Briefing: What is compassionate care?

Principles, practice, and possibility

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What is compassionate care?

This briefing document is designed to support practitioners, policymakers, commissioners, and educators in developing a richer understanding of what compassionate care looks like in practice, particularly when working in pressurised systems that are increasingly shaped by targets, metrics, and standardisation.

Drawing on the theoretical work of Singleton & Mee (1), Annemarie Mol (2), and Tveit & Raustøl (3), it challenges the idea that compassion is simply about being kind or empathetic. Instead, it presents compassion as a reflective, relational, and responsive practice – something that involves emotional engagement, professional discretion, and an awareness of the wider structures and inequalities shaping people's lives.

The document aims to bridge theory and practice by grounding abstract concepts in real-world examples. Through a set of carefully developed vignettes, it illustrates how compassionate care can be enacted, sometimes quietly, sometimes against the grain of policy, and how discretion, judgement, and contextual awareness are essential tools for those delivering support. It also outlines key principles and practical implications that can help reshape policy, training, and frontline delivery around a more humane and equitable vision of care.

By making the case for a more critical, situated, and justice-informed understanding of compassion, this resource invites readers to reflect on how systems can create the space for care to be done well and what is lost when compassion is reduced to a checklist.

1. Theoretical foundations of compassionate care

Understanding the roots of compassionate care helps us move beyond viewing it as a vague sentiment or soft skill. Instead, it becomes a structured and ethical way of thinking about how we support people. The work of Singleton & Mee and Annemarie Mol provides two important ways of thinking about what compassion means in practice, especially when delivered in complex systems such as health or social care.

Singleton & Mee (2017): Critical compassion

Singleton and Mee introduce the idea of *critical compassion*. This means recognising that compassion isn't just about feelings; it's about power, structure, and responsibility. They show how care is often shaped, limited, or even distorted by policy requirements, institutional pressures, or limited resources. Compassion, in this view, must be more than good intention; it should involve professional discretion, awareness of inequality, and a readiness to respond meaningfully within constraints. Their call is for compassion that is thoughtful, situated, and attuned to the emotional and structural realities of people's lives.

Mol (2008): The logic of care

Mol offers a different but complementary perspective. She contrasts what she calls the "logic of care" with the "logic of choice". In many systems, people are expected to make choices (about treatment, lifestyle, or services) as if everyone has equal resources, knowledge, or opportunity. Mol argues this model often fails. Instead, she describes care as something co-created: a process that involves working with people in the context of their everyday lives. She sees care as something that requires ongoing adjustment or "tinkering", responding flexibly, using professional judgement, and shaping support in collaboration with the person receiving it.

Tveit & Raustøl (2017): Discretion as core to care

Tveit & Raustøl challenge whether *compassion*, often treated as a feeling or innate trait, is the most helpful concept to explain care failures. Instead, they argue that *discretion* is the key competency in professional care. Discretion involves the ability to reason under uncertainty, balance competing demands, and act sensitively in complex situations. It also requires the structural space to do so: time, trust, and supportive environments. Without this, even well-intentioned staff may be unable to act compassionately.

Together, these perspectives remind us that compassionate care is not about following a script or delivering a fixed message. It is about working relationally and reflectively, being aware of systems and inequalities, and staying grounded in the real conditions in which people live and work.

2. Why discretion matters

In health and care systems increasingly governed by performance management, audit, and standardisation, discretion can appear risky or even discouraged. Yet discretion is central to good care. Tveit & Raustøl describe discretion as both:

- **Epistemic**: the ability to reason and decide what matters in a particular situation.
- **Structural**: the space and autonomy to act on that judgement.

Their work shows that discretion is not the opposite of accountability - it is what makes care accountable to people, rather than just to procedures. When practitioners are trusted to act with care, and given the support to reflect, consult, and adapt, compassion becomes more than a hope, it becomes a practice.

Policies that reduce discretion through rigid scripts, performance targets, or checklist thinking may undermine the very qualities they seek to promote. Compassionate care requires time, trust, and ethical formation, not just compliance or emotional labour.

