



## Editor's Forum

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The papers in this issue of *Health Ethics Today* relate to some of the presentations from the JDHEC *Health Ethics Symposium* "Compassion and Care" held on 7 June 2011. The symposium presentations included a philosophical examination of compassion, an analysis of the range of compassion in health care settings, a review of the tradition of compassion in medical care, a research based description of compassion fatigue experienced by health care professionals (HCPs), and a philosophical presentation on the need to be self-compassionate in our daily lives.

While recognizing the difficulty of doing so in a busy work environment, the presenters and audience strongly supported the need to retain compassion as a "core value" in providing care to the sick in all clinical settings. The clinical and personal illness experience of symposium attendees supported the published accounts of patients' descriptions of the importance of compassion to HCPs themselves and to those in their care. It was recognized that the level of compassion shown by good palliative care HCPs should also be expected in most other health care settings.

And yet from descriptions in the media and health journals there appears to be a serious erosion of compassion in encounters between HCPs, patients and families. While often satisfied with the clinical outcome of medical treatment there is a great deal of anger, resentment and grief at the lack of caring and compassion demonstrated by HCPs providing the "cure". This lack has been explained by the fragmentation of care today, with teams of HCPs representing multiple specialities replacing the traditional MD or MD led team providing all care for the patient. This is however only part of a broader problem involving a predominantly science-based

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view of illness, as disease needing therapy, replacing a view of patients as sick people needing help with burdens. The former view provides therapy while the latter provides healing.

These concerns have been eloquently addressed by the late Dr. Robert Buckman among others in education and research. Buckman described the skill of helping the sick with care and compassion as demonstrating “natural empathy”. He argued that those who did not possess natural empathy could be taught it to some degree and that this would translate into more caring and compassion in clinical practice. Resulting from this work, medical undergraduate and residency educational programs are placing increased emphasis on the need for a humanistic side to physician education. It remains to be seen whether Buckman’s contention that a more humanist emphasis in HCP education will result in a more caring and ethically appropriate attitude towards the sick.



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## Compassion? – No Thanks, Give Me the Cure Doc!

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To discuss compassion as a MD seems like a straightforward task. The history of medicine supports the view that clinical practice involves a commitment to caring for and healing the sick. Physicians traditionally were expected to devote themselves to those who needed care, even to the extent of placing their own health and safety at risk. Healing involved components of knowledge, art, spiritual belief, and even magic until the advent of a science based understanding of disease in the 19th century. Cures came from outside intervention,

either supernatural (divine intervention – miracles) or natural (plants and animal derived), or from inside the person. The sick person or community was also called upon to help the “cure” be effective. Praise or blame depended on whether results were good or bad. In many cases the patient had to overcome the dangerous effects of various medical “treatments” in addition to the disease process.

A belief in the nobility of suffering became valued in many cultures as part of the spiritual life of the “enlightened” and the healing practices reflected

this value. Pain, suffering and death were regarded as commonplace and unavoidable at all stages of life; childbirth, infancy, early adulthood and rarely beyond. A fatalistic worldview held sway, somewhat supported in religious belief about the necessity and value of suffering as enabling a reward in the afterlife. Ritual and healing went hand in hand with priest or shaman or druid, holding power over life and death, and often expected to intercede spiritually on behalf of the sick and dying.

Long before cognitive psychology, healing had been known to contain an important self-driven element, tied to spirituality, to one's view of the self, to internal strength and power, and to being "favoured by the gods". Weakness, illness, disease was regarded as punishment and as such did not engender compassion. Healers were highly regarded (and feared) due to their power over life and death. Healing was seen as a cleansing both corporally and spiritually, reaching a peak in exorcism rites. It is remarkable how little has changed over millenia. Today, treatments are for the most part judged solely

as good or bad by survival statistics, and media reports indicate that many people regard several illnesses, including AIDS, as a divine punishment.

By the end of the 19<sup>th</sup> century physicians were beginning to be formally trained and regulated, mainly to distinguish them from the many self-trained "quacks" purporting to be doctors. Most medical treatments were based on plant extracts and chemicals. Surgery remained separate from the "healing arts", having been born in warfare, and remained brutal in the pre-anesthesia era. Analgesia was used only for severe intractable pain as analgesics were feared for their addictive qualities. Solace was often the only support given to the seriously ill, in keeping with the Hippocratic tradition of "not treating patients overburdened by their illness". The need for analgesia, empathy and compassion for the dying was developed primarily as a nursing practice on the battlefield, to be later adopted into medical training.

