Porter (1992), Forchuk (1995), Gijbels (1995) and Cleary & Edwards (1999) have all focused the importance of interpersonal processes and therapeutic interaction in psychiatric nursing. In other words nursing theorists focus on the importance of the encounter or “meeting” with patients. Nursing might, in other words, be described as an interpretive meeting, which takes place between the nurse and the patient with the aim of understanding the one who is ill and seeks care. Gallop et al. (1990) underline that the concrete aims of the nurse–patient relationship are to explore and become familiar with the patient’s own understanding of his/her present situation and the past, and to contribute to the patient’s well-being and personal growth (Peplau, 1992; Müller & Poggenpoel, 1996). Furthermore, a functioning nurse–patient relationship is considered a necessary condition for providing care, which is looked upon as the very essence of nursing (Schafer, 1997, p. 206). The literature on psychiatric nursing is very considered with nursing as a practice, and consequently focuses the abilities and qualities one should expect from a psychiatric nurse. Emrich (1989), Hellzén et al. (1995) and Lindström (1997) underline acceptance, affirmation, and generosity as dominant professional qualities. Other authors emphasise the nurse’s ability to show empathy and to recognise the patient’s problems (e.g. Hellzén et al. 1995). In other words, the role of the psychiatric nurse has been discussed in terms of relationships, under-
standing, attitudes, as well as feelings (Mereness & Taylor, 1982, p. 10) and caring (Martinsen 1989; 1993; 1996). Explicit and often implicit compassion seems to be an important concept when focussing on nursing in general and specifically on psychiatric nursing. The paper intends to “re-examine” the concept of compassion and use this concept while analysing a meeting between a patient and a psychiatric nurse. This necessitates a closer look at the origin of compassion as an idea.

The Bible story of the Good Samaritan is often used to illustrate and examine the idea of compassion. In short, the story tells of a man who is travelling from Jerusalem to Jericho and who is set about by thieves, who beat him and leave him half dead by the wayside. A priest comes by, and when he sees the wounded man he passes by on the other side. A Levite comes by and does the same. But then a Samaritan comes by, and when he sees the man lying there, he is “moved to pity”, he empathises with the sufferer. He goes up to the man, bandages his wounds and takes him to an inn. The next morning the Samaritan gives the innkeeper two silver pieces, and says, “Look after him; and if you spend any more, I will repay you on my way back.” (Luke 10, 31–35). This story has had a considerable influence as a nursing ideal, and it illustrates two aspects of compassion: compassion as an idea, and compassion in practice (Hansen, 2001).

**COMPASSION – IDEA AND PRACTICE**

In the Bible story both the priest and the Levite see the man by the wayside. The following is the whole point of the story: “For in the act of seeing, two people are confronted with each other and from this confrontation springs the ethical appeal for care” (Hansen, 2001:20). But the priest and the Levite ignore the man’s distress. The Samaritan also sees him, but in contrast to the other two he feels pity for the man. He is moved by the man’s situation, he responds to the appeal that the suffering man emits. In the story the wounded man is anonymous: he is not described in terms of age, social class or where he lives. Hansen (2001:19) claims that the anonymity is being used deliberately to indicate “a universal humanity”. A nurse’s mandate is to care for the sick stranger (Nortvedt, 2000), and in this light the story expresses the ideal of helping everyone who is in need, purely because of their need.

The nurse’s moral responsibility to care for the sick is determined by “the individual’s helplessness, vulnerability and suffering” (Nortvedt, 2002:31). The basis for every kind of help is the acknowledgement of the fundamental features of human existence: vulnerability, dependency, fragility and mortality (Henriksen & Vetlesen, 1997). Dependency and vulnerability are what make a person human, and care is directed towards these fundamental aspects of the human condition, about which we have no choice. Thus relating to the patient as a dependent, vulnerable person is to be within a moral sphere of activity. In other words: nursing is moral praxis (Martinsen, 1989, 1993, 1996), in the sense that the patient’s is is the nurse’s should (Martinsen, 1996).

