Fisher, P. and Freshwater, D. (2014) Towards compassionate care through aesthetic rationality, *Journal of Scandinavian Caring Sciences* **(doi: 10.1111/scs12109).**

ABSTRACT

The Francis Report, which was based on the investigation of complaints regarding standards of care in the Staffordshire NHS Trust in the UK, was published in 2013. The Report revealed that while the Trust appeared to be compliant with the standards set by official regulating bodies, the quality of care provided to patients was often appalling. While the Report constituted a 'critical moment' in healthcare, its findings resonated with widespread concern in the UK and elsewhere that healthcare is sometimes characterised by a lack of compassion. The Francis Report partially attributed this lack of compassion to a task-based culture which tended to prioritise the meeting of targets over the quality of care provided to patients. Older patients, in particular, were identified as being vulnerable to neglect. This qualitative study of hospice volunteers responds to concerns regarding the quality of organisational forms of care by considering how motivations to care may be sustained and enhanced within organisational contexts. Charitable and third sector organisations, such as the hospice in this study, have been identified as potentially relevant to other health and social care contexts precisely because they emphasise values such as altruism, goodwill. Our sociological approach suggests that altruism or compassion can be encouraged within contexts that emphasise a sociability of care. We argue that a sociability of care may be encouraged in organisational contexts if dominant understandings of rationality are extended through the incorporation of aesthetic rationality, a feminist perspective taken from Roslyn Bologh. This, however, would require a degree of authentic emotional

engagement on the part of formal caregivers which is more typically associated with relationships in the private sphere.

KEYWORDS

Compassion, informal and formal care, aesthetic rationality, resilience, Francis Report, hospice

INTRODUCTION

In many countries the provision of palliative care is heavily dependent on the contribution made by the charitable sector. This is particularly so in the UK, where independent, charitable hospices provide almost 80% of all inpatient hospice and palliative care (1). There is a growing body of knowledge about hospice volunteers, which has focused mainly on volunteers' personal motivations (2-5). The approach has generally been to consider an individualised model of motivation with less attention being paid to how a commitment to care is encouraged and sustained relationally within palliative contexts. This absence reflects organisational culture in the West, which is often based on a solipsistic view of human nature that is neglectful of relationships. While we share the view that personal experiences, identifications and values are highly significant in relation to motivations, our attention in this paper is directed primarily towards the development of a sociological interrogated understanding of how motivations to care may be sustained and enhanced. Drawing on a study involving hospice volunteers this paper suggests that compassionate care requires an enlarged understanding of rationality, one that prioritises the importance of relationships. From a feminist perspective taken from Rosalyn Bologh (6), we argue for an acknowledgement of the value of what she terms, aesthetic rationality, in engendering a sociability of compassion within care environments.

Our approach seeks to provide a counter-balance to the notion that altruism or compassion are essentially qualities attached to individuals (7), a perspective that can foster caring environments characterised by a lack of collective empowerment (8). The model that often

prevails is one of the lone practitioner isolated from colleagues, alienated from the organisation and subjugated by a disciplinary culture of targets. From this perspective, people working in health and social care organisations are located as motivated by a narrow form of defensive instrumental rationality, devoid of emotions, values and identifications (9). Previous research (10) however, has shown how practitioners construct 'ecologies of practice' which are more responsive to and sensitive of service users by negotiating managerial requirements without being subjugated by them. We believe that this study may be useful in revealing an approach that facilitates the development of 'ecologies of practice' in health and social care organisations.

We acknowledge that transferring findings across diverse health and social care settings is in many respects problematic. Charitable hospices cannot for a host of reasons be compared sensibly with large publicly funded organisations. Hospices are generally organised on a much smaller scale and are significantly financed through private donations and fundraising activities. At the same time, hospice volunteers enjoy high levels of flexibility in relation to the extent and timing of their contributions; the fact that their work is not related to the existential necessity of earning a living inevitably attenuates many of the anxieties associated with professional roles. Nevertheless, charitable and third sector organisations have been identified as politically important precisely because they are underpinned by values such as altruism, goodwill and a concern for the plight of others, factors which are increasingly being identified as vital dimensions of care (11- 13). For this reason it has been suggested that public services have much to learn from the third sector, particularly when it comes to understanding the needs of service users and communities and in gaining a greater 'closeness to people' (14).