By the 20<sup>th</sup> century medical education had become more regulated, expectations of professional



behaviour by physicians became more formalized, and professional codes of ethics appeared. The combination of progress in pharmacology and in understanding the physiology of disease mechanisms resulted in an explosion of research and treatments. Standards of practice in hygiene, sanitation, nutrition, and clinical medicine became science based and thus very effective. For the first time in history, enormous improvements in health, economics, and education were experienced by large populations beyond the traditional powerful elites. Physicians occupied a central place in this new “science driven” curative health care. Preceding these developments came new ideas about the importance of individuals in society, about self direction, about the status of women, about children needing protection, about the societal obligation to balance individual and common good. Driving these ideas was the concept that there was an intrinsic worth to each person, irrespective of gender, ethnicity, intelligence, illness, wealth, education, social standing, and that this worth supported the right of every individual to be respected as autonomous.

The unprecedented success of medical treatment through the 20<sup>th</sup> century led to amazing progress in technology including developments such as respirators, kidney machines, organ transplantation, new hips, knees, (even faces!), test tube babies, etc. In each case only decades earlier these developments had been regarded as science fiction. Given this remarkable medical progress it is apparent why we commonly encounter a “death denying view” in our society today. Gone are the physicians’ explanations of death of loved ones purely in terms of divine will, arbitrary causes, punishments, etc. This discussion has been replaced by a scientific based causation of disease and death. Moreover, this scientific explanation of illness can be explored, examined, combatted and often cured. So, who needs compassion if we do not commonly experience another’s death? In our society many adults have never personally encountered death before it strikes

a loved one. Gone is the previous commonplace experience of communities mourning the loss of infants and children, women in childbirth, young men being sent off to war, all contributing to a familiarity with death of a deeply personal nature.

Medical education has mirrored these social developments and has become almost totally focused on disease rather than on the sick person. Disease aetiology, diagnosis, treatment, all based on science, is the gold standard. In this paradigm there is little room for exploration of emotions,



fears, hopes, dreams, horrors, wishes. Only in the speciality of palliative care has the primacy of caring holistically for the sick person been retained as the major priority. And yet, sick people in general, not only those close to death, those who are beyond cure, describe and demonstrate a need for care which reflects a humanity beyond what science teaches us. They show a need to be cared about as well as treated for pain, bed sores, mouth ulcers, incontinence, fevers, seizures etc. Families, often in shock and denial, also show a need for empathy and compassion as they struggle to understand that the medicine cannot cure their loved one's illness.

The palliative care narrative of illness and caring is now seen as being applicable to many clinical encounters beyond the dying or terminally ill. In keeping with the retreat of medical paternalism as the dominant mode of decision-making has come recognition of the need to engage the patient in dialogue about illness and possible treatment plans. This reversal of the role of the physician as sole arbiter produces a climate of shared planning which allows emotions to be discussed. Beyond terminal illness, it is appreciated that sick people may have a multitude of anxieties and fears which need attention, using an empathic and compassionate approach. Unfortunately, in the daily work of today's very busy, cure focused, and somewhat overworked health care professionals (HCP), this requirement may get short shrift.

Medical educators have long argued about whether students can be taught empathy and compassion if they do not innately possess such humanistic traits. This argument has reflected a much older philosophical one as to whether or not virtue can be taught. In support of the view that these traits can be learned, is the tradition of mentorship – apprenticeship. An often overlooked component of this process is that a significant period of time is a necessary requirement to acquire this expertise. But is this mentorship – apprenticeship sufficient? The “best physicians” have always been regarded as

those who demonstrate humanistic traits in addition to the required diagnostic and therapeutic expertise. As many physicians today fall below this standard, the traditional medical education model has been questioned as being insufficient to train truly compassionate physicians.

