Compassion

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ABSTRACT

The term 'compassion' has been much used and little discussed. I argue that compassion is a virtue in the Aristotelian sense, one of a family of other-regarding properties and belongs to the affective qualities of a moral agent. Its exercise is an essential component of good medical care in many situations and requires grounding in moral principles. Although our dispositions vary, compassion is a quality that can be developed in all of us.

KEYWORDS: Compassion, care, virtue, etiquette

Thinking about compassion

Compassion has had a good outing recently. Compassion has been the missing factor in care. One prominent member of parliament, Ann Clwyd, raised the public profile of the lack of compassion she witnessed in the care of her dying father. She claimed an avalanche of correspondence that attested to similar experiences.[1] The Health Services ombudsman, Mrs Ann Abrahams, reported on a failure to respond with compassion in her inquiry on the care of elderly and frail patients in 2011.[2] Failures in compassionate care were also reported by the Care Quality Commission in 2011[3] and the Healthcare Commission in 2007.[4] A lack of compassion was a prominent theme in the Francis Report into failings in the Mid Staffordshire NHS Foundation Trust,[5] even advocating that training was required in compassionate care (recommendation 185) and that an aptitude test for compassion should be introduced (recommendation 188). The Royal College of Physicians emphasised that doctors should 'display compassion in their daily work',[6] while its Future Hospital Commission entitled one of its chapters 'building a culture of compassion and respect'.[7] Compassion seems to be important in healthcare and its deficiency a failing.

In all this comment, there is an assumption that we all know what compassion means. Its meaning is rarely analysed. It is just assumed to be a good thing. Yet we might want to ask, is it always needed? Or can there be too much compassion? Is its demonstration always to be 'displayed' as part of the carer's duty or is it some sort of additional extra for those of an appropriate disposition?

Compassion features in two famous stories that have become part of our culture: the stories of the prodigal son and that of the Good Samaritan. (Even the Medical Defence Union refers to 'emergency (Good Samaritan) acts'.[8]) I select these stories, not because of their provenance, but simply as well known tales that illustrate what I want to say. In the former, a son takes his inheritance, spends it and, after reducing himself to misery, chooses to return. His father recognises his returning wastrel son and the writer says he 'had compassion and ran…and kissed him.[9]' This translates in a standard modern text as 'his heart went out to him.[10]' In the latter, the Samaritan sees a half-dead man on the road, who has been ignored by establishment figures who walk by, and 'when he saw him, he had compassion on him.[11]' Again, a modern text translates this as 'when he saw him, he was moved to pity.[12]' The common feature in both of these stories is that compassion features essentially as an emotional, and not a rational response. It is an expression of the character of the individuals, not the direct result of their principles. Compassion is here a virtue.

A similar conclusion is equally explicit in Aristotle's *Rhetoric*.[13] Although this translates as 'pity', it is clearly compassion to which Aristotle refers. This is defined as 'a feeling of pain at an apparent evil, destructive or painful, which befalls one who does not deserve it, and which we might expect to befall ourselves or some friend of ours'. Again, this definition asserts compassion as part of our emotional, and not our rational, lives. In our ordinary discourse, we talk about being moved by compassion or feeling compassion. Compassion is therefore part of a moral relationship that involves moral psychology as well as moral philosophy. Aristotle says that to feel it, we must 'obviously be capable of supposing that some evil may happen to us or some friend of ours, and moreover some such evil as is stated in our definition or is more or less of that kind.' The central idea is 'that could be me.'

In Snow's analysis,[14] compassion is one of a family of other-regarding emotions that include pity, sympathy and grief, all evoked in response to an object that is negative: a misfortune or loss. It therefore requires a belief about that negativity and its sufferer, making compassion a composite of belief and feeling. To take an alternative example, it would be seen as natural enough to grieve for the death of someone we love, but if we discover them to be alive, then continued grief would be irrational. Compassion has a cognitive component. We would (and should) cease to feel it, if we discover that the supposed

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sufferer is deliberately faking it. Psychologically it requires an imaginative indwelling into the condition of another, requiring identification with the victim. Compassion has an immediacy, a proximity and an urgency. We may feel sorrow or pity or concern for the victims of a disaster far removed from us, but we do not feel compassion. Compassion belongs at the patient's bedside or sick room, not in the office of the public health physician or epidemiologist. Those doctors *qua* doctors at least can do without it, for they do not deal with individual suffering patients. Compassion crosses an emotional distance between ourselves and the sufferer's plight. Snow states, 'the ability to identify with another's distress makes the other's suffering real to those who feel compassion, and facilitates benevolent desires for the other's good.' It also implies a relatively serious condition: we may feel sympathy for someone who has cut their finger, but not compassion. By contrast, sympathy is too weak for one who is in distress from serious illness and compassion more appropriate.