BACKGROUND

In February 2013, the final report of the Mid Staffordshire NHS Foundations Trust Public Inquiry, which had investigated complaints regarding standards of care in the Staffordshire Hospital, was published. The Report (15) revealed that while the Trust appeared to be compliant with the standards set by official regulating bodies, 'appalling conditions of care were able to flourish'. This was partially attributed to a culture which prioritised targets over care, resulting in a particular neglect of older patients. The regulatory mechanisms had

clearly failed to ensure 'compassionate care', a value that had become subordinate to the pressures of complying with managerial targets.

We suspect that the dangers of poor care will always be present in contexts where the values of care are obliged to cede in the face of instrumental rationality. We welcome the view represented in the Francis Report (15) that blaming individuals for systematic failures is generally fruitless, but we note that the Report advocates a route towards compassionate care through the enforcement of professional values associated with 'strong leadership' and 'the rigorous policing of fundamental standards'. While peer review is identified in as a valuable approach towards ensuring consistency of care, understandings of peer review in the Report remain embedded in dominant interpretations of rationalism which are neglectful of relationships. Following on from previous work (16) calling for a prioritisation of the core values of care over managerial mantras and requirements, this paper suggests that compassionate care can only be enacted within supportive social relationships.

While the Francis Report may well be regarded in the future as a 'critical moment' that exposed a 'crisis of care', the warning signs that something has gone awry have been around for some time. In 1995 *The Crisis of Care* (17) highlighted how the moral obligation for compassion and goodness was being eclipsed by depersonalised procedures and market imperatives in the USA. Similar problems have been unearthed in Scandinavia (18).

A detailed discussion of the implementation of New Public Management (NPR) is beyond the scope of this paper, however, one of its unfortunate dimensions which is worth highlighting in this context is its tendency to retrench the ideological separation of the private and public realms. We suggest that this has resulted in a reinforcement of Weberian understandings of rationality. Weber (19) famously identified two forms of rationality: value rationality which is associated with pursuing abstract ideals, for example, duty and honour and so forth, and instrumental rationality which is directed towards the most effective realisation of certain ends (the value of which is not open to scrutiny). Instrumental rationality is most often associated with the pursuit of organisational targets and outcomes in health and social care organisations operating according to quasi-market forms of accountability. There is little space for personal emotion or personalised

compassion within either instrumental or value rationality. Admittedly, care and compassion could be regarded as abstract values, however, the principles of value rationality rule out embodied and emotional responses at the level of individuals. From a Weberian perspective, values are external to individuals and should be enacted with detached rationalism. The emphasis is on the quantifiable rather than the experiential.

THE STUDY

This study, which was conducted at a hospice in the north of England, involved six in-depth interviews with established volunteers. Ethics approval for the study was obtained from the School of Health Care Research Committee at the University of Leeds in January 2013 (SHREC/RP/285).The research participants participated voluntarily and, indeed, were keen to do so; we believe their readiness to participate may be attributable to their conviction that they could offer a valuable perspective on care – perhaps one which does not receive sufficient societal recognition. We have used the pseudonym, Sandybank, when referring to the Hospice. We have also protected the anonymity of the interviewees by not using their real names. Four of the interviewees worked with patients in the day hospice and the other two were primarily hospice fundraisers, although roles were not clearly delineated. Day-hospice volunteers, for example, also contributed to fundraising activities, and the volunteers who worked principally as fundraisers also attended to other administrative tasks. The interviewees were women in their forties, fifties or sixties, and in most cases retired from full-time employment. The youngest had herself previously been a patient in the hospice and had a demanding caring role in her home life. While the interviewees appeared to have busy and full lives, their voluntary work at the hospice was central to their sense of self; in some cases it had been prioritised over other volunteering opportunities.

This study is a small one and our findings are necessarily tentative. However, the interviews were in-depth, generally lasting in excess of an hour, and were supplemented by notes taken during several informal visits to Sandybank and discussions with the management team there.

Our central concern when interviewing at Sandybank was to gain an understanding of what prompted the volunteers' ongoing commitment to their voluntary work. A conversational

approach was used in the interviews in which questions such as 'Why do you work as a volunteer?', 'Can you tell me what the rewards and challenges of volunteering are?' and, 'How does volunteering fit in with your other commitments?' It became apparent when conducting the interviews that the interviewees passionately held views that had been developed over a period of time; interviewees needed little prompting in expressing their views. The interviews were transcribed and subsequently returned to the interviewees to enable them to make any amendments or additions. The data were then analysed according to techniques associated with thematic analysis. After several close readings of the data, initial codes were established, for example, 'appreciation', 'happiness', 'family', 'rewarding', 'creativity' and 'support'. These were subsequently organised into linked categories or themes: including 'community of practice', 'identity and caring', 'networks of support and relationships', 'blurring of the private and the public', 'authentic emotional engagement' 'the philosophy of the present', 'altruistic resilience'.

