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Making normative structures visible: The British National Health Service and the hospice movement as signifiers of compassion and hope

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Abstract
Compassion and hope are vital to individual and societal flourishing, not least through the solidarity and change that they facilitate. This article considers the importance of these two social phenomena for welfare institutions, and in particular for the hospice movement and the National Health Service in Britain. Compassion and hope are enacted due to the normative structures in which citizens are embedded. From here it is argued that a dialectical process exists whereby compassion and hope spur the creation of, and are embedded within, healthcare and hospice institutions. In turn, these institutions encourage and give rise to the practice of these emotions across society by virtue of making normative structures more visible. However, the role of these institutions as signifiers of compassion and hope is not straightforward. Tensions exist between the instrumentalism required to provide expansive healthcare access for all, and the communicative action through which hope and compassion are practised at the interpersonal level. More positive norms, such as compassion and hope, intersect with a range of other frameworks which may constrain or undermine their outworking across society. Future research and policy-making needs to acknowledge institutions’ broader influence and value when appraising their role and effective management.

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Introduction

The NHS is not only a great Health Service, it is also the embodiment of an attitude towards one’s fellow man. The fact that we have it amounts to a communal declaration that this society does care about its citizens and their welfare. (McCall-Smith – quoted in Tempest, 2006)

... as an institution the NHS remains a stunning testimony to human altruism and the principles of a caring, civilized society. (Baron-Cohen – quoted in Tempest, 2006)

As these two quotes suggest, there is much about the role of the welfare state (Taylor-Gooby, 1999), and healthcare systems in particular (Brown, 2008), which goes beyond instrumental service provision. Indeed, ‘the moral legacy of welfare citizenship’ (Taylor-Gooby, 1998: 1) bequeathed by universally accessible service provision has been significantly neglected by both recent policy-making and, moreover, much social policy analysis. Health inequalities (and approaches to counter these) have been inferred to say much about the society in which they persist (Wilkinson and Pickett, 2009; Leonhardt, 2010), not least in the way socio-economic inequality acts as an obstacle to wider flourishing of society as a whole. This article seeks to contribute to theory pertaining to the ways in which healthcare provision, in spite of its limited ability to redress deeper inequalities (Illich, 1975), can nonetheless contribute to the flourishing of society through its role in symbolizing hope and compassion.

The broader impact of welfare institutions on society has been understood in terms of social capital (Kumlin and Rothstein, 2005) and trust (Rothstein, 2000; Gilson, 2003). Effective provision of welfare by the state not only performs a legitimating function which solidifies the authority of political institutions, but, moreover, impacts on the attitudinal positions of citizens within the particular polity: ‘Motivations are shaped through the internalization of symbolically represented structures of expectation’ (Habermas, 1976: 95). A healthcare system accordingly can be thought of as imbued with a symbolic value which impacts on those who do not use it, as well as those who are its patients (Leonhardt, 2010). Its very presence within a society, in all that it represents or fails to embody, has a much broader impact on the functioning of social systems and the attitudinal positions of actors within these.

Our argument revolves around the basic societal dialectic whereby subjective social reality gives rise to an objective social world which, in turn, is internalized back into subjectivity (Berger and Luckman, 1967: 149). We observe how compassion and hope can spur the creation of and become embedded within institutions which, in turn, impact upon the diffusion of these emotions across society. The first three sections of the article each deal with one of the moments of this dialectic. Part one considers the role and value of compassion and hope when externalized as subjective emotions in the public sphere. The second section goes on to trace the objectivation of the former two norms within the NHS and the hospice movement. The third and core section then proceeds to consider the symbolic significance of these institutions in demonstrating, and thus imbuing, norms of compassion and hope within the wider society (i.e. internalization). However, this
process is not without its inherent difficulties. Often macro pressures to maximize utility of service provision (due to limited resources) may impose an instrumentalism on those working within these institutions which impinges on the communicative action by which they demonstrate compassion at the micro level (Brown, 2008). The detrimental effect this has on these institutions – in terms of hope and compassion – is considered in a fourth section alongside ways in which these notions (together with trust) may act to mitigate against some of these tensions.