More recently medical education has assessed the humanistic requirements of trainee physicians and these have been incorporated into residency standards and evaluation tools (CanMEDS). The late Dr. Robert Buckman spent his career teaching with humour about the empathic conversations that needed to occur with patients and families. His teaching contains a fund of knowledge and experience about the many pitfalls of care that we see in clinical practice every day. In a recent paper he proposed that what is needed in teaching trainees to succeed in connecting with patients on a human level is a set of empathic behaviours. These behaviours come naturally to some people but all physicians need to possess them in order to provide care with a sense of empathy and compassion. Buckman called for this approach to become the standard of teaching and practice. He further stated that this teaching method will confront the “hidden curriculum” whereby paternalistic and self-serving values have been handed down from generations of physicians to their students.

A qualitative interview based study of “intensive caring at the end of life” showed how differently HCPs and various family members described the same specific clinical situations. Even when considering specific discussions about procedures such as disconnecting life support, withdrawal of the endotracheal tube, limits of CPR, the descriptions varied widely as to the meaning of the conversations. Valuable observations about family needs were highlighted in the study, ranging from simple needs like rest, sleep, and food during the medical crisis, to more complex needs such as finding meaning in the death of a loved one. Physicians were often oblivious to these needs in the acute situations discussed.

Patient and family accounts of illness have great value in illuminating the experiential trauma that serious illness produces for patient and family despite “a good outcome”. Illness narratives generally illustrate the need for a broader view of the clinical encounter on the part of HCPs. Small kindnesses and slights are remembered in detail when often the HCP has no recollection of the events. Taking time to wait, to listen, to nod (and not nod off!), to remain silent, to not interrupt, to touch, are all widely described as important in building up trust between HCPs and patients and families. Even physicians who work with seriously ill or dying patients, such as oncologists, miss most verbal and non verbal cues from patients wanting to talk, wanting hope, wanting the truth about diagnosis, wanting reassurance, etc.

It appears that even though we are lucky to live in a society with remarkable life-saving treatments, as individuals we need to experience humanity and compassion whether the outcome is good or bad. When cure is no longer possible the need for compassion is maximal. Good end of life care provided by palliative specialists is regarded as truly a vocation due to the enormous emotional impact of the work. And yet a recent report suggested that the personal satisfaction, value, and meaning of the work experienced by these specialists, can be attributed, in part, to the availability of training and support to deal with the emotional intensity of their work. The priorities of their speciality support this investment in meaning, in marked contrast to the priorities of the technology driven curative medical system which values diagnosis, treatment, cure, transfer, efficiency, cost effectiveness, etc.



The common excuse for physicians lacking empathy and compassion in the daily clinical care of patients is that there is a binary choice between excellence in curative treatment (diagnostic wizardry, newest complex therapy, intensive life support, extraordinary surgical talent, etc.) or “hand-holding bedside manner”. Of course this is not a valid choice as technical expertise, knowledge and ongoing education are as essential as compassion to being a good physician, especially to the sick, at their most vulnerable. At the stage of serious illness we are all fearful and we crave respect, consideration as a person, and compassion even in small measure. While this emotional support may be given by individual wonderfully dedicated HCPs in large measure, more often it is totally lacking. It seems that the medical career rewards of prestige, honour, wealth, and fame that accrue with “curative magic” are more important than the rewards of caring for the chronically ill, the disabled, the destitute, the demented, and the dying. Hopefully the renewed

attention to improving undergraduate education in the humanistic essentials of becoming truly caring will result in a generation of more caring, compassionate physicians.

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## The “Problems” of Compassion...

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The question of whether compassion deserves a place as a central moral virtue is an interesting one. I certainly maintain that it does, not by mere opinion, preference, or even appeal to religious or philosophical traditions. At a more fundamental level, compassion continues to reveal itself as an essential and unmistakable characteristic of the nature we share as social creatures. In the project of providing universal healthcare in Canada, it is clear at many levels that we have decided to embrace compassion, at least in word, as a guiding value. From the various professional codes of ethics that guide the practice of doctors, nurses, and other allied professionals, to the newly adopted code

of conduct that guides Alberta Health Services, “compassion care” resounds as a goal from the practice of individual clinicians to the behaviour of the often massive organizations that make caring work possible. On the face of it, it is difficult to question the rationale for making compassionate a professional goal. How is it possible, then, for an explicit commitment to provide compassionate care, to become problematic? I will suggest three forms the “problem of compassion” may take:

1) faking compassion, 2) insatiable compassion, and 3) political compassion. As well, I will argue that the failure to recognize and provide structures to support the compassionate clinician result in net



harms ranging from widespread cynicism to the manifestations of moral distress and compassion fatigue, widely recognized as accounting for the attrition of clinicians across the spectrum of care.