However, the story of the Good Samaritan does not only point to which attitudes and which kind of personality matter in relations between people. On the basis of pity for a man’s suffering a tie is formed between two strangers, the wounded man and the Samaritan, and the Samaritan carries out a series of care actions (Hansen, 2001). The help given by the Samaritan is described in very specific detail, which implies the emphasis on good deeds. The Good Samaritan’s actions are not the result of calculation. On the contrary, they are spontaneous, a natural response to a specific situation. The Samaritan acts, not after due reflection or according to a programme, but from pity for the suffering man because of his suffering. The Samaritan asks for no return from the sufferer for his kindness (Hansen, 2001), which
emphasises the unselfish nature of compassionate acts. A compassionate person acts without thought of reward. Practical care means acting in response to the patient’s appeal for help and without expecting any return from the person being cared for. Martinsen (1989, 1993, 1996) points out the importance of clinical discernment for a correct understanding of the situation, and she emphasises the intrinsic value of such practical acts.

The question of what it means for a nurse to be morally responsible in relations with psychiatric patients needs to be discussed in an empirical context, and we therefore present a case history as an illustration. First we present the study’s design.

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THE STUDY

Material and methods

The data were compiled at a medium-sized Norwegian psychiatric hospital in autumn 1999 (Hem, 2000; Hem & Heggen, 2003; Hem & Heggen 2004) as part of a larger study of communication between psychotic patients and psychiatric nurses. The first author (MHH) spent 65 hours (over a period of two and a half months) on a locked ward that had five patients. Most patients stayed on the ward for about one week. The majority of the patients were psychotic, but to which degree they were psychotic could vary. Most of them were involuntarily committed. The researcher observed six nurses carrying out tasks with and for patients. She paid particular attention to the interaction between the nurses and the patients and to what the nurses thought and said about what they were doing. In addition the researcher participated in the daily life of the ward. These observational data, in the form of field notes (divided into ‘observational notes’, ‘theory notes’, ‘methodology notes’ and ‘personal notes’) (Hammersley & Atkinson, 1996; Henriksson & Månsson, 1996; Wadel, 1991; Hansen, 1995; Savage, 1995; Dahlgren, 1996; Heggen & Fjell, 1998), were filled out, supplemented and validated (Kvale, 1995; Holstein, 1995; Svensson, 1996) by data obtained from narrative interviews (Ramhøj, 1993) with the same six nurses. The narrative interviews lasted 20–60 minutes; they were recorded on tape and transcribed verbatim. Some 80 pages of field notes and interview transcriptions were made. The field notes describe what nurses did in their interaction with patients, while the interviews record nurses’ personal understanding of their work (Hem & Heggen 2003; 2004).

Data analysis

A number of cases that were typical examples of the variety of problems arising in clinical communication between nurses and psychotic patients were selected. The case descriptions illustrated the nurses’ experiences in situations in which they took responsibility for patients or ignored patients, as well as situations in which they showed understanding and sympathy or took no notice of and disregarded the patients.

Each case was analysed in depth and classified according to categories that reflected the tensions, nuances, discrepancies and contradictions in the material. One of these cases was chosen for the present study because it provided a good opportunity to analyse the concept of compassion in the context of nursing practice.

Ethical considerations

In accordance with the ethical guidelines for medical and health research (Kvale, 1995; Hammersley & Atkinson, 1996; Henriksson & Månsson, 1996; Solbakk, 1998), consent was obtained from the hospital management, the department in question and each individual patient and nurse.

CASE: THE MORNING MEETING

What follows is an abridged version of our field notes. The field notes describe a morning meeting between patients and staff members in the locked ward. The names and other information have been changed to ensure anonymity.

Four patients and three staff members take their places round the coffee table in the ward common room. This is where the morning meeting regularly takes place. The day’s newspapers are lying on the table. The television has been turned off. Most of the participants have brought a cup of coffee with them from breakfast, which they have just finished eating. The autumn sun is shining through the windows. The room looks cosy and the atmosphere is pleasant and peaceful. Christoffer (a nurse) is chairing the meeting. He is sitting in the middle of the sofa with patients and nurses on each side. He has a piece of paper in front of him, which he occasionally refers to. He tells the patients which nurse is their contact person for
the day, and what appointments they have with physicians, psychologists, physiotherapists, etc.