In focusing on the normative structures around compassion and hope, our intention is not to suggest that the NHS and the hospice movement symbolize only these social phenomena. A wide array of attitudinal positions and normative frames are drawn upon, and reproduced by, these healthcare settings – from fairness and equity of access to trust and comfort, as well as norms which are not necessarily deemed as positive, such as rationing, efficiency and considerations of the ‘sick’ body (Shilling, 2002). Such varied normative structures may often stand in complex and contradictory relation to one another, while hospices may even evoke notions of suffering, death and fear.

Centring on compassion and hope is necessarily selective (to facilitate a clearer analysis) while seeking to contribute to the field of ‘positive sociology’ – understood as the systematic study of forms of feeling, thinking and acting conducive to human and societal flourishing. Compassion drives care in the here and now, while hope refers to the ‘structures of expectation’ which Habermas describes (above) as vital to motivational resources in society. Implicit within our focus on these two concepts are assumptions regarding their salience for healthcare institutions and especially their contribution to wider societal flourishing – through facilitating solidarity and care in the present and change in the future. It follows that the threats and limitations to the reproduction of these structures, as explored later in this article, have adverse consequences not only for health care but for society more broadly.

Compassion and hope in the public sphere

Focusing on the first moment of the basic societal dialectic – subjective social reality – in this section we aim briefly to outline the contours of compassion and hope while reflecting upon the contribution that these emotions\(^1\) can make to the development of a society committed to the cultivation of social justice and human dignity.

In compassion, we ‘suffer with’ other beings whose flourishing we consider in serious danger due to events beyond their control (Nussbaum, 2001: 301): ‘death, bodily assault or ill-treatment, old age, illness, disfigurement, immobility, reversals of expectations, absence of good prospects’ – all of these are deemed causes of compassion in a remarkably large number of societies (Clark, 1997: 83; Nussbaum, 2001: 307). In spite of its perils – for both object and subject (sufferer and sympathetic onlooker, respectively) – compassion has been argued to be a fundamental ingredient of social life, not least in virtue of its capacity to mobilize care and create bonds between sufferer and onlooker (Wuthnow, 1991; Nussbaum, 2001; Williams, 2008).

In turn, hope is vital as a means of coping with the negative aspects of the present – through its focus on the potential for good in the future (Nussbaum, 2001: 28). As Kierkegaard (1957: 55) notes, the anxiety and disquiet attached to a particular context are partly due the objective ‘reality’ of the situation, but moreover because of the attentional gaze which is placed upon it. Shifting the interests of members of society towards a future where the hardship and inequalities of the present are addressed and ameliorated can thus act as a potent resource for dispelling unease and social friction. In late-modern societies where risk and uncertainty (and their unequal distribution) are increasingly visible and problematic, the utility of hope as a coping mechanism is of heightened
salience. Whereas trust involves the construction of positive expectations in the midst of uncertainty (Möllering, 2001), hope is able to facilitate action even when the likelihood of positive outcomes may seem distinctly remote. Hope thus enables agency through the concomitant existence of a positive vision alongside mistrust and probable failure. In its positive form, hope is a valuable means of bringing about emancipation and better futures.

Shared aspirations of what a good, or at least better, society would look like create bonds based on a shared recognition of, and concern with, the present context of dysfunction (Marcuse, 1964) or ‘despair’ (Zizek, 2006), as well as a unifying utopia emblematic of shared norms and values. Thus hope, like compassion, is a basis for solidarity across society (Rorty, 2002). Far more than a useful distraction, hope is furthermore a catalyst for change in its ideological function of translating ideas and values into practical action (Martin, 1996). Whereas the weight of uncertainty, complexity and risk would otherwise be paralysing (Luhmann, 1979), the prospects offered through hope compel action based on the promise of a better set of circumstances which can be proactively brought about. Hope can therefore be understood as an impulse, an energy, towards change – in contrast to the conservatism which is indicative of its absence (Fenn, 2001). Hope is thus present in people’s ‘will to power’ (Nietzsche, 1968) and ‘will to trust’ (Möllering, 2006) – it enables the initial vision in which the willingness to act is rooted.

Far from being a hindrance to virtuous action – as a philosophical tradition going from the Stoics to Nietzsche would have us think – there are good reasons to believe that compassion and hope can bear significantly and positively upon both private and public action. They open possibilities for human action that would be inconceivable in their absence. Yet both compassion and hope are surely fallible – their expression a potential hindrance to human flourishing. In the absence of an accompanying appropriate ethical and political framework they can co-exist as functional parts of unjust societies – humiliating the oppressed while white-washing the oppressor’s consciousness, or leading people to tolerate unacceptable conditions of social injustice (Nussbaum, 2001: 414; Sayer, 2005: 147).