## Faking Compassion

Jon Sobrino, S.J. (1992) The Fifteenth Nash Lecture:

Everyone, just because we are human, must walk in history, and we all meet up with the beaten persons along the roadside. If we look them in the eye and dedicate our lives to saving them, the compassion-principle unites us all. But if we avoid them in order not to see them, then we have sullied the essence of what is human and the compassion-principle divides us.

The “problem” of compassion begins (paradoxically) with taking compassion seriously. Nowhere is this clearer than in healthcare, for it is in the very effort of institutionalising care for others that we create the perfect conditions for compassion’s corruption. On its face, this claim is puzzling, how can an effort to provide care at the same time undermine the virtue that may motivate us to care for one another in the first place? Is it possible that we fail to make compassion a priority amongst the other necessary criteria for good care in health facilities? However, I am much more interested in the possibility that compassion, rather than nurtured, is “unlearned” in the process of training and working in healthcare. My interest in this possibility stems from, and is supported by, a growing mass of evidence from the population of Canadian trainees and clinicians alike who support this view. If this is the case, is it possible that the very institutionalization of care is responsible for suppression of compassionate care; or could it be a particular mechanism or structure that bears responsibility? Most importantly, can we take compassionate care seriously or is it time to set more realistic expectations of ourselves and our organizations?

I hope to address several key issues that potentially contribute to the inability of clinicians to provide compassionate care. It is important first to describe what I mean by compassionate care. I propose a very simple definition for our purposes: Compassion is the two-fold process of feeling the suffering of another and then being motivated to alleviate that suffering. In the West, our current use of the term traces back to the Greek *splanchnizomai*, literally, “to be moved within one’s guts”. The sense here is that when one is moved to compassion, one is moved essentially, not motivated in some instrumental fashion, but rather responding to suffering in some fundamental human capacity.

The affective dimension of compassion is important here because it distinguishes what we are discussing from shallower aspects of personal interactions that are sometimes suggested as “safe” replacements or compassion simulacra. I don’t mean anything more here than the distinction between the warm smile and greeting of a close friend and the smile and greeting of a host seating you at a restaurant. We can certainly fake compassion, but space does not permit a nuanced discussion of how and why we should not advocate such strategies.

One might think that an obvious “problem” with compassion would be its simple denial as important, useful, essential, etc. It is rare to find anyone actually articulating this position however. A more troublesome tendency, with an accompanying long historical legacy, is the perversion of compassion into mere sentimentality, the “bleeding heart” as it were. This effort recognizes the symbolic importance of compassion, but does not attribute compassion a central or functional role in life. It attributes emotional responses the mere significance of being either appropriate or inappropriate but no more. I was recently reminded of this perspective by the late Dr. Robert Buckman. In memoriam, I listened to a lecture he had given on a topic he championed and pioneered, that being, effectively breaking bad news.

In the last part of the talk, he suggested that it was essential that physicians use empathy to identify and recognize the emotional states of their patients. What I found interesting was Buckman’s insistence that the role of empathy and the recognition of the patient’s emotion was to ensure that the physician appeared sympathetic to the patient. In fact, in variations of this popular talk, he has suggested to physician trainees that it is not important how they feel, one way or the other, but rather that the patient feel recognized and supported.

The project of faking compassion likely has several historical roots. The “stoic physician” tradition would claim that to become emotionally attached to one’s patient necessarily undermines the ability to provide an objective and rational assessment of the condition. Although this view is becoming less pervasive, it is arguably still very much part of the “hidden curriculum”. However, it does not account for the advocacy of “acting” as if one were compassionate, as the physician/stoic would be philosophically committed to both dispassionate practice and appearance. The goal of faking compassion assumes that the actual existence of compassion would be beneficial and that the manifestation of authentic compassion is somehow thwarted. This phenomenon leads us to the second problem of compassion.

