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Citation for final published version:

Clouston, Teena 2018. Transforming learning: Teaching compassion and caring values in higher education. *Journal of Further and Higher Education* 42 (7) , pp. 1015-1024. 10.1080/0309877X.2017.1332359

Publishers page: <http://dx.doi.org/10.1080/0309877X.2017.1332359>

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Teaching compassion and caring values in HE

**Cover page**

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Teaching compassion and caring values in HE

**TITLE PAGE:**

**Transforming learning: Teaching compassion and caring values in higher  
education**

## **Abstract**

As a result of reported failings in the care of people in the health and social care sector in the UK, HE providers who produce professionals to work in these areas being challenged to address caring values in the student body. As values are subjective and affective, this requires the learning environment to not only promote critical thinking and the development of professional competencies, but to facilitate personal growth and change within students at cognitive, emotional and spiritual levels. As the latter dimensions are frequently ignored in education, this is very challenging: it requires a curriculum that supports students to understand, reflect on and, if necessary, restructure their own caring values in order to develop a transcendent lens i.e. the ability to put others before their own self interests and that of the organisation in which they work. It also requires students to develop the skills to challenge others in situations where caring values are not achieved or sustained. This can only be accomplished as a coproduced phenomenon, as it requires students who are prepared to engage in the process and educators, in both HE and practice settings, who are able and willing to role model appropriate skills and facilitate a learning relationship in which students can grow. However, if the true wisdom of caring values is to be realised in everyday practice, then this kind of transformational learning has to be supported at wider structural levels, and this just may be its achilles heel.

## **Key words**

Caring values; compassion; education; transcendent; emotional; spiritual.

## **Introduction**

Those who have read or have heard the reports of people dying through a lack of basic human care and compassion in health and social care organisations in the UK will have been horrified by these damning accounts. The Francis (2013), Keogh (2013), Andrews (2014) and Climbé (2003) inquiries offer just a brief synopsis.

How these incidents could occur at all in modern 21<sup>st</sup> century Britain is challenging to understand, but sadly the reality of *why* this happened is palpable. Strong convergence in all the aforementioned reports conclude that the achievement of performance indicators, concerns over the completion of paper work, limited financial and human resources, huge workloads and ineffective leadership and management all conspired to prevent practitioners meeting even the most basic needs of those in their care.

Whilst this, in itself, is a staggering indictment of contemporary organisational cultures in health and social care settings, there were other notable factors that played a critical part in these distressing events. First, many of the employees in these organisations did not raise concerns about this lack of care, specifically because they feared reprisals if they did (Francis 2013). Moreover, this was not without reason: bullying, abuse from colleagues and pressures to leave from management have all been reported as responses to those who did raise concerns (Francis 2015). Second, when patients/clients, their family members and/or carers raised complaints or queries, these were ignored (Francis 2013).

These kinds of behaviour create a cultural context that is counterintuitive to the relational constructs necessary for caring values; in simple terms, they work to reduce the ability of the caregiver to be attentive and responsive to the needs of others. Staff who find themselves dealing with this kind of cultural dichotomy experience moral dilemmas and cognitive dissonance, resulting in inappropriate decision-making,

emotional distress and ‘compassion fatigue’ (Adam and Taylor 2014, 2412).

Ultimately these kinds of pressure can lead to high levels of stress, disengagement and burnout in the workforce (Clouston 2014; 2015).

Recent directives have recognised the existence and impact of this destructive cultural milieu and targeted organisational and individual core values as the key element for change (Francis 2013). Values are the underpinning foundations of both organisational cultures and subjective beliefs; it is they that shape essential characteristics, influence decision-making and underpin the subsequent actions and behaviours enacted in the workplace on a daily basis (Argandona 2002). The envisaged outcome is that by creating a culture of caring values so health and social care settings will re-orientate themselves to do what they should already do i.e. accentuate

the critical importance of values and behaviours in creating a system that is truly focussed on quality and always places the interests of patients ahead of individual or organisational ambition (DH 2013a, 5).