Furthermore, as with any energy source, compassion and hope do not necessarily spring eternally (cf. Pope, 1950 [1733]; Clark, 1997). Societies can either enable them to flourish – where aspirations are supported and seen to result in accomplishments – or diminish them – where there is significant and continued experience of hope being disappointed. As we shall argue in the next sections, institutions play a key role in enabling or dashing these emotions.

**Development of hospitals and hospices and their relation to compassion and hope**

While compassion and hope are chiefly visible in the public sphere within the realm of face-to-face sociality known as the lifeworld (Habermas, 1984), the influence of these emotions upon the social and the latter’s influence upon the former take place also through other (systemic) avenues, like institutions and organizations in our particular case. Focusing on the objectivation of subjective social reality – the second moment of the dialectic under examination (Berger and Luckman, 1967) – in this section we outline the way in which compassion and hope are woven into the institutional fabric of the NHS and the hospice movement, while seeking to draw parallels between the two institutions in terms of their relationship with compassion and hope.

Institutions express the value commitments a given society happens to embrace (cf. Marmor et al., 2002: iv; Bellah, 2006a); in turn, institutions are one of the main avenues through which emotions (compassion and hope in particular) and values find an expression in the public sphere
of late-modern societies – not merely as decorative elements, but as sources of meaning and legit-
imation (Rothstein, 2000; Brown and Calnan, 2010). Whether or not a society upholds the propo-
sition that universal health care should be a right available to all its members, for example, and
whether it manages to crystallize this proposition into institutions, is to a significant extent an out-
come of the value-commitments that define such society, as the debate surrounding President
Obama’s attempt to reform America’s health insurance system illustrates.2

In Britain, two sets of institutional arrangements are particularly active in mobilizing hope and
compassion into the public sphere: the welfare state, especially the NHS, and the voluntary sector –
wherein we would like to focus on the hospice movement. Historically, however, both institutions
have been more than just service providers in so far as they also symbolize emotions – compassion
and hope in particular. It is our argument that both institutions, but especially the NHS, are instru-
mental in making compassion and hope universally accessible to the British public, thus rendering a
service not only to social solidarity but also to the quest for social justice, as we shall illustrate.

The momentous contribution of the NHS to the well-being of British society (cf. Webster, 2002;
Berridge, 2008) goes well beyond the service provision associated with health care. From its begin-
ing (1948), the NHS has been inferred to embody compassion and hope – alongside other norma-
tive structures to do with equality and justice. The establishment of a universally available
healthcare system not only marked a fundamental departure from previous models of organizing
health care in Britain, and indeed the capitalist world, but also signified, at least in the minds of
those who created it, society’s ability to build a better future through looking after the health of
all its members. ‘Socialized medicine’ was taken as a means to affirm ‘civilization’ in the midst
of the dire economic conditions of the post-war years (Webster, 2002: 1).

Indeed, the NHS embodies first and foremost the promise of social justice coupled with com-
passion (and thereby hope). According to John and Sylvia Jewkes:

The driving force behind the creation of the National Health Service was not the search for efficiency
or for profitable social investment. It was something quite different: it was a surging national desire to
share something equally. (Fuchs, 1976: 352)

As far as this article is concerned, we should note that the NHS is premised on a notion of compas-
sion articulated to a wider value framework committed to social justice that extended, in matters of
health, society’s circle of concern to every member of the polity, regardless of social origin or any
other consideration.

Though of recent creation in 1967 (Hoad, 1991), the modern hospice movement stems from a
long British tradition of philanthropy which, prior to the establishment of the NHS, was largely
responsible, alongside the family, for social welfare and healthcare provision in particular. With
its insistence on reducing pain and anxiety, affirming patients’ and relatives’ dignity, and giving
priority to personal care over bureaucratic structures, the hospice movement, too, signified a depar-
ture from previous medical practice and offered an innovative model of care for the terminally-ill.
This ethic has advanced beyond the institutional confines of the movement, its principles permeat-
ing the medical profession and indeed the NHS (Abel, 1986; Hoad, 1991).