He then says to Finn (a patient), “We are trying to organise a visit home for you today. We may not manage it, because there are so few of us at work. If we don’t manage it today, we’ll try and organise it for tomorrow.” This sparks off a long interchange between the two of them. Finn leans forward on his upright chair; his face is red with emotion. He seems excited. Finn is upset because he has been involuntarily committed and feels he is in a hopeless situation, that the staff make all the decisions and not him, that as a patient he has no rights. “I’m just kept hanging about here day after day and nothing happens. It’s absolutely dreadful.” Hanne, a fragile little woman very nicely dressed in an attractive sweater and trousers with a matching scarf, says she agrees. “I have exactly the same feeling.” She interrupts Finn’s sentences with her own views and feelings. She is preoccupied with the feeling that patients lose their dignity in a ward like this. She says she thinks the whole situation is so awful that sometimes she “blows right up in the air”. Finn asks Olga, who is leaning back in a comfortable chair with her feet up on a footstool and a rug tucked around her, what she thinks is most important: listening to the patients or to the staff. “Listening to the staff,” she replies. A couple of times during the meeting Olga breaks in with questions like, “D’you know where my husband is?” or “D’you think I need to wash my hair today?”. She is not interested in the same things as Finn and Hanne. Pelle, who last time he was admitted was in opposition to the entire system, sits quietly and registers what goes on. He makes supportive remarks to both patients and staff. For example, “This is the best ward in the whole hospital.”

Finn keeps on and on. He and Christoffer get caught in a dialogue, just the two of them; none of the other nurses says anything. Christoffer sits quietly; he watches Finn and lets him talk before he himself says anything. He says he understands that Finn finds the situation difficult. He says Finn should take up these personal issues with his doctor. Finn says he has done this, but that it doesn’t help. “I get absolutely nowhere there, he doesn’t listen to me!” He says he is completely healthy, but has been told he is mentally ill. “How can they be allowed to lock up a healthy person for weeks at a time? I think a lot about kindness. I think it’s important for people to care for each other, have real contact, listen to what other people have to say. People nowadays don’t listen, they aren’t interested in other people and what’s happening to them. People are only interested in themselves.” He looks at the other nurses, but no one says anything. Christoffer repeats again and again that this is a personal problem, Finn must talk to his doctor about it. The morning meeting is not the place for personal problems. “This is an information meeting,” he says. Finn replies, “Yes it’s a meeting for information from you to us. What about our need to be heard?” Christoffer says, “I hear what you’re saying. The staff don’t have any influence on decisions that have already been made. We’re just a mouthpiece. But you can rely on us to do everything we can to make your stay here as good as possible.” Finally he says, “I think we’ll end this discussion now,” and goes on to assign practical tasks for the day. After a short time both Finn and Hanne leave.

A little later Finn stops Barbro, a nurse, in the corridor. He asks, referring to the meeting, “Did I go too far?” Barbro says no. He says he is “fully equal to everyone else as regards human dignity and human rights”. He has tears in his eyes. He says, “I give up, I’m going to bed.”

**INTERPRETATION AND DISCUSSION**

**Rejecting the patient’s appeal**

This case will be discussed as a test of compassion in a situation that many psychiatric nurses will recognise. The framework is the regular morning meeting between nurses and patients. All the patients on the ward are present, but it
is Finn who plays the most active role. A nurse, Christoffer, chairs the meeting. When, after giving out a good deal of practical information, Christoffer addresses a specific message to Finn, this seems to trigger a great many thoughts and feelings in Finn about his situation as a whole and the problems he experiences being in hospital. The “administrative input” from the nurse is not met by a simple “administrative response” from the patient.