FINDINGS

An authentic community

For Weber (19) emotional involvement, including feelings of fraternity, are in conflict with rationally organised organisations. This Weberian perspective of leadership as involving rationalised detachment is quite contrary to the interviewees' experiences of Sandybank. Emphasising solidarity and togetherness, the interviewees described an informal atmosphere characterised by a lack of overt hierarchies. Jill who had previously worked in local government explained,

> And everybody helps everybody, and everybody seems to sort of know everybody's else's job at bit. So if they're off ill somebody can jump in and do it, whereas if you work for the local authority, it's your job and it's left'.

This sense of solidarity was inclusive of volunteers and staff and appeared to be consolidated in 'after work' recreational activities which included the Hospice choir and yoga group. When speaking about their work at Sandybank, the volunteers tended to use the pronoun 'we' (far more frequently than 'I'), possibly suggesting the absence of the type of competitive discourse associated with many working environments (20). While it may be countered with some justification that a charitable hospice works on a scale that is more amenable to a more personal approach than larger public service organisations, this does

not necessarily point to a less pressurised environment. The volunteers commented on the significant workloads of the paid staff at Sandybank. As Suzy, one of the volunteers who contributed mainly to fundraising events made clear, the culture of solidarity has been developed despite considerable pressures,

> It upsets me actually […] they're very dedicated, but when I look at the amount of work that they do for the number of staff.

The 'community' at Sandybank clearly incorporated the patients who were recognised as positive social agents that contributed to a pleasant social environment. One of the interviewees, Celia, who works in the day-hospice, commented, 'I think you probably get your strength from the patients'. She also spoke about the importance of humour and praised the patients for their ability to stay cheerful.

> Laughter is very important but it has to be from them, if you know what I mean, You can't just do something silly and they laugh. You have to have a genuine feeling for people deep down (Celia, volunteer in the day hospice)

Other volunteers similarly indicated that their relationships with patients were mutually beneficial. Words such as 'rewarding', 'enjoy', 'laughter' were often applied to describe encounters with patients. This level of positivity could be interpreted as simply reflecting a veiled form of emotional labour. The term emotional labour refers to the (commodified) work that is necessary to present an appropriate face in the workplace or to elicit certain emotions in others (21). Crucially, emotional labour is performed in the interests of organisations and is not associated with a person's authentic feelings. The interviewees' testimonies evoked, in contrast, what has previously been termed felt 'philanthropic' emotion work (22). In other words, their emotional contributions involved an embodied form of generosity based on largely genuine emotional engagement. Put differently, emotional contributions were given as a gift, based on a tacit understanding that wellbeing may be generated within social encounters.

The resilience of community

Despite the sense of Sandybank being, in one interviewee's words, 'such a happy place', it would be naïve to assume that working with people with life-limiting illnesses is without its

attendant stresses. Indeed, Jill (involved primarily in fundraising) explained that working directly with patients would be, for her, too emotionally draining. Similarly, Dawn explained,

> It's so hard and at first it was very difficult seeing them. You'd be sat with them one week and the next week you'd go and sit with them and you'd think, 'well they looked fine last week'. But we know what this illness can do but it's learning to go home and switch off.

Suzy's comments below point to a complex emotional ecology of happiness and sadness, and yet an ultimate ability to prioritise the positive,

> It's not difficult getting up and getting organised early to come here because it's such a happy place. It's not depressing or sad. [There are] a few very sad occasions. You do get attached to some patients more than others, and you're going to have a little cry when some of them die. But on the other hand, it's almost a sort of pleasure to have known them, isn't it?

Previous studies have shown (23, 24) that emotional fulfilment can be associated with taxing circumstances if these are also shaped by opportunities to engage in practice that is meaningful. This is perhaps what Titmus (25) has termed 'creative altruism'. As Liz put it,

> I think with any volunteering, I think it's the fact that I'm giving something back and I can give something back.