## Insatiable Compassion

I described compassion as a two-fold process, the feeling of the suffering of another combined with the motivation to alleviate that suffering. In the first step we experience the unpleasantness of suffering-with-another, but this experience is satiated (satisfied and resolved) when the suffering is removed. Clinicians have a special relationship with compassion, such that, they not only place themselves in occupations which vicariously expose them to seemingly endless amounts of suffering, but they are duty-bound to care for those who suffer. That being said, there is a great personal reward associated with care for

others, not excluding the very suffering we have discussed. Experiencing the suffering of others is often mischaracterized as wholly and cumulatively negative. However, just like other human desires, there can be unique and immeasurable satisfaction arising from the satiation of compassion. Given the choice, it would seem unthinkable to distinguish the experiences of hunger, thirst, weariness, or sexual desire. In fact, it is the satisfaction of these desires through eating, drinking, sleep, and sex that constitute some fundamental joys of human existence. Just as fundamental is compassion. Yet, just as starvation and sleep deprivation are considered forms of torture, insatiable compassion is equally unpleasant. But what does this look like and why is it especially relevant to clinicians?

With few exceptions, members of healthcare teams are professionals, governed by codes of ethics, characterized essentially by fiduciary duties to the patients. This means that every clinician has a professional and moral duty to advocate for his or her patient's best interest. However, although the moral duties of health professionals are virtually identical, the responsibility for clinical decision-making still, for the most part, relies on traditional systemic hierarchical structures. This means that clinical decisions regarding patient care are made by agreement with patients (or surrogates) and physicians. In rare but predictably occurring situations, it can be the case that there is widespread disagreement about the philosophy of care of a patient and/or treatment choices within a philosophy of care. Such disagreements can be particularly troublesome if the decision in question carries with it a significant burden to the patient. These examples can range from dramatic interventions from overly-aggressive treatment of a dying patient to inappropriate low-tech interventions like the restraint and forced feeding of an elderly patient with advanced dementia. Nor is such distress relegated to clinicians at the bottom of a hierarchy. Moral distress, through a variety of circumstances

can be experienced by anyone who provides patient care and is equally as potentially devastating to all.

In such situations, clinicians can experience what has come to be known as "moral distress" characterized by a clinician offering care that is contrary to the best-interest of the patient while not ultimately being responsible for the decision or powerless to question it. The root of moral distress lies in the experience of "insatiable compassion" and is different in kind to the ordinary frustrations we all share when we bear the burdens of decisions made by others. Witnessing suffering is difficult at the best of times. When that suffering is iatrogenic in nature, meaning that it is caused by the very intervention meant to help the patient, there is the potential for that witness to suffer as one who is complicit in its cause. This experience is so traumatic because it is the very antithesis of compassion; instead of alleviating suffering, we create or prolong it.

There is growing literature concerning moral distress including strategies to address its occurrence. The relevant aspect of the phenomenon for us is that it is the very foundation of caring work that makes clinicians susceptible to the distress experienced by being unable to help those in need, not to cure them necessarily or always.

## Political Compassion

Dom Helder Camara, Archbishop of Recife, Brazil:

When I feed the poor, they call me a saint.

When I ask why the poor have no food, they call me a communist.

The Buddhist tradition describes two inseparable cardinal virtues, compassion and wisdom. Reflecting on the second virtue, wisdom provides a convenient segue to reflect on the topic at hand, the so called third "problem with compassion". I have described the experience of compassion as a two-fold process, the experience of the suffering of another which compels one to alleviate the suffering. Both steps of this process require forms of competency for

lack of a better word. The first is an attunement or openness to experience the suffering of another. I am often asked if it is possible to teach compassion. My response is simply to suggest that this is the wrong question. If we believe the experience of compassion to be an authentic condition, the more interesting question becomes, how do we “unlearn” the filters that prevent us from experiencing this genuine sympathetic state?

Once we are rightly motivated by the suffering of another the question becomes what to do, how can I alleviate this suffering? Often the answer is clear; for example, when my daughter falls and hurts herself, she needs to be hugged, kissed, and assured that all is well. However, the roots of human suffering are exactly as complex as the world that causes people to suffer. For the Buddhist, the virtue of wisdom, does not so much describe the ability to make good

choices but rather the ability to see the world as it is, to understand the causal nexus in which we exist.