3. Key principles of compassionate care

- **Compassion is built through relationships:** Care happens in real time, through connection and trust. It's not something that can be delivered from a script or checklist. Practitioners build compassion by listening, being present, and responding to what each child or family needs in that moment.
    - ***In practice:*** Taking time to hear someone's story before offering advice can help ensure your support is relevant, respectful, and well-received.
- **Compassion involves feeling and reflection:** It's not just about being kind; it's about thinking carefully about how actions affect others. This means using both emotional awareness and professional judgement to respond with care.
    - ***In practice:*** Before giving advice about weight, ask yourself, what is this family facing? Is this the right time and way to offer support?
- **Compassion is grounded in real-life situations:** Care must consider the daily realities people live in, such as poverty, housing, stress, or trauma. Advice that doesn't connect to these realities may feel irrelevant or even harmful.
    - ***In practice:*** Offering healthy eating tips is less helpful if a family doesn't have access to a fridge or enough food. Support might mean connecting them to other services first.
- **Practitioners need room to use their judgement:** Every family and situation is different. Truly compassionate care gives practitioners space to adapt their approach based on what they know and observe, not just what the policy says.
    - ***In practice:*** It's okay to hold back on advice when it feels like the wrong time. That can be an act of care, not a failure to deliver a message.

- **Compassion must look at the bigger picture:** True compassion doesn't just respond to individuals; it sees and challenges the systems and inequalities that shape people's health. This includes poverty, prejudice, discrimination, and access to services.
    - ***In practice:*** Talking about healthier lifestyles must go hand-in-hand with recognising the social pressures that make healthy choices difficult or impossible.
- **Compassion may challenge the rules:** Sometimes, doing what is right for a child or family means bending the rules or working around rigid systems. Compassionate care can mean quietly resisting policies that feel unfair or unhelpful.
    - ***In practice:*** If a standard referral doesn't feel right, a more informal conversation or a different kind of support may serve the family better.
- **Discretion is a condition for compassion:** Compassion isn't just about what we feel – it's also about having the time, support, and permission to act astutely. When professionals are trusted to use their judgement, care becomes more thoughtful, flexible, and responsive.
    - ***In practice:*** Creating space for reflection and decision-making helps practitioners offer support that truly fits the situation, not just the policy.

4. Illustrative vignettes: compassion in practice?

Vignette 1: Choosing when to speak

Setting	Primary school, as part of the National Child Measurement Programme (NCMP)
Scenario	The nurse measures Lucas, a quiet 10-year-old boy. His BMI is above the 98th centile. As Lucas steps off the scale, she notices him glance at the form in her hand, then quickly look away. His shoulders are slightly hunched. There is no requirement, or permission, to discuss the result with Lucas directly, but the moment hangs in the air. He mutters, "Bet I'm the biggest," and gives a forced laugh. The nurse offers a neutral but warm thank you, makes a note in her record, and gently steers the interaction back to the normality of the day. Later, when reviewing the anonymised results and considering the number of children in the school falling into the highest weight categories, she starts to reflect. The standard protocol is to send feedback letters home. But she wonders: what else could be done to ensure this is a supportive experience for children?
How the principles apply	• **Relational, not just procedural:** The nurse notices Lucas's discomfort and responds with quiet reassurance, protecting his dignity. • **Discretion as care:** She uses her judgement to avoid causing harm, even within a standardised task. • **Reflexivity beyond the moment:** She reflects on what the experience means for children more broadly, not just the individual. • **More than metrics:** She sees the child behind the data, recognising that how care is delivered matters as much as what is delivered.

Vignette 2: More than a referral

Setting	GP consultation in a community clinic
Scenario	A GP sees Amina and her 12-year-old daughter Layla, who presents with joint discomfort that may be related to her weight. The GP initially considers referring Layla to a healthy weight service. However, during the conversation, Amina explains that they are living in temporary accommodation and that recent changes in their family situation have made daily life challenging. The GP thanks her for sharing and, recognising the broader context, decides to prioritise referrals to local support services that can help with housing, food access, and emotional wellbeing. The conversation around healthy weight is not dismissed but carefully deferred.
How the principles apply	• **Care rooted in real-life context:** The GP recognises that housing and stability are essential to enable any health-related changes. • **Compassion as discretion:** Rather than strictly following referral pathways, the GP adapts to what matters most in this moment. • **Systemic awareness:** Health behaviours are viewed within the wider lens of social and economic circumstances.