Though the guiding principles of the movement have been observed to stand in tension
with the expansion of hospices and their growing connections with mainstream medical health

care (Abel, 1986) – with its attendant demands based on instrumental rationality – the hospice
movement is still, we wish to argue, a palpable example of the way in which compassion and the
value of human dignity can be embodied (objectified) into institutional settings. In today’s

Britain, the hospice movement acts as a key ‘sympathy broker’ (Clark, 1997) – an agent and catalyst of compassion in the public sphere – despite its obvious limitations: its relatively narrow scope (terminally-ill patients suffering mostly from cancer), which excludes from its reach most members of the public. And yet the hospice touches lives beyond this narrow realm, as we shall illustrate in the next section.

The central, though often implicit, role of compassion and hope within the NHS and hospices is demonstrated by the manner in which they enter public discourse. During the 2009 Labour Party Conference, for example, Gordon Brown talked about compassion twice during his speech – the first referring to the NHS, the second to a local hospice:

I come from a family which, independent and self reliant as it was, could not have kept going without the compassion and caring of the NHS, because my parents could not easily have afforded to pay for operations on my eyes. So I come from a family for whom the NHS was quite simply the best insurance policy in the world. For us the NHS has not been a sixty year mistake but a sixty year liberation.

And,

For a few days this summer Sarah and I worked helping in a local hospice near our home and I say now that the care and compassion shown by volunteers and staff must be matched by greater support for this work of mercy.

Beyond political rhetoric, the lines quoted here make apparent the value commitments around compassion (and the hopes these give rise to) that underlie the work and the very nature of the NHS and the hospice movement – and the ideological weight carried by these institutions. In so far as ideology is about translating values into action, there is something to be said about the role of these institutions in making compassion and hope visible throughout the social body. This is the focus of the next, and central, section of this article.

The NHS and the Hospice Movement as signifiers of compassion and hope

Thus far it has been suggested that the prospect of compassion, through its visibility elsewhere, instils a hope which propels action that in turn may well result in the practice of compassion through its seeking to bring about better futures. Yet the development of such virtuous circles is, of course, not necessarily so. As Nietzsche (1968) more pessimistically argues, hope in one’s own self-aggrandisement may create a much more vicious spiral where selfish acts, devoid of compassion, lead to furthering of purposive interests in spite of the detrimental impact of this on others; or even on one’s material self. The impact of such approaches on others would be either to undermine their hope in benevolence and compassion, or to direct their hope towards the appropriateness of similarly instrumental actions which are largely ambivalent to a communicative action rooted in shared norms and values.

Hence hope is far from innately coupled with virtues such as compassion, but rather requires orienting in such positive directions through the embedding of the hopes in normative structures which render such positive hopes appropriate and deemed worthwhile. Social structures accordingly will make hope in positive virtues such as compassion more or less likely within particular social cleavages. The recognition of certain future possibilities, and the extent to which these are deemed worth hoping for, are certainly structured by the socio-biographical history of the
individual actor within a specific milieu and range of experiential events. Similarly, the potential for reacting emotionally in a compassionate sense towards others’ misfortune, and moreover acting upon this, is embedded within the socialized experiences of certain normative contexts of care and reciprocity (Clark, 1997). Thus appears the third moment of our dialectic – internalization (Berger and Luckman, 1967).

The importance of social structures for hope in positive outcomes, such as compassion, is underlined when we consider the role of this hope in coping with aspects of uncertainty. Hope, as with trust, is always highly contingent – based as it is on future expectations which may well be disappointed. This lingering uncertainty, combined with making oneself vulnerable to being let down, means that resources must be drawn together in order to bridge over the possibility of negative eventualities (Möllering, 2001). The bricks and mortar with which these positive inferences are constructed are norms and values (Möllering, 2005), and the normative obligations which these impose upon the actors in which the hope is vested (Brown and Calnan, 2010). Or rather it is more correct to say that hope (as again with trust) is vested in the normative structures in which actors are embedded, as opposed to the individuals themselves (Möllering, 2005).

It is the embedding of agency within structures that makes actions ‘predictable’ or positive outcomes deemed likely, not any characteristics which are innate within the actors. Hope in positive outcomes, such as compassionate responses, is highly dependent therefore on normative structures which exercise a ‘civilizing process’ on individuals through moral obligation to act in certain ways (Elias, 1982). The threat of shame and/or guilt is thus a sanction which compels action in a more purposive-rational sense. Though, it may well be the case that compassion is expected and ‘performed’ in an unreflexive way via norms and habit; rather than due to such calculative approaches. The more potent the normative framework, the more inherent the response is likely to be due to actors being blinkered from alternative possibilities for action. This in turn is due to the depth of shame and embarrassment attached which imposes sanctions against other actions at a purposive-rational level, or which renders alternative courses of action invisible within mainstream society and accordingly unconscionable/inconceivable.