To support this change, UK education providers preparing students to work in health and social care have been challenged to address the subjective values and beliefs that underpin the ability to care and show genuine compassion for others (NHS Employers 2014). Many professional courses already reflect the standards of conduct, performance and ethics necessitated for students to become practitioners in their chosen fields. These identify the parameters of practice, including the need to achieve excellent communication and interpersonal skills, as well as measurable ethical standards, clinical and/or professional reasoning and applied knowledge and technical skills for the benefit of those they serve (Epstein and Hundert 2002). This raises

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interesting questions about what educators actually need to address in higher education (HE) in order to meet the stipulated directives of caring values.

Caring values have been defined as giving care through relationships based on empathy, respect and dignity; it has also been described as intelligent kindness (Ballatt and Campling 2011) or ‘a deep awareness of the suffering of another and with wish to relieve it’ (Chochinov 2007, 187). This dialogue then, is not just about interpersonal and communication skills but about personal values, beliefs and perspectives on the world in respect of relational skills and behaviours.

Consequently, it is not only about shaping the ethical practice of care, but about challenging personal mindsets and values and exploring the meaning of *being* caring, in terms of how that is understood by the individual student and enacted in the relational context with another. Thus, it would seem that HE providers have to think not only about the development of interpersonal skills and ethical standards, but the *emotional* and *spiritual* dimensions of care, because these underpin how human beings, understand and respond to caring (Clouston forthcoming; Cranbourne-Rosser forthcoming).

If these skills are to be taught in the HE environment, then curricula and the tutors/lecturers who deliver these programmes will not only have to ensure that scholarly and disciplinary competence is achieved, but engage with the more affective elements of personal values to develop the dimensions of emotional, moral (Aalberts, Koster and Boschhuizen 2012) and spiritual dimensions necessary to engender caring values (Clouston forthcoming; Cranbourne-Rosser forthcoming). It is only through this kind of curricula that values and abilities to facilitate caring and the emotional resilience to work in these settings and the ‘judgement to do so wisely’ (Colby et al. 2003, 7) can be fostered.

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This is complex and requires a learning environment in both education and practice settings that engenders not only critical thinking, but facilitates personal growth and change that is actually meaningful to the individual student (Mezirow 2003). This kind of deep and transformational learning is necessary because it can facilitate the questioning of one's personal values and beliefs and the opportunity to adjust any distorted views (Cranton 2006). For students in the health and social care professions, this kind of deep learning is essential if they are to gain awareness of their personal values and understand how these underpin behaviours like care and compassion and shapes decision-making in their everyday practice.

Crucially, this deep reflective level of learning can only be achieved as a *co-produced* phenomenon, formed between the relational context of students, the educators and the learning environment because it needs commitment and active engagement; moreover, because caring values exist in a web of significance that is individually, organisationally and socially constructed (Geertz 1973), these values cannot be addressed in isolation and need to be situated in the wider meso and macro system. In this paper I will debate some these complex dimensions and consider how both educators and students can progress through this complex web of interconnected factors. To set the scene, I will begin by exploring values, care and compassion and then consider the notion of teaching these constructs in the HE environment.

### **What are 'caring values'**

The Education Outcomes Framework (DH 2013b, 8) suggests that caring values are the abilities to:

have the necessary compassion, values and behaviours to provide person centred care and enhance the quality of the patient experience through

education, training and regular Continuing Personal and Professional Development (CPPD) that instils respect for patients.

This then is about value-based qualities that enhance person centred, compassionate care and consequently reflect an individual student's personal skills and perspectives. Thus the challenge for educators is to consider what these abilities might look like in a student and how, as education providers they can be recognised, taught and measured.

Waugh et al. (2014, 1195) suggest that in order for a student to develop caring and compassionate values they require the qualities of honesty, trustworthiness, good listening and communication skills, patience, tact, a sensitive and compassionate approach and an ability to seek and act on guidance. Whilst there is some suggestion that the presence of these qualities, however nascent, could be assured through the process of values based recruitment (DH 2013c), there is little or no guidance on how these qualities can then be facilitated or nurtured in the HE environment.