Vignette 3: A missed opportunity for care

Setting	Community centre, part of a 'Making Every Contact Count' (MECC) initiative
Scenario	A community health worker is delivering brief lifestyle advice as part of a MECC approach during a wellbeing drop-in for adults. One attendee, an adult male in his 30s, asks a few questions after the session and then quietly shares that he's struggling with stress, has recently lost his job, and feels overwhelmed managing his health. Although the worker wants to explore this further, the session is designed for one-way delivery with limited follow-up. She provides a leaflet and a phone number for a local wellbeing service but feels the format prevents her from offering the support he clearly needs.
How the principles apply	• **Limits of standardised interventions:** The MECC format allows limited time for dialogue or deeper engagement. • **Compassion as more than delivery:** While she fulfils the formal expectation, the worker recognises the gap between what's required and what's needed. • **Systemic challenge:** The vignette reveals how systems focused on message delivery can fall short when human needs require conversation, flexibility, and longer-term support.

5. Implications for policy and practice

- **Let care lead, not just compliance:** Policies and procedures should support professionals to care with flexibility, rather than forcing everyone to follow the same steps regardless of context. Compassionate care works best when there's room for thoughtful judgement.
- **Build in time and space for relationships:** Care takes time. Practitioners need support to build trust, listen properly, and respond sensitively. Rushed or transactional encounters rarely allow for meaningful compassion.
- **Make training practical and human:** Training should go beyond theory and include real-life examples, role plays, and reflective exercises. It should help staff deal with emotionally complex situations and feel confident using their discretion.
- **Design policies that see the whole picture:** Good policies recognise that people's health is shaped by housing, income, food access, and social support. Compassionate care means acting on these wider issues, not just giving individual lifestyle advice.
- **Value the judgement of practitioners:** Staff should be trusted and supported to make decisions based on what they see and hear; not just what a flowchart or template says. Judgement is not a risk to manage, it's a resource to nurture.
- **Measure what really matters:** Instead of only counting how many leaflets were given out or conversations held, evaluation should consider whether families felt heard, supported, and treated with dignity. Compassion is not always easy to measure, but it is always meaningful.
- **Support discretion as a system value:** Create the conditions, time, supervision, team reflection, that help practitioners make wise, compassionate decisions.

6. Conclusion

Compassionate care is not simply about kindness or emotional sensitivity. It is about creating space, within people, practice, and systems, for relational, reflective, and responsive ways of working. As Singleton and Mee argue, compassion must be critically engaged: it is not just about individual disposition but about how care is shaped by power, policy, and institutional pressures. Mol similarly reminds us that care is not a one-time intervention or a matter of personal choice, it is something co-created through ongoing adjustment, situated in the real conditions of everyday life.

Tveit and Raustøl extend this thinking by reframing the so-called "compassion crisis" as a crisis of discretion. Without the time, support, and trust to exercise professional judgement, even well-meaning practitioners can become agents of impersonal, transactional care. Their work underlines the idea that discretion is not a risk to be managed, but a resource to be nurtured; one that allows care to remain meaningful, responsive, and humane.

The vignettes in this briefing show what this looks like in practice: a nurse responding quietly to a child's vulnerability; a GP prioritising social stability over clinical referral; a community worker recognising the limits of a scripted intervention. These are not acts of avoidance, they are deliberate, thoughtful choices grounded in compassion and context.

For practitioners, compassionate care means being supported to listen, to pause, and to act in ways that are attuned to people's lives. For systems, it means designing policies and environments that allow care to be flexible, just, and grounded in trust. This includes valuing relational work, enabling reflective practice, and attending to the broader determinants of health and wellbeing.

Ultimately, compassionate care is not a soft skill; it is a serious, skilled practice. It must be supported not only through training, but through policy, leadership, and culture. If we want compassion to thrive, it must be structurally enabled, professionally respected, and politically defended.

References

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