Similar to the way in which hope is constructed, reciprocity (as contingent upon, and helping build, social capital) is also made possible through assumptions based on the normative ‘codes of conduct’ which compel action. People’s compassion towards others is made more likely if acts of compassion have in turn been experienced as beneficial for themselves, where the latter experience reinforces the notion that it is possible to understand the other’s experiences through placing oneself ‘in their shoes’ (Schutz, 1972). Moreover, the greater extent to which actors have themselves been the recipients of compassion, ceteris paribus, the more adequate their understanding of how this compassion is able to be demonstrated and the more intrinsic this compassion becomes to the norms of everyday life. Reciprocity in this way depends on norms – in a purposive-rational sense due to the sanctions attached to acting outside a normative code – or more subtly through the assumptions and expectations in which everyday activities are embedded.

It is in the light of this significant role of normative structures – for hope in, and the reciprocity of, compassion – that the wider social impact of institutions such as the NHS and the hospice movement emerges as highly salient. First, by elevating the visibility of a common responsibility for care, alongside the regular practice of compassion, such institutions make these norms (out of which they are hewn) more visible across the public sphere. Hence, where the construction of hope and practice of compassion depend to a large extent on the perception of normative frameworks, the NHS and hospices act as normative signifiers; testaments to their existence.
Second, at the level of the private sphere, local hospices and NHS professional teams are able to extend the practice of compassion into the lived experiences of many millions across British society. Of course, private health providers also render significant compassion and offer hope in private individual contexts. Yet these fail to extend such provision to marginalized social spheres with relatively low social capital. Thus, in lacking the ‘principle of solidarity’ (Lohmüller and Borgers, 2009) and corresponding normative visibility in the public sphere, ‘for-profit’ health care fails to extend experiences of compassion and hope across as many private spheres as the NHS and the voluntary sector. The universal access to private experiences of compassion, which these latter institutions provide, again demonstrates certain norms in a very powerful way. These structures in turn facilitate hope and reciprocal acts of compassion as a ‘mass’ product.

Examples of these normative frameworks, and especially the way these are made visible, are clearly apparent within a recent study into the practice of compassion within the UK (Flores, 2009: 158). Comments recorded at a service of thanksgiving for a local hospice (here represented by three of many similar ones) illustrate our argument:

‘Mere words cannot express how much I appreciate the caring kindness and understanding support shown to me by the medical team and volunteers, without whom I might not be here today.’

‘Thank you for the example of unconditional love.’

‘From an acorn great oaks grow. . . . Thank you for restoring my faith in human kindness at a time when the world seems so cruel. . . .’

The former two quotes bear recognition of the way norms of compassion have been made clearly apparent within the lives of the people touched by the hospice. Similarly, the latter testimony notes the growth of a ‘faith’ or hope, based on a wider norm of humane treatment and care, which has been made visible to the author in the midst of suffering.

These private, first-hand experiences of compassion are surely more ‘concrete’ for the subjects in terms of the way these norms resonate with them so powerfully (Schutz, 1972). This contrasts with the more abstract notions of compassion made visible within the public sphere by notions of hospices or the NHS which are not experienced directly (Brown, 2009), yet both are effectual in illuminating, communicating and instilling norms of compassion across large swathes of society. As Wuthnow (1991) has argued then, compassion does not only happen to benefit those directly touched by it, but also sends a message to society at large. Collective stories of compassion are part and parcel of what helps society gain self-confidence in its capacity for betterment; and accordingly hope for the future (Wuthnow, 1991). Thus, there is an internalization process occurring, as referred to earlier, whereby institutions of compassion create symbols which then resonate with individuals in terms of their own expectations, motivations and attitudinal positions within their social spheres (Habermas, 1976).

**Tensions between solidarity of universal access and individual experiences of compassion**

It must be acknowledged that the primary data cited in the final paragraphs of the preceding section referred particularly to a hospice context rather than NHS health care. Rather than assuming the two institutions as representing analogous expressions of compassion, there are important differences between the norms and values generated within the NHS and those of the hospice movement. The following comment, once again made at the hospice thanksgiving service,
epitomizes the tensions and contrasts that exist: ‘Thank you. When the medical world seemed to have turned its back on us you were there with care, comfort and support’ (Flores, 2009: 157).