The health education mandate, however, does advise that all students need to reflect and remain commensurate with the six values and seven principles identified in the NHS constitution (DH 2013c) (see Table 1). These define both the necessary organisational culture and the subjective behaviour and decision-making processes of those who intend to deliver services in the caring fields (DH 2009).

*Insert Table 1 here: The principles and values of the NHS constitution*

### ***The principles***

Described as the basic building blocks or the underpinning philosophy of creating a culture of care, the principles define the ethical and moral fabric of what a caring

environment *should* look like. Steeped in the essential values of the NHS, they reflect the need for a comprehensive service, one that is free at point of delivery and is open to all who have need, irrespective of the ability to pay (DH 2009). Whilst these may reflect what is expected of the NHS in the UK, they do not address the inequity of a two-tier system, i.e. the speed and efficiency offered to those who can afford to pay privately, or the social injustice underpinning this in respect of those who cannot.

In relation to aspiring to high quality care, this is of course an essential prerequisite, as failings to date, in the majority, fall firmly into this category (Francis 2013). But how students can be educated to be progenitors of a new ‘caring’ quality culture remains rather vague.

In terms of the remaining principles (see Table 1), a service that reflects the needs and preferences of the patients is of course, a person centred one, focused on meeting individual needs; a service that is accountable to the public, the communities and patients that it serves, is one that takes responsibility; a service that works across organisational boundaries and in partnership with others is a networked and interactive one; a service that is committed to best value in terms of the use of taxpayers’ money is a morally just and ethical one. However, how students can raise concerns if this does not happen in their workplace, or how students can develop the emotional resilience and coping strategies to deal with cognitive dissonance in their practice is not addressed; this leaves a liminal space for HE to fill.

Using strategies such as dilemma orientated discussion groups (Aalberts, Koster and Boschhuizen, 2012), problem or inquiry based learning (Clouston and Whitcombe 2005) and appreciative inquiry (Roberts and Machon 2015) to encourage awareness and ethical decision-making (Cranton 2006; Mezirow 2003) can all aid to achieve an understanding of a principled and ethically constructed service. However, research in

practice settings, an integral part of all professionally related health and social care programmes, has found that students, even at this nascent level of development, can become acculturated to the embedded cultures of speed, pressure and discharge before care and compassion (Maben, Latter and Clark 2007; Reiss 2010). Conversely, several studies have shown that empathy and compassion can be maintained in the practice setting if sound working conditions (Lelorian et al. 2012), good communication channels (EACH 2013) and emotional and caring support strategies for staff (Goodrich 2014) prevail.

This cultural context of care for staff is a notable one and touches on the issues of the role modelling of caring and compassionate values by staff in both practice and HE settings (Ross et al. 2014). Notably, role modelling appropriate skills is a requirement of health and social care professionals in order to maintain the registration necessary for practice (HCPC 2014). This not only calls on educators who are registered practitioners to embody student-centredness as pivotal to their teaching philosophy, but to be subjectively reflexive in their work and embody their own caring values in terms of care and compassion toward the student body and their colleagues. Whilst this can be a daunting challenge for individuals at a personal level, the real barriers for educators in terms of engendering caring values in their students is at the organisational level (Mooney and Nolan 2006).

Freire (2000) has argued that education should be about providing an environment that promotes students and educators to question the status quo: the cultural norms in terms of political, social and economic contradictions. If this kind of questioning approach about health and social care could be adopted in the relative safety of the educational setting, so students could be supported to develop the skills and confidence to speak out about poor care and compassion and address the fears that

underpin raising concerns in practice. However, education, like health and social care settings, exists in a culture of corporate ideology and financial acumen that shapes how it functions; it is the outcome not the process of education that is the master of the university setting (Goodman 2014). The challenge for the HE sector (Plowright and Barr 2012), in tandem with health and social care sector (Freidson 2001), is to create a culture that will facilitate students and staff to confront and address the forces of managerialism that impact on nurturing caring values in these work environments and through this action, create ‘a world in which it will be easier to love’ (Freire 2000, 40). This requires a questioning and resilient student, prepared to challenge the status quo and address social dichotomies: in the present neoliberal marketplace, built on an ideology of growth, greed and individualism, caring values in a public sector workplace makes an uncomfortable bedfellow.