Finn is upset. This is visible in his physical posture; he sits leaning forward in his chair, he is red in the face and his whole aspect expresses his disturbed and distressed state of mind. Throughout the meeting he shows his vulnerability, dependency and suffering (Henriksen & Vetlesen, 1997; Nortvedt, 2002). He expresses himself strongly. He thinks the whole situation is “hopeless”, he feels he has no rights, he feels he is not allowed to make decisions and is not listened to. His experience of involuntary commitment and of not being able to make decisions is “absolutely dreadful”. It is obvious that for Finn this is vitally important, and he explicitly confronts the nurses with this. In this way he gives the nurses an opportunity to respond to or ignore his appeal. But there does not appear to be any response to his appeal (i.e. compassion as a value), nor does the appeal lead to understanding and pity and by extension to specific action by the nurse to help him deal with his difficulties (i.e. compassion in practice). In this case the patient’s distress was expressed very clearly, as it was in the story of the Good Samaritan. The priest and the Levite guard themselves against the wounded man’s suffering and appeal in a passive way, by not acting, and Christoffer guards himself more actively by telling Finn that he cannot help him. Christoffer ignores the appeal by establishing a framework of “administrative logic” for the meeting and by keeping within it. The fact that nurses ignore patients’ appeal is also supported by the international research in the field. Empirical studies have investigated how and to what degree psychiatric nurses establish a therapeutic relationship with their patients (Delaney et al., 1995; Gijsels, 1995; Clarke, 1996; Ryrie et al., 1998; Cleary & Edwards, 1999). Several studies have, for instance, focused on how patients have experienced psychiatric nursing (Beech & Norman, 1995; Pejlert et al., 1995; Müller & Poggenpoel, 1996; Lepola & Vanhanen, 1997; Lindström, 1997; Cleary & Edwards 1999). Patients have reported that their psychiatric nurses have been friendly, but that the patients understood this friendliness more as an impersonal social attitude than as a sign of personal commitment related to the therapeutic relationship (Müller & Poggenpoel, 1996). Patients feel offended because of the nurses’ abuse of power, use of constraint, and lack of support. Patients often have the impression that nurses are vague, distant, and neither physically nor emotionally available when they need them (ibid.; Hem & Heggen 2003; 2004).

Ignoring the patient’s distress
The morning meeting is unpleasant for both Finn and Christoffer and also for the other patients and nurses. One possible reason for this is that Finn and Christoffer have different expectations of the meeting and ideas of what it is supposed to be for. Christoffer’s approach is practical; he gives out information on appointments and specific tasks. Finn wants to talk about his problems, or more specifically about his feelings about being committed against his will to an acute psychiatric ward. The nurse gives the impression of understanding the patient but insists on maintaining an administrative framework around the meeting – a framework that ignores the patient’s distress.

Finn tries to include other patients in the discussion of his distress at being involuntarily committed. He is only partly successful: Pelle makes some generally supportive remarks. Finn’s distress seems to be aggravated by the fact that the other patients respond so little to his unambiguous appeal to them to understand...
his distress. Nor does Christoffer seem to be able to respond to Finn’s invitation to the other patients to really see his distress. Two of the patients leave before the end of the meeting. Finn may well interpret this as being his fault: that by voicing his distress he has “ruined” the meeting. But it can also be interpreted as a signal of support to Finn: that these two patients do not accept the fact that the nurse is “administering” Finn’s distress. This also has a parallel in the story of the Good Samaritan: the fact that the priest and the Levite pass by without alleviating the man’s suffering may be because his appeal for help upsets their plans. Christoffer also passes by: he has a programme for the meeting that he wants to follow, and he does not allow Finn to upset his plans. Ignoring the patient’s distress, like Christoffer does, might lead to loneliness for the patient, which, in fact, studies have pointed at. For instance, Lepola & Vanhanen (1997) and Lindström (1997) found that patients tend to feel lonely in the ward. Pejlert et al. (1995) report that patients tend to develop the feeling of not belonging to the community in the ward. Accordingly, patients are appreciative of nurses who are available, who listen, who are friendly, tolerant, and who show respect (Beech & Norman, 1995).