This perspective is characteristic of a wider assumption (more or less explicit) within British society – that of an overstretched, business-like yet flawed, NHS with poor quality service and overstretched staff who are generally assumed to be unable to offer the quality of care that is associated with hospices. In contrast to the private-sector-influenced ‘new public management’ approaches of the NHS, the voluntaristic ethos of hospices – combined with their high staff-to-patient ratio – are generally perceived to provide the ‘soft’ aspects of health care (such as ‘care, comfort and support’) much more effectively than the NHS (Seymour et al., 2007).

This contrast with hospice care is only one part of a much wider discourse which has questioned the ability of a market-oriented, instrumentally driven NHS to continue to motivate professionals, care for patients and be popular among citizens – due to the neglect of important ‘welfare norms’ such as altruism and solidarity (Taylor-Gooby, 1999, 2008). On the one hand, efficiency is a vital component of a quality public service in maximizing the utility derived from limited resources (Maxwell, 1984). Similarly the application of evidence-based medicine is essential in applying resources with the maximum effect and safety for patients. Yet these ‘excellent reasons’ behind NHS reform have also developed pathological tendencies (Taylor-Gooby, 2008: 167), in the form of ‘efficiency fetishisms’ (Jones, 2001) and a ‘scientific bureaucratic’ practice of medicine (Harrison, 2009).

There is thus a tension in publicly-funded healthcare systems between maximizing beneficence (and correspondingly legitimacy and solidarity) at an instrumental level and providing quality, holistic, care in terms of communication and compassion (Maxwell, 1984; Brown, 2008). It must be noted, however, that, for all its qualities, voluntary-run health care is much more limited in its ability to provide universally accessible services – as the pre-NHS era testifies. In spite of its limitations, the NHS’s ability to offer care to all plays a key role in bringing together compassion with an appropriate notion of social justice (Nussbaum, 2001). And yet a vital question remains as to the continued ability of the NHS to demonstrate and symbolize compassion to its patients – especially when the communicative action through which these norms are exchanged may often be impeded by the demands of instrumental rationality – which ‘filters off’ conceptions of emotion, suffering and care (Habermas, 1974; Brown, 2008). As Nussbaum notes, compassionate institutions need always to be accompanied by compassionate individuals (Nussbaum, 2001).

Patients’ complaints about the NHS lacking in compassion as a result of attempts to impose efficiency-orientated guidelines (Taylor-Gooby, 2009: 154) make apparent the symbolic value that citizens give to the NHS, and the extent to which such value is upheld above any consideration of service provision. The ‘moral legacy of welfare citizenship’ entails value commitments towards notions such as compassion without which ‘civilized’ life would falter (Taylor Gooby, 2009: 152f). Where these norms of compassion are contravened, hopes are dashed and people’s trust in the ability and willingness of others to provide compassion is tainted. Sustained disappointment would of course have severe repercussions for the wider society’s hope in institutions such as the NHS, and moreover a hope in compassion across society.

And yet there is an important paradox by which the lifeworld – the interactive space where communication and compassion, norms and values are practised – wards against its erosion and the compromising of compassion and hope therein. The increasing domination of instrumental rationality in terms of the way the NHS is run is itself visible and comes to colour the public’s expectations of services; for example, that resource pressures and efficiency drives render healthcare professionals too busy to spend significant amounts of time with patients. While this feature may
well undermine perceptions of a compassionate NHS within the public sphere, in private contexts presumptions of instrumental rationality actually make communicative action more visible. For example, patients are now more likely to presume that professionals will have little time for them and will have many other pressing concerns. Hence, when they do make time for the patient and give them significant attention this is seen as ‘over and above the call of duty’ (Brown, 2009: 403) and especially compassionate.