### ***Values***

The accompanying values (see Table 1), are, by their very nature, more subjective and, in essence, guide how individual practitioners behave and act in any one situation in the field. The NHS constitution describes these values as staff evidencing respect and dignity for others; having a commitment to the quality of care and to improving lives; to putting patients first, whatever the pressures, and having the ability to be compassionate i.e. having the ability to respond with kindness to others (DH 2009). Essentially, these values strive to assure that respect, dignity and compassion for all is paramount in practice and that practitioners recognise the needs of others and respond to them, whatever the pressures at the time.

To date, HE has been argued as addressing compassionate care as a tick box exercise as opposed to facilitating a meaningful encounter between two or more people with

time to listen, be silent, respond and to reflexively challenge personal mindsets (Firth-Cozens and Cornwell 2009). If present directives to produce students with caring values are to be met, then this rather hollow approach has to be addressed.

Care and compassion within the health and social care environment is a form of emotional labour (Smith 2012) concerned about ‘action and reaction, doing and being’ between giver and receiver in a way that is meaningful to both in its context (James, 1992, 500). This requires the ability to *manage* and *use* emotions appropriately and evidence a genuine aptitude to engage meaningfully with another (Msiska et al. 2014). In health and social care professions this is specifically known as the therapeutic use of self (Freshwater and Stickley 2004) defined as ‘A practitioner’s planned use of his or her personality, insights, perceptions and judgments, as part of the therapeutic process’ (Punwar and Peloquin 2000, 285).

What is essential in this form of caring is not only the ability to reflect on personal values and beliefs and be open to changing or adapting them, but also to be fully present and authentic in the process of caring. It is this emotional dimension of *genuine* care giving that can be missing in HE students. They may meet professional requirements and give practical care, but whether the emotional, and thus this very personal dimension of caring, is genuinely given or is observed more in terms of a contractual exchange is unclear. Hochschild (1983) for example, has argued that where people who practice emotional labour feel *obligated* by standards and requirements to *perform* the act of caring, so they can be superficial in the giving and can experience emotional distress and fatigue. In a similar vein, Phillips and Taylor (2009, 52) note that when ‘Ordered to be kind, we are likely to be cruel; wanting to be kind we are likely to discover our generosity’, thus suggesting a genuine desire to be caring is necessary in order to be authentic and truly compassionate toward others.

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This is about fostering intelligent kindness in students (Ballatt and Campling 2011), identifying a spiritual and emotional dimension to care that resonates with ‘the very heart of the art of’ caring (Freshwater and Stickley 2004, 93) and providing techniques to develop the emotional resilience to sustain this approach in testing environments (Grant, Kinman and Alexander 2014).

### **Facilitating compassion and care in health and social care curricula**

For educationalists, then the challenge is to translate this concept of caring values meaningfully into the learning environment. The first issue to consider is whether or not HE can physically facilitate the development of caring values in others because these are both subjective and socio-cultural constructs. In terms of the former, this necessitates HE providers to facilitate personal growth and change in terms of the student’s individual perspectives; for the latter, it requires the development of personal resilience in terms of subjective wellbeing and the ability to question and raise concerns about others and organisational cultures. Second, and essential to the effectiveness of this change process, is the readiness of the individual student to adapt in terms of their subjective mindset and world-view (Cranton 2006; Mezirow 2003). Third, and paramount to frame this shared and co-produced learning environment, is the teaching approach and pedagogical principles within the curricula and the associated learning practice environments that can be effectively utilised to structure and engender the successful delivery of caring values and the change process.