Compassion as rational?

The ability to identify with the suffering of another or to imagine ourselves in a similar state varies between individuals. (If consciousness is understood as the ability to experience the environment, internal or external to ourselves, then the unconscious cannot suffer.) Not all have the talent for imaginative indwelling well developed. Where moral action stems from altruistic concern for the benefit of another, inclination will vary according to the development of our moral appetites. It is not irrational not to feel compassion. However, the uncomfortable conclusion is then that persons could be considered of unequal instrumental value, to be valued according to how often they're able to feel compassion and how effectively they can act for another's benefit on its basis. For Snow, a broader construal of 'rational' incorporates a person as rationally responding to the world on the basis of true, or at least justified, beliefs. If people have a common susceptibility to misfortune, it is rational to want a world (or a hospital) where others can be viewed as possible helpers: a kinder, gentler society.

A morality that grounds itself entirely in the virtues will leave a great deal optional in healthcare. The development of the character of the moral agent requires the grounding in defensible principles. To express that technically, virtue ethics require principlism. If compassion is something to be displayed in the doctor's daily work, it should be more than an option. Perfectionist demands may lead to 'burnout' but equally minimalism shouldn't be defended in saying 'I'm just not like that'. Somehow compassion has to be brought within the ambit of duty – which is to say, within the professional's obligations and not, or not only, within the province of the supererogatory.

The difficulty of imaginative indwelling is that of transposing one's own views into another person. People vary in what constitutes suffering. Backgrounds, values, culture, needs and understanding all vary. Moreover, such understanding of another requires an intimacy with them. This will be most apparent in the management of chronic disease, especially the vulnerable and highly dependent. 'Imaginative understanding of suffering can at times be a worthy achievement like other medical achievements.[15]' Compassion cannot be learned by observing the behaviour of seniors as role models – not least because not all senior figures in medicine exhibit this quality to an inspiring or even adequate degree – nor can it be permanently instilled by courses in human values, or the reflection on suitable film, literature, case studies and so on: much as these may help. Medical humanities has its place in the curriculum and the teaching of virtue ethics (see examples in the following publications[16–18]) should certainly take its place alongside the current overemphasis on four principles. However, what can be asserted is that compassion may be snuffed out by environments that discourage its expression, a factor that is more important than individual role models. Poor behaviour can easily result from adverse political and excessively mechanical or managerial viewpoints – major factors in recent incidents.

Compassion is more than good manners, although it is hard to imagine a compassionate doctor who is ill mannered and discourteous. But compassion is not required in many situations. Much illness is minor, may be unfortunate, but hardly tragic or even upsetting for its victim. A migraine attack, an attack of influenza or a mild short-lived episode of gastroenteritis, are unpleasant; so too are long-term conditions such as an arthritic joint, strabismus or a trigger finger. Compassion as a necessary response from the health carer is then overstated. Rather what is required is respect or courtesy. Kahn[19] suggests that patients may care less about whether their doctors are reflective and empathic than whether they are respectful and attentive: good eye contact, body language, dress and manners. Whereas compassion is an emotion, etiquette is a function. Compassion concerns what is felt and etiquette, in what is done. Whether compassion can be taught has been much discussed; nobody doubts that etiquette can be taught – Kahn even proposes a check list that can be evaluated and practised. It is easier to change behaviour than attitudes.

Reconciling attitudes and behaviour

Yet these two may not be so far apart. Attitudes may owe much to our upbringing and genes; but equally, we need skills in developing and applying appropriate attitudes in clinical practice and knowledge both to assess that appropriateness and to develop those attitudes in the first place. Aristotle writes:[20]

> *Now true virtue cannot exist without prudence any more than prudence without virtue…Virtue is not merely a disposition in conformity with the right principle but a disposition in collaboration with the principle, which in human conduct is prudence. So, while Socrates thought that the virtues are principles, we say that they work along with a principle. So we see from these arguments that it is not possible to be good in the true sense of the word without prudence or to be prudent without virtue.*

And dispositions can be developed through practice. Lewis[21] uses the analogy of a tennis player:

> *Someone who is not a good tennis player may now and then make a good shot. What you mean by a good player is the man whose eye and muscles and nerves have been so trained by making innumerable good shots that they can now be relied on. They have a certain tone or quality which is there even when*

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he is not playing, just as a mathematician's mind has a certain habit and outlook which is there even when he is not doing mathematics. In the same way, a man who perseveres in doing just actions gets in the end a certain quality of character. Now it is that quality rather than the particular actions which we mean when we talk of a 'virtue'.