When pressed on the emotionally draining elements of the work, Liz explained that despite a busy lifestyle which included photography, teaching and caring for a husband with MS, volunteering was the activity that provided her with the most satisfaction,

> If I had to put them [activities] into a ranking order, my volunteering would be the most rewarding and the one that I wouldn't let go of. If anything went, it would be work, that would be the first thing to go.

This level of commitment to Sandybank appeared to be related to a particular type of sociability that involved the whole community of staff, patients and volunteers. Ann, explained,

> if you wanted to there's always somebody here to listen to you, if you needed anybody, you know full well that you could phone up even as a volunteer and say […] I'm in a terrible state, can I have a word with whoever. And here will be somebody who would give you time if you needed it.

Ann's comment above suggests that the values of care enacted with patients are also expressed within relationships with care providers (volunteers and staff). This is an important point and one that may be overlooked in some contexts in which practitioners' responses to each other may be shaped by organisational mechanisms of disciplinary power. In contexts such as these the resilience of staff is likely to be undermined as suggested by a recent study (26). The study shows that the introduction of NPM into the Nordic countries in the 1990s coincided with increased problems of staff turnover and absenteeism, and a sharp rise in multiple health problems including depression, anxiety, exhaustion, musculoseketal injury and mortality. It is suggested (26) that the escalation of these problems within Scandinavian health services may be attributable towards an organisational reconfiguration that subordinates high quality care to economic concerns for productivity and efficiency. Conversely, developing a therapeutic relationship with patients through person-centred approaches has been identified as contributing to the wellbeing of patients and nurses alike (27).

The philosophy of the present

For three of the volunteer interviewees who participated in this study craft work constituted a longstanding interest which, they argued, was key in promoting therapeutic relationships. Liz explained that this type of activity occurs when individuals are untrammelled by paperwork,

> You can focus on what the individuals want to do because they will come in one day and some will absolutely love doing crafts, and some [will say] 'Oh I can't do it. I don't want to do it'. And you can talk them round to doing little things, just doing little bits and feeding them snippets and then all of a sudden they're creating something.

This appreciation of the value of craftwork among the volunteers was not primarily related to the quality of product but to the creative process which was in itself therapeutic, both in terms of providing an enjoyable pastime and in encouraging a sense of togetherness and conversation. As Dawn explained,

> We enjoy ourselves, you know, we do this and do this, and as they get used to you they start to talk to you about things and tell you about their life, their family and what's happening.

The main purpose or *telos* of the craftwork was therefore to promote wellbeing in the present through meaningful activity that can be interpreted as a form of mutual gift exchange involving all parties. This evokes what has elsewhere been referred to as the 'philosophy of the present' (28, 29). Essentially, the philosophy of the present is associated with an appreciation of and ability to live in the present, whilst accepting that the future cannot always be controlled. People who adopt the philosophy of the present tend to view their lives as relational and ongoing rather than focusing on future objectives, an orientation that sometimes appears to be associated with higher levels other-relatedness. What we draw from our findings is that caring for people with life-limiting illnesses (and older people and people with chronic conditions) requires an attention to present wellbeing through supporting the development of meaningful relationships. This often remains insufficiently acknowledged in organisational contexts.

Towards a sense of agency – personal and relational

The interviewees did not see themselves as individualised units whose purpose was to deliver goals or plans imposed from above, but as key sources of agency in themselves, and through their relationships with others. When people see themselves this way, their commitment extends beyond what are considered normally acceptable levels. At Sandygate, this fosters a commitment to patients and to very necessary but time-consuming funding raising events. Suzy explained,

> I mean sometimes when they've got the ball and then the Christmas events and the *Light up a Life,* it's just absolutely mad. That's why I come in extra, so if I'm needed, just shout'.

Suzy's comment appears to be describing a supererogatory obligation, that is a feeling that one has a personal sense of responsibility (that goes beyond the call of duty). Similarly, Jill described her motivation in terms that pointed to an absence of the compartmentalisation of life that is often a characteristic of paid employment,

> And the thing is like when I used to work, I used to think, right at the end of the day, everything is cleared, so you're starting fresh [next day]. There's no way in a million years that you could finish what you're doing [at Sandybank].

A cautionary note needs to be added here as volunteers equally spoke of the ability to compartmentalise their lives, although it was evident that their commitment exceeded the

normal boundaries associated with professional roles. Although her volunteering was primarily in patient care, Liz explained,

> And I watch the volunteers and paid staff work so hard [at arranging fund raising events].We've just had one on Sunday, and we did the Christmas market, and I spent nearly six hours there in Santa's Grotto, but [high levels of] work they [paid staff and volunteers] have to put into doing it, to make those event happen.