***Teaching caring values***

*‘Transformative learning...means taking the position that without developing a deeper awareness of our own frames of reference and how they shape practice, there is little likelihood that we can foster change in others’.*

*Edward Taylor (2008, 13)*

The wider health and social care context is, critically, the environment in which many of the caring based value judgements will take place. As Francis (2013; 2015) can attest, the facilitating of care in these wider cultural milieus can be challenging. For the student practitioner to be prepared to engage with the kinds of ethical dilemmas and the cognitive dissonance that can occur when caring values are not the predominant force (e.g. when subsumed by external forces of finances and managerialism), the education environment needs to prepare them to feel confident in their ability to rank and prioritize conflicting values (Epstein and Delgado 2010; Stanley and Matchett 2014).

In order to achieve this students have to be able to think critically, problem solve and reason at metacognitive levels (Mezirow 2003). Only by working at this deep level of thinking can students be prepared to ‘achieve a deepening awareness both of the sociocultural reality which shapes their lives and their capacity to transform that reality’ (Freire 1972, 51). This kind of deep learning can be facilitated through supporting students to reflect on the affective emotional and spiritual dimensions of learning, which may require an exploration of the subconscious levels of thinking (Dirkx 2006). Although this may seem a little too therapeutic for comfort, it is really about exploring ‘a semi-conscious discord—an unresolved conflict that the individual is generally able to acknowledge with prodding or encouragement’ (Boyd 1991, 179-180).

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When seen in this light it is no more than facilitating a meaningful, reflective process to enable a student to explore and understand a situation more clearly in order to learn from that and essentially, to be able to develop the skills to question or challenge it. It is through this process that metacognitive reasoning and personal resilience can be fostered. It is also about enabling students to develop the skills required to be compassionate and caring (NES 2008), and the emotional intelligence to deal with relationships with wisdom and maturity (Freshwater and Stickley 2004).

This of course requires collaborative, trusting and respectful relationships between educator and student, both in the HE and practice settings (Brazil et al. 2010; Ross et al. 2014). This not an easy task and requires educators to be fully present in the learning situation (Williams and Stickley 2010), to role model the appropriate caring values and interpersonal skills (Newton 2010) and facilitate a safe, transformational 'place of possibility' for both students and staff to explore subjective caring values (Gillespie 2005, 211). This would suggest that the educators in both HE and practice settings have to investigate their own emotional and spiritual dimensions of care as well as utilising their own caring values with students, colleagues and patient/clients in their everyday work.

### ***Student readiness and engagement***

*'Perspective transformation is the process of becoming critically aware of how and why our assumptions have come to constrain the way we perceive, understand and feel about our world.'*

*Jack Mezirow (1991, 167)*

When deliberated in the caring context, there are a few essential characteristics considered necessary in the individual student practitioner in order to facilitate a compassionate and caring approach toward others: these include personal insight and

self-awareness, a recognition of one's limitations or needs in terms of personal growth, and an openness and willingness to address these in order to have the insight and ability to adapt oneself to meet the needs of others (Taylor 2006).

Critically, an altruistic approach is also required, with the ability to put the needs of others before subjective or personal concerns. Argandoña (2002, 3) has described this as the ability to develop a 'transcendent lens' i.e. to be able to consider the impact of one's decisions, not only in terms of the intrinsic (impact on self), or extrinsic (e.g. externalised organisational) outcomes, but the impact of actions on *other* agents; thus the ability to empathise and consider something beyond the self and the organisation or social motives and see the world from the perspective of the other. This requires the ability to be reflective, mature and open to changing taken for granted mindsets and world-views (Mezirow 1991; 2003), a process Frith-Cozens and Cornwell (2009, 11) describe as 'cognitive restructuring'.

However, as discussed previously, there are also *affective* processes at play, including the emotional and spiritual; it is only by working with these liminal dimensions that the more value based levels of learning can take place (Dirkx 2006). This is essential learning component for health and social care professionals, who are a tool of healing and have to use care and compassion therapeutically as well as ethically (Solman and Clouston 2015). In terms of the learner, this means the individual's personal qualities, as well as practical knowledge and skills, are brought into play in order to interact and seek solutions at an emotional level with self and others (Epstein and Hundert 2002; Taylor et al. 2009); this, in turn, requires high levels reflexive action and the maturity, readiness and preparedness for critical thinking and personal change (Clouston and Whitcombe 2005).