Shifting the responsibility
Finn expresses his despair at not getting anywhere with “the system”, and he reacts to being involuntarily committed. Christoffer responds by saying that he understands that Finn feels his situation is difficult. Christoffer sees Finn and demonstrates what might at first sight seem like a compassionate attitude and actions. But in fact the term “compassion” is not an accurate description of the situation because what Christoffer actually does is to reject Finn. He re-assigns what is distressing Finn to the doctor’s sphere of responsibility. When Finn says that he has tried to talk to the doctor about “personal things”, but that the doctor doesn’t listen, Christoffer replies, “I hear what you’re saying. The staff don’t have any influence on decisions that have already been made. We’re just a mouthpiece.” And then he adds, “But you can rely on us to do everything we can to make your stay here as good as possible.” Christoffer’s message to Finn is ambiguous.

Christoffer explicitly says he understands that Finn feels he is in a difficult situation, but at the same time he shifts responsibility for the problem over to the doctor. He indirectly becomes part of the doctor’s decision and allies himself with the system by assuring the patient that the staff will “do everything we can to make your stay here as good as possible.” The model of the Good Samaritan requires the nurse to commit himself and to act in order to demonstrate his compassion. Christoffer does not commit himself; he takes refuge in the institutional rules about division of responsibility in order to guard himself against Finn’s appeal. In this context one could say that the institution and the practice of its rules prevents the exercise of compassion. Christoffer also ignores Finn’s appeal by insisting that the meeting follows an administrative logic in which personal distress like Finn’s has no place. Christoffer’s actions are underlined by a feigned compassion, which further paralyses Finn. When Christoffer says, “we’ll do everything we can to make your stay here as good as possible,” this does not allow Finn much room for protest. It is difficult for a patient to criticise a nurse who assures him that he wants what’s best for him. The attitude described can be understood as a kind of professional distance. This professional distance (Hem & Heggen, 2003; Hem & Heggen 2004) has been debated from a variety of perspectives. Foucault (1965/1988), for instance, has shown how modern society has created a distance between being normal and insane. The power knowledge relationship, creating a distance between those who suffer from mental illness and the experts, is also illuminated by influential researchers as Latour (1987). The concept of professional distance in nursing was
also discussed as early as in the 1960’s. Based on an empirical study of the nursing service of a general hospital, Menzies (1960) showed how nurses developed techniques to help them to separate the relationship between nurses and patients and to allow them to distance themselves from the suffering patients.

Reflections
The morning meeting made an impression both on the nurses and on Finn. Both parties needed to talk afterwards about what had happened. Christoffer took it up with his colleagues in the duty room. In their conclusion they attribute the situation to Finn’s qualities: he can be very difficult, “that’s the way he is”, and he “has little insight into his illness”. The nurses do not try to imagine how distressed Finn is or how he feels at losing his freedom, autonomy and power to make decisions by having been involuntarily committed. Not do they think about the morning meeting as an interactive situation where what happens, especially between Finn and Christoffer, is the result of a two-way process. The categorisation employed by the nurses is very far from the idea of compassion. If they had drawn on compassion it would in fact have made them aware of Finn’s distress. Instead their attitudes to the meeting show that they had immunised themselves against Finn’s suffering. The immunity might be interpreted as an effort to protect oneself. Bray (1999) found that psychiatric nurses who work in acute wards experience difficulties in working closely with patients suffering from psychological disorders. This work is emotionally demanding and they employ various strategies to create a space between themselves and patients. For example, they might physically distance themselves from patients (ibid.; Menzies, 1960).

Finn, for his part, expressed his need to talk about what had happened by addressing one of the other nurses. This shows that, in spite of the nurses’ categorisation of him as difficult and lacking in insight, he was in fact thinking about what happened at the meeting in general, and his own part in it in particular, and evaluating it. He even expressed a fear that he had gone too far. It is possible that he was afraid he had created a difficult and unpleasant situation for the other patients, for Christoffer and for the other nurses.