This sense of holistic involvement is contrary to traditional notions of professionalism which have traditionally been associated with a rationalist-instrumentalist mindset which compartmentalises personal life from working life. In contrast, at Sandybank, the blurring of boundaries between private life and volunteering appeared to be associated with a view of agency as relational. The relational incorporated wider social networks that included family members and friends. On several occasions, the contributions of family members were referred to,

> I mean my friend who lives in Wakefield, she came and helped out [with the garden party]. Whilst me and my sisters were on the barbecue – there were four of our family and three of my nieces just did that (Suzy).

Motivation and commitment among the volunteers clearly do not stem from a target culture associated with instrumental rationalism. At the same time, the volunteers' sense of identification with others is not sufficiently captured by value rationality that prompts striving towards abstract values that are external to agents. Therefore, as a way of conceputalising the psychosocial environment at Sandybank we have turned instead to a feminist perspective (6) offered by Bologh in *Love and Greatness.*

Before discussing Bologh's (6) contribution, we begin by reminding the reader that feminist perspectives generally reject the separation of the public and private spheres of life, viewing this an ideological division of life which devalues domestic work and 'feminine' values derived from engagement in the private sphere. According to feminist critiques (30), women's voices have been stifled in the public sphere, and qualities deemed suitable for professional life, such as detachment and objectivity, are generally those traditionally associated with a 'masculine' standpoint (30). Specifically in relation to this paper,

professional life has been traditionally connected to Weberian technical rationalism which, as previously discussed, neglects the value of relationships. In the discussion below, we draw on Bologh (6) who argues, from a feminist perspective, for an enlarged understanding of rationalism. Specifically, Bologh argues that 'aesthetic rationality' which is generally seen as connected to the promotion of domestic wellbeing should be incorporated into organisations with traditional forms of Weberian rationalism which are, as discussed above, associated with a detached and masculinist perspective. In this paper we suggest that the value of aesthetic rationality should be seen as of particular relevance in formal caring contexts where it should enjoy parity with traditional forms of organisational rationality.

Bologh (6) sees aesthetic rationality as a mainly unacknowledged a female form of rationality (in the sense that it is associated with domestic and communal relations) which is in the broadest sense appreciative of and responsive to beauty. This is not a reference merely to visual beauty but encompasses anything which 'attracts our feelings in a way that we deem desirable' (6). In other words, the ultimate gain is the realisation of a subjective sense of wellbeing – physical, social and emotional. Aesthetic rationality joins together mind, body, feelings and senses and seeks to create a world that enriches and empowers people. Activities associated with aesthetic rationality include tending to the body in physically sensitive ways or in invoking wellbeing through the organisation of playful of social activities, or simply listening attentively and responding in ways that foster a person's sense of belonging. The inclusion of the emotional dimension in Bologh's thinking is of especial significance as this has traditionally had little legitimacy within organisations that are mainly run according to Weberian understandings of rationality which discourage the view that emotion may be a positive force for good. This is now being increasingly challenged by philosophers, neuroscientists, psychotherapists and social scientists whose work suggests that emotions cannot be disentangled from evaluative judgements (24, 30-32). What these authors are suggesting in different ways is that emotions tell us what is important.

The findings of this study suggest that much of what happens at Sandybank is based to a significant extent on a sociability generated through a collective and tacit identification with the values of aesthetic rationality. The emphasis on the 'beauty' of relationships and how to

enhance these may be enhance through collaborative and meaningful activities together work towards the enhancement of present mutual wellbeing.

DISCUSSION

Bologh (6) sees aesthetic rationality as an approach that can engender what she terms 'female sociability' (defined as sociability that is generated within domestic and community relations). We prefer the term 'sociability of care' on the basis that we consider that its legitimacy should be extended into the public sphere. Irrespective of the term that is applied, however, we feel that while it cannot be quantified or 'commanded from above', this type of sociability can be quickly sensed in an environment, such as Sandybank, where it informs relationships. At first glance, a 'sociability of care' ostensibly resembles Simmel's (33) well known sociological understanding of sociability in the sense that this equally prioritises pleasure and playfulness. Simmel, however, sees sociability as a *performance* of playfulness by *individuals* whose personal interests precede collective interests. For Simmel the emphasis is on the *performance* of tact and good form. In contrast, Bologh's sociability acquires values through sincerity and is produced through an authentic orientation towards others. The notion of authenticity is particularly pertinent to the study at Sandybank where the volunteers' focus was not on the abstract but on the person at hand, seen as an embodied, feeling, and thinking agent. While emotionally charged relationships may be draining, there is a growing body of sociologically informed literature suggesting that denying emotional engagement in caring environments leads to yet greater devitalisation (see for example, 23, 24).