In this way the agency of individuals, in spite of instrumental pressures, highlights the embeddedness of their actions in normative structures due to the extent to which instrumental concerns are put to one side. The lifeworld around care and compassion is therefore able to resist many of the encroachments (‘colonization’) (Habermas, 1987) that economic and bureaucratic systematization of the healthcare system represent. Even where the possibilities for demonstrating compassion may be curtailed, these more modest displays of care are nonetheless contrasted vividly against the instrumentalism of the system. Yet while this process may ensure that normative structures continue to be made visible within private-direct experiences of the NHS, the colonization of ‘welfare norms’ such as altruism by system pressures of technocracy and efficiency may still challenge the normative visibility of the NHS in the public sphere (Habermas, 1976, 1987; Taylor-Gooby, 1999). Moreover, the shift away from secondary care (as seen in declining in-patient beds across Western medicine) puts an increasing onus on primary services to demonstrate norms in the private sphere – empirical research is necessary to explore whether primary care providers are more, or less, capable of fulfilling this role.

The fact that the positive normativity of public services, including the NHS, is under pressure means that the legitimacy of these institutions is challenged. Where legitimacy is understood as the goals of an institution being congruent with wider norms and values across society, then the ambivalence of performance pressures towards ‘welfare norms’ is decidedly problematic (Taylor-Gooby, 2008). As we have discussed, this not only represents concerns for the long-term integrity of these institutions but also for the functioning of compassion and hope throughout society. If the symbolic value of the NHS is tainted, then the message communicated to society is similarly polluted and dulled.

Given this impeded legitimacy, it is of little surprise therefore that UK policy-makers have increasingly sought to harness voluntary sector organizations as providers of welfare services. Along with a number of practical benefits in terms of cost, local tailoring of services and flexibility, voluntary sector organizations are able to draw on a range of resources such as voluntarism, altruism and trust, which are typically in greater supply than in the public sector. In the short term this assists the quality of services provided as regards the provision of care, comfort and support. In the longer term, however, there are at least two worrying tendencies unfolding: first, a growing body of literature following Knapp et al. (1990), among others, notes the way instrumental pressures placed on providers to demonstrate value-for-money for the funds which they are allocated filters into voluntary sector organizations and undermines the social capital they are able to draw upon; second, the visibility of normative frameworks through the voluntary sector at local community levels is not replicated within the national public sphere.

The threats to the symbolic value of the NHS discussed in this section are thus not sufficiently countered by funding services through the voluntary sector. Indeed, as stressed in the introduction, all institutions act in signifying a whole array of (potentially conflicting) normative frameworks and the hospice movement is no different – leading to the reproduction of negative as well as positive norms (Bradshaw, 1996). One such negative framework is apparent in the overt focus of care within the hospice movement upon cancer (Field and Addington-Hall, 1999). There are
a number of institutional/resource barriers to the extension of palliative care beyond cancer patients (Field and Addington-Hall, 1999), but these more objective aspects have been partly influenced by the visibility of cancer and the resonance across society of the metaphors which surround it (Sontag, 1978). This framework intersects with the norms of compassion and hope discussed above, limiting their availability (at least through the hospice movement) to certain types of illness experience. In turn, this institutional role, and its limits, may act to signify the ‘worthiness’ of certain types of illness – reproducing compassion and hope in certain instances yet stigmatizing and excluding in others. In this sense the societal dialectics referred to above are not independent of one another but complexly interwoven into a tapestry of signs which institutions represent.

Conclusions

In considering the normative structures underlying the NHS and the hospice movement in terms of compassion and hope – and the societal dialectic involved therein – we have aimed to draw attention to a dimension which, we argue, is of critical importance to understanding these institutions and their role within wider society. We have argued that both the NHS and the hospice play a critical role in making the practice and value of compassion and hope visible throughout British society. In so doing, and beyond their role as service providers, they stand as symbols of the possibilities of society to cultivate care and social justice (through compassion), but also to transform itself for the better (via hope). In spite of its importance, this dimension often eludes policy-making analyses that focus too narrowly on instrumental and utilitarian conceptions of these institutions. We conclude by summarizing our argument and pointing towards future research avenues.

Through their contribution to social cohesion, but also towards social justice and emancipatory futures, compassion and hope are significant forces towards individual and social flourishing (Wuthnow, 1991; Nussbaum, 2001). In mobilizing our care towards other beings’ ‘undeserved misfortune’, compassion links our own flourishing to that of others (Nussbaum, 2001: 301). Hope, in turn, points at the expectation, amidst present uncertainty and dysfunction, of a better future – one where we have access to objects we have reason to value, like good health, a dignified death or a caring society (Nussbaum, 2001). In so doing, compassion and hope are important motivational forces – both at the individual and institutional level – towards the attainment of social justice and human dignity (Williams, 2008). As we have argued, they also provide institutions with legitimacy and meaning.