CONCLUDING REMARKS
The aim of the present article was to examine specific nursing practices in the context of compassion, and to show how the content of this concept challenges such practices. We also wished to examine whether the idea of compassion was relevant and what effect it might have on nursing practices. We arrived at the following findings.

Absence of compassion
It seems quite clear from the above that in the case analysed here the nurses’ interaction with the patients does not reflect compassion. One of the nurses (Christoffer) seems to be aware to some extent of the patient’s sufferering, but is inhibited from going further by, among other things, his own administrative logic and the division of responsibility and labour between the physicians and the nurses; he also deals with the situation without using words that would make the patient’s own understanding of his distress more visible. The above analysis clearly shows what good results might be achieved by the active use of compassion. We can see that Christoffer could have met the patient’s distress in a more committed way and could have paid more attention to human dignity by establishing a different framework for the situation. It is worth noticing that Benedetti (1974) claims that patients appreciate professional helpers who try to understand them and who make an effort to find out what is the matter with them. What is essential for patients is that the professional helpers demonstrate that they are willing to and make every effort to commit themselves. In fact, just by demonstrating the will

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and effort to commit themselves, nurses can make a deep impression on patients (ibid.).

Although compassion is explicitly mentioned in the Norwegian code of ethics for nurses, it is in fact often not practised. Thus we cannot draw the conclusion that including a new idea in a set of guidelines is sufficient to alter practices. Moving from idea to theory to practice is never a simple linear process. Thus the inclusion of the idea of compassion in the code does not immediately improve nursing practice in the sense of making it more compassionate. And a romanticised description of a nurse’s practice that does not correspond to the actual interaction between nurse and patient can aggravate the situation. It can mean that nurses’ actions are put into words in a new way, and that nurses have an idealised idea of themselves and their practice that does not correspond to their patients’ experience (Heggen, 2000). A romanticised idea of nursing practice can result in worse patient care, not better, and thereby violate patients’ human dignity (Heggen, 2002). Hummelvoll and Rosset (1999) found a similar phenomenon in their study of psychiatric nurses, who claimed to have a humanistic approach while in fact their actions showed a disease-oriented, diagnosis-based focus, which appeared to be in conflict with their stated ideals. There is no point in having “a good attitude” and a humanistic approach to patients if this is not translated into practice.

**Collective approach to nursing practice**

The nurses’ conversation in the duty room showed that compassion had little effect on their collective interpretation of the situation. In their comments they blamed the patient for his lack of insight into his illness and classified him as difficult. They made no attempt to explore the potential in this situation, which consisted in allowing the patient’s suffering and distress to come to the fore.

An interesting point in this connection is what happened when one of the nurses met Finn in the corridor. In this situation she seemed to depart from the collective way of thinking in the duty room, and to ally herself more closely with the patient. But her attempt at compassion seemed to reinforce Finn’s distress. His impression that when things were difficult he was alone against the world was confirmed. Even though he was given to understand that one of the nurses understood his distress, it also became clear that there were no adequate, articulate advocates to plead his cause. The nurse’s response aggravated his feeling of being alone in an impossible situation. This shows that it is not enough that one nurse is aware and supportive of a patient in distress. It has to be a **collective response**.

**The critical potential in the idea of compassion**

We have pointed out the traces of compassion to be found in the situation we have analysed and considered what opportunities are open to those whose actions are based on compassion. We have also shown that there are many limitations attached to using compassion as a basis for nursing practice. These depend to some extent on the individual nurse. We wish to point out, however, that if the potential inherent in compassion is to be fully utilised, it requires a collective ability and willingness to put the idea of compassion into practice and also the possibility of doing so.

This analysis makes it clear that compassion is a **radical idea**, with a **critical potential**. It also shows that compassion is demanding and difficult in practice and as an ideal. Acknowledging the necessity of compassion in the ethical guidelines for a profession, as has now been done in Norway, is a necessary but by no means sufficient condition for the radical step of taking a patient’s distress seriously.

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