CONCLUSION

Bologh (6) argues in favour of the incorporation of aesthetic rationality into the public realm in order to counterbalance the prevailing tendency to prioritise detached instrumental rationality. While Weber was aware that the instrumental rationality associated with modern organisations works against the development of a commitment to values and ideas that give meaning to life, he addressed this by turning to the possibility of charismatic leaders who would be able infuse values and meaning into social life. As Bologh points out, this was based on the assumption of 'patriarchal' control, a form of leadership involving

obedience rather than agency. We suggest instead that a 'sociability of care' might be generated through aesthetic rationality, and that this should receive higher levels of recognition within public and social care organisations. This is perhaps especially pertinent to the care of older people and people with chronic conditions, where the emphasis on present wellbeing (rather than on future-oriented 'cures' or outcomes) should be the main concern. This can only be accomplished in a context in which flourishing – not merely instrumental - relationships are esteemed.

While this study relates principally to volunteers' contributions in a charitable hospice, we suggest that the findings may be of some relevance when considering professional forms of care in a range of organizational contexts. In the current 'crisis of care' there is an urgent need to question current understandings of professionalism and the narrow interpretation placed on rationality in many organizational contexts. We suggest that organizational forms of professionalism might be reconfigured to incorporate a recognition of the value of aesthetic rationality, and that this might contribute to the development of more compassionate care. While it is beyond the remit of this paper to consider in detail what such a reconfiguration would involve in practical terms, we would briefly suggest that it would entail supplementing task-based approaches with the expectation that compassionate professionalism requires close attention to the nurturing of relationships. Equally, biomedical preoccupations with future outcomes – for example, the restoration of health – would be accompanied by a greater recognition that compassionate care requires a focus on the dignity and wellbeing of people *in the present*. This greater focus on present wellbeing would be one which would also benefit care providers. On the basis of this study, we suspect that the quality of care at Sandybank is enhanced through a sociability of care which supports (rather than polices) the care providers.

A sociability of care cannot be conjured up or enforced through the imposition of authority, it requires a deeply embedded change of culture that is achieved though collective commitment. We suggest that aesthetic rationality might be a good starting place for its development.Before aesthetic rationality can gain ground in the public sphere, a fundamental shift is needed whereby professional achievement is no longer assessed by criteria restricted to Weberian rationality alone. An enlarged interpretation of rationality is

needed, one that incorporates the aesthetic. Specifically, it is about broadening conventional notions of rationality to incorporate a notion of organisations as networks of relationships. This is not to suggest that aesthetic rationality is on its own a sufficient basis for the running of an organisation, an argument that would be as irrational as the repressive tendency of the public sphere to reject the values of the private spheres. What is required, however, is the aspiration to transcend the opposition between the private and public sphere and to reformulate the relationship between them.

Enacting such a change would involve a profound reconsideration of what constitutes rationality in professional contexts and an obligation to stand up for some of the values of the private sphere which have not received sufficient recognition within organisational contexts. If aesthetic rationality is to become fully rational, this will not be achieved by 'specialists without spirit, sensualists without heart' (34), but by people who are collectively empowered to overcome its subservience.

REFERENCES

1. Sevigny, A., Dumont, S.,Cohen, S.R. and Frappier, A. (2009) Helping Them Live Until They Die: Volunteer Practices in Palliative Home Care, *Nonprofit and Voluntary Sector Quarterly* 39 (4): 734-752.

2. Fox, J, (2006) 'Notice How You Feel': An Alternative to Detached Concern Among Hospice Volunteers, *Qualitative Health Research* 16: 944-961.

3. Claxton-Oldfield, S. and Claxton-Oldfield, J. (2008) Some common problems faced by hospice palliative care volunteers, *American Journal of Hospice and Palliative Medicine* 25: 121-126.