Dispositions are formed by repeated intentionality and right actions. Reich[22] further suggests that neglect of compassion may relate to an inability to explain the meaning of suffering for the individual. An account of compassion must begin, in his view, with a definition and an account of suffering. Suffering is different from pain.

It is an anguish which we experience on one level as a threat to our composure, our integrity, and the fulfilment of our intentions but at a deeper level as a frustration to the concrete meaning that we have found in our personal existence. It is the anguish over the injury or threat of injury to the self – and thus to the meaning of the self that is at the core of suffering.

Such anguish may include the sense of unfairness at being deprived of life's possibilities, or the sense of loss of control or the feeling of shame that might accompany dependency. Autonomy suffers whether the patient is mute or expressive in response. Compassionate others offer solidarity which can transform suffering. The iteration between the suffering patient and the compassionate person was about narrative and is only possible if the suffering can be understood. Narrative plays its part in palliative medicine in terms of interacting with patients, getting information and helping them to change their perceptions, so they are controlling circumstances and not being controlled. Recognition, review, revision and reconciliation are part of the narrative, helping to develop a new voice and a new story. Behaviour and manners matter in helping patients, but attitude is key. Compassion is a virtue.

Finding a voice

This account of how to engage with suffering is probably unfamiliar to many physicians and moves from problem solving to active listening and empowerment. The system has risks in terms of transference, countertransference, compassion fatigue and crossing personal and professional boundaries. It requires skills and supervision, but works. Sometimes, writes Reich, compassion may help to find a voice for the voiceless. RS Thomas says,[23] 'we have all been victims of vocabulary too long.' In her essay 'On being ill', Virginia Woolf writes:[24]

Finally...there is the poverty of language...the merest schoolgirl when she falls in love has Shakespeare or Keats to speak her mind for her; but let a sufferer try to describe a pain in his head to a doctor and language at once runs dry. There is nothing ready made for him. He is forced to coin words himself and, taking his pain in one hand and a lump of pure sound in the other (as perhaps the people of Babel did in the beginning) so to crush them together that a brand new word drops out. Probably it will be laughable...Yet it is not only a new language that we need...but a new hierarchy of the passions; love must be deposed in favour of a temperature of 104...sleeplessness play the part of the villain and the hero become a white liquid with a sweet taste – a mighty Prince with moths eyes and feathered feet.

Compassion may need skill in language and cultural understanding to be effective. Cultural understanding and language skills can certainly be taught, even if compassion demands silence on some occasions: a waiting only. And it also demands a sense of mutuality that is difficult for those who still express the traditional paternalistic benevolence of the doctor.

Compassion often requires time. It is hard to be compassionate after several hours coping with a series of distressing emergencies: sheer physical exhaustion and continuing pressure with a limited resource puts the ideal out of reach. It may be impossible to respond adequately in the face of a tide of human misery: imagine the experience of those dealing with the victims of a bombing or a poison gas attack arriving in overwhelming numbers. Healthcare workers can only do the best in the circumstances, but in developed countries in peace time there is a responsibility of health service management to promote the conditions under which compassionate care is possible. Schulz[25] points out some of the difficulties. Programmes, such as respite care or caregiver skills training, will not impact on caregiver distress unless they impact on the patient's suffering. We would benefit from better research on the factors that contribute to patient suffering and the healthcarer's compassion: contact time, personal relationships between professional and sufferer, and resources. It cannot be accepted that because the medical profession is innovative, even radical, in terms of scientific change, that it will also be open to social change that affects its authority and autonomy.[26] In the light of recent events, medical education may have to be modified to place a greater emphasis on the personal qualities that arise in the doctor–patient relationship and less on teaching and assessment of reliably and objectively measured technical and factual knowledge.[27] The question of Plato's *Meno*[28] may be unanswered as to whether compassion can be taught, but we should reject Socrates' conclusion that a virtue like compassion is merely a 'gift of the gods'. ■

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