Finally, there is also the need to recognise that self care is an essential characteristic in order to maintain the emotional energy to facilitate support for others (Adam and Taylor 2014), something Bush (2009, 27) has termed ‘responsible selfishness’. This is an essential technique for personal resilience and is a necessary skill in order to reduce compassion fatigue and burnout and maintain effective caring and compassionate relationships with others.

***Teaching approaches and pedagogical principles***

*‘In thinking about wisdom in relation to the field of adult education, it is helpful to consider its current academic landscape in order to begin to vision the future, hopefully with greater wisdom’.*

*Elizabeth Tisdell (2011, 9)*

There are a number of critical theories of learning that are relevant to the education of health and social care professionals in terms of engendering caring values. These include: transformational learning (Mezirow 2003), purporting the development of self-knowledge and critical thinking in the student practitioner; those focused around the re-conceptualisation of student empowerment, required to achieve the integrated and coproduced learning environment necessary to facilitate personal growth and commitment from the learner (NASPA 2004); the therapeutic use of self as a tool of healing (Solman and Clouston 2015); the emotional, affective and spiritual dimensions of care and compassion (Clouston forthcoming; Cranbourne-Rosser forthcoming; Dirkx 2006); and finally, those that promote the dimension of wisdom in education, particularly in the professional context of learning (Plowright and Barr 2012).

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In terms of health and social care professionals, wisdom has two distinctive facets: first, *phronesis* or practical wisdom i.e. the technical and knowledge skills and second, *transcendent* or *spiritual* wisdom, which adjuncts to caring values in human relationships (Tisdell 2011). Whilst both these aspects of wisdom are recounted in the literature as essential qualities for health and social care professionals, the latter, to date, has not been linked to emotional or spiritual dimensions; rather, it is determined in terms of ethical principles and professional standing, for example, the practice of nonmaleficence (do no harm) and beneficence (do good) (Freidson 2001). This interpretation holds little resonance to the relational concept of transcendent lens (Argandoña 2002) or very personal emotional and spiritual dimension of being caring and compassionate. This is an intriguing consideration in terms of the education of such professions at a time when the ability to be caring and compassionate in health and social care settings has been called into question and in that context, throws an uncomfortable light into dark places.

This brings us full circle and back to the central point of this paper. It is clear that educators do need to engender personal awareness and growth in terms of care and compassion and facilitate the resilience and skills to challenge practice in the student body if the growth of caring values in the health and social care sector is to be accelerated and sustained. However, this kind of transformational learning is something that cannot be done in isolation: it requires commitment and meaningful collaboration from students, educators, practitioners, professions, HE and health and social care organisations, as well as individual human beings and social structures if the true wisdom of caring values are to be realised. In the present neoliberal context, the latter just may be its Achilles heel.

## **Conclusion**

Recent history has shaken the taken for granted beliefs that health and social care practitioners hold caring values as paramount and that they have the skills and qualities to be caring and compassionate in their everyday work. At this critical time, educators working in these fields have been challenged to create and sustain caring values in the student body, in order to assure that the workers of the future will have the emotional and spiritual wisdom to be caring and compassionate to others. This, in essence, requires a transformational approach to learning, with fully committed learners and emotionally embodied educators who, together, can co-create an environment that stimulates personal growth and exploration in terms of being caring and compassionate. However, individual practitioners and health social care organisations have not worked in isolation to create these failings; they are part of wider neoliberal social system that drives financial efficiency and is counterintuitive to being caring in the health and social care context. This wider social context is a barrier for change in HE, in health and social care settings and in the individual student practitioner; moreover it is one that is challenging to overcome. However, through working together with students to deal with dissonance, to question and challenge failings, to raise concerns, to develop and sustain resilience, to role model appropriate skills and to explore the emotional and spiritual dimensions of being caring, so some strategies to address the development of caring values and to promote and influence change in the caring context can become manifest in both HE and health and social care practice.

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