4. Pavey, L., Greitemeyer, T. and Sparks, P. (2012) I Help Because I Want to, Not Because You Tell me to: Empathy Increases Autonomously Motivated Helping, *Personality and Social Psychology Bulletin 38* (5): 681-689.

5. Schnell, T and Hoof, Matthias (2012) Meaningful commitment: finding meaning in volunteer work, *Journal of Beliefs and Values* 33 (1): 35-53.

6. Bologh, R. W. (2009 [1990]) *Love or Greatness: Max Weber and Masculine Thinking – a Feminist Enquiry. Ta*ylor & Francis e-Library.

7. Le Grand, J. (2003) *Motivation, Agency and Public Policy*. Oxford: Oxford University Press.

8. Jaeger, A. (2011) Facing the Music. In NMC (2011) *NMC Review. Policy, Practice and Public Protection*, Issue 3: 4-11. Available at http://www.nmc-uk.org/Documents/NMC-Review/NMCReview_issue3.pdf.

9. NMC (2011) NMC Review. *Policy, Practice and Public Protection*, Issue 3. Available at http://www.nmc-uk.org/Documents/NMC-Review/NMCReview_issue3.pdf.

10. Author 1.

11. Clohesy W.W. (2000) Altruism and the Endurance of the Good, *Voluntas*, 11, 3, 237-253.

12. Dekker P and Evers A (2009) Civicness and the Third Sector: Introduction, *Voluntas*, 20: 217-219.

13. O'Brien L, Townsend M and Ebden M (2010) 'Doing something Positive': Volunteers' Experiences of the Well-Being Benefits Derived from Practical Conservation Activities in Nature, *Voluntas*, 21: 525-545.

14. National Audit Office (no date) available at http://www.nao.org.uk/sectors/third_sector/successful_commissioning/successful_commissioning/introduction/what_is_the_third_sector.aspx

15. Francis, R. (2013) *The Mid Staffordshire NHS Foundation Trust Public Inquiry*. available at http://www.midstaffspublicinquiry.com/report.

16. Bishop, V. (2011) Leadership and clinical governance: immoveable concrete or tsunami for change? Journal of Research in Nursing 16 (1) 3-6.

17. Philips. S.S. and Benner P.E. (eds) (1995) *The Crisis of Care: Affirming and Restoring Caring Practices in the Helping Professions.* Washington DC: Georgetown Press.

18. Borbasi, S. and Chaboyer, W. (2006) Taking the lead: opportunities await nurses, *Scandinavian Journal of Caring Sciences* 20 (2): 111-112.

19. Weber, M. (1978 [1922*]) Economy and Society*. Roth, G. and Wittich, C. (eds). Los Angeles and London: University of California Press.

20. Hoggett, P., Mayo, M. and Miller, C. (2006) Private Passions, the Public Good and Public Service Reform, *Social Policy and Administration* 40(7): 758-773.

21. Hochschild, A. (1983) *The Managed Heart: Commercialization of Human Feeling*. Berkeley: University of California Press.

22. Bolton, S. (2000) Who cares? Offering emotion as a 'gift' in the nursing labour process, *Journal of Advanced Nursing*, 32, 3, 580–86.

23. Author 1.

24. Author 1.

25. Titmuss, R. (1970*) The Gift Relationship.* London: George Allen and Unwin.

26. Orvik, A. and Axelsson, R. (2012) Organizational health in health organizations: towards a conceptualization, *Scandinavian Journal of Caring Sciences* 26: 796-802.

27. Lehulante, A., Nilsson, A. and Edvardsson, D. (2012) The influence of a person-centred psychosocial unit climate on satisfaction with care and work, *Journal of Nursing Management* 20: 319-325.

28. Ezzy, D. (2000) Illness narrative: time, hope and HIV, *Social Science and Medicine* 50 (5): 605–17.

29. Author 1.

30. Landes, J.B. (ed.) (1989) *Feminism and the Public and Private*. Oxford: Oxford University Press.

31. Nussbaum, M.C. (2001) *The Upheavals of Thought: The Intelligence of Emotions*. Cambridge: Cambridge University Press.

32. Author 2.

33. Damsio, A. (2006) Decartes' Error. London: Vintage.

34. Simmel, G. and Hughes, E.C. (1949) The Sociology of Sociability, *American Journal of Sociology*, 55 (3): 254-261.

35. Weber, M. (2003 [1904*]) The Protestant Ethic and the Spirit of Capitalism*. New York: Dover.