In turn, institutions are fundamental in mobilizing compassion and hope throughout the social body. Thus, and this is our central thesis, virtuous circles may be established whereby hope and compassion are embedded within normative frameworks which their outworking in turn reinforces. Institutions thus represent a means for overcoming the socio-pathologies which would bury and/or dash compassion and hope – while also representing a transformation and recognition of their drive and ambition (Deleuze, 2004; see also McMahon, 2004: 137).

Although the NHS and hospice movement are not analogous as far as the cultivation of hope and compassion is concerned, they nevertheless share many commonalities in this regard. To be sure, hospices are more readily identified with compassion and hope in the British public imagination than the NHS. However, there is a strong case to be made for the NHS as a signifier of compassion and hope in so far as this institution has been a powerful force towards the universalization of compassion throughout British society in a manner that is committed to the cultivation of social justice, especially within the private spheres of those in need. In bringing together compassion and social
justice, the NHS represents a momentous contribution to the well-being, and expectations of flourishing, of the British population.

Yet, while the institutions and emotions discussed may establish virtuous circles between each other, this is not necessarily so. As far as the NHS and the hospice movement are concerned, there are forces at play which threaten to pull them away from a compassionate ethos. In spite of the remarkable resilience that these institutions have shown against bureaucratic encroachments, instrumental rationality in the form of policies narrowly oriented towards efficiency threatens to undermine the symbolic value of these institutions (Brown, 2008; Taylor-Gooby, 2009). There are long-term concerns here as institutional failure to reproduce social norms and values would lead to an undermining of compassion and hope as forces of social change in the public sphere. The ensuing disappointment can breed cynicism and undermine the legitimacy of institutions which lie at the very heart of British civic life. Given their importance in signifying normativity, the undermining of these institutions does not bode well for the social body as a whole, not least in areas such as social capital, altruism and solidarity. The long-term future of both the NHS and the hospice movement rests on the recognition that if their symbolic value is undermined then so too is their legitimacy and, alongside this, certain core values and emotions which are central to society.

A more sensitive attentiveness to the emotional and normative underpinnings of institutional settings, particularly in terms of compassion and hope, could open up novel research avenues and inform policy-making around health care, an area which continues to be at the centre of public debate in many polities. For example, it remains a task for future empirical research to engage with the concrete ways in which compassion and hope are enacted within these institutions and beyond them. At a more theoretical level, this would contribute to the ongoing sociological task of mapping the landscape of compassion and hope under conditions of (late-) modernity. At the level of policy analysis and political activism, the above-mentioned concerns raise questions as to how the threats posed by instrumental rationality may be countered. This points towards a research agenda for policy-makers and scholars, third sector agencies and social activists.

Notes
We are grateful to Jeremy Kendall, Beth Breeze and the two anonymous reviewers for their insightful comments.

1. In Martha Nussbaum’s account, which we follow here, emotions are not antithetical to reason, but necessarily incorporate reasoning and judgment about the value of objects conducive to our well-being (Nussbaum, 2001: 2).

2. Obama’s case for healthcare reform marshalled, among other things, an argument based on the centrality of ‘compassion’ for American civic ethos: ‘That large-heartedness – that concern and regard for the plight of others – is not a partisan feeling. (…) It, too, is part of the American character – our ability to stand in other people’s shoes; a recognition that we are all in this together, and when fortune turns against one of us, others are there to lend a helping hand…’ (Obama, 2009). In spite of commitment to compassion, prevailing socio-political norms include other elements which render the idea of a universal National Health Service highly contested.

3. Of course there is not one NHS in Britain, but effectively four – where the healthcare systems are governed separately in each of the four nations: England, Northern Ireland, Scotland and Wales. While in many ways distinct, much of the political and normative history of the systems
is intertwined. However, it should be noted that the tendencies towards instrumentalism (epitomized through ‘New Public Management’-type approaches) referred to later in the article are much more apparent in the English NHS.

References


Author Biographies

Patrick Brown obtained a PhD from the University of Kent in 2008, where he then lectured in health policy and research methods. He was recently appointed as an Assistant Professor in Sociology at the University of Amsterdam. His current research focuses on the role of hope, alongside trust, in contexts of risk and uncertainty – especially mental health care.

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