So much of the ethos of the clinician is bound up in the conception of professional as advocate. As I have mentioned, all health professionals have inherent fiduciary duties to patients. In fact, this duty can be accurately described as the necessary condition of professionalism itself. In the second problem, I described the scenario of the clinician being prevented from acting in such a way as to alleviate the suffering of a patient, or worse, being forced to participate in a philosophy of care that potentially harms a patient. Such barriers to compassion in example two are interpersonal or inter-professional. Although the hierarchies that exclude decision-makers are systematic, there remains potential for good decisions to be made. What if, however, a clinician is prevented from effectively treating a patient due to



the lack of a specific necessary resource? What is the role of compassion in the absence of available acute care beds, rural dialysis circuits, or even precious extra minutes to talk to a patient?

Often an unanticipated and unwelcome dimension of compassion is the political. In particular, the experience of compassionate wisdom highlights the identification of systematic structures which create suffering or act as a barrier to its alleviation. Nowhere are conditions for this form of advocacy more present than in healthcare. Clinicians have privileged access to, knowledge, and experience of



barriers, systemic and other, that prevent patients from receiving the most effective and timely care needed. However, the hierarchical structure of healthcare is similar to other enormous organizations with the power to make decisions coming from the top down. Here both clinicians and the organization experience the third “problem of compassion”, i.e., duty-bound clinicians attempting to embody the ethos of compassionate care, recognizing systematic barriers to effective care or the unfair allocations of resources, and feeling compelled to advocate for structural change within the system.

Authentic compassion will have a political component if the root cause of suffering is a systemic structure. Hence, the compassionate clinician will necessarily at some point advocate for systemic change. This becomes a problem if the organization itself is not prepared to receive such information, or does not recognize the legitimacy of such advocacy.

During my short career, I have witnessed all three problems, faking, insatiable and political compassion described henceforth. I have also witnessed the small-scale solution to each of these problems through the care and attention of dedicated team members, administrators, patients and families. These so-called “problems of compassion” are neither necessary nor purely theoretical. I would be very surprised if any clinician could not immediately call to mind a host of examples. Current academic research on compassion fatigue<sup>1</sup> clearly supports this contention. If we intend as an organization to take compassion seriously, we must start with a sober assessment of what it actually means to be a compassionate health care professional, and build an organization from the ground of care.

1 Social Sciences and Humanities Research Council of Canada (SSHRC), Standard Research Grant “*Compassion Fatigue*” As Experienced By Canadian Health Professionals  
Principal Investigator: Wendy Austin, Faculty of Nursing, University of Alberta and Co-Investigator: Brendan Leier, John Dossetor Health Ethics Centre, University of Alberta.

# Pragmatics of Compassion

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Pragmatics refers to the social purposes of communication in context. While the basic meaning of compassion is sharing in the suffering of others it often implies a significant obligation to alleviate that suffering.

This article discusses some of the pragmatic ways that the term *compassion* is being used in contemporary healthcare literature. It is based on a content analysis of scientific and popular publications between 1980 and 2010. In reviewing the scientific literature, it was obvious that the use of the words *compassion* and *compassionate* have more than doubled in popularity. An electronic medline search was performed to determine the prevalence of these words in health science literature. In 1980, they appeared in the title or abstract of just 0.04 of one percent of titles or abstracts of scientific articles, but by 2010, this had almost tripled to 0.11 of one percent.

The terms *compassion* and *compassionate* are generally discussed as justification for action and often as an argument for taking or permitting actions. Although these terms are frequently used, they are rarely the primary focus or topic. Only about 2% of the articles identified actually addressed the psychological or ethical nature of compassion. In most cases compassion was used as a kind of descriptor to categorize other events or phenomena. In order to explore the pragmatics of compassion, it is useful to consider some of the ways that compassion has been used in healthcare communication during recent years. Just four of the most frequent are briefly described here for the sake of brevity. *Compassionate care benefits* and *compassionate care leave* refer to time off or other accommodations made for workers while

they provide care for a serious ill or dying family member. *Compassion clubs or centres* are agencies that distribute or assist with the acquisition of medical marijuana. *Compassionate use clinical trials* refer to research studies in which access to investigational drugs or procedures that have not met all the safety standards for normal clinical trials are available to patients. *Compassionate homicide* is a term that is sometimes used in place of euthanasia referring to killing another human being in order to eliminate suffering. Of course, all four of these phenomena could be easily described and understood without introducing the concept of compassion, and compassion is not necessarily a critical factor in the application of any of them. For example, if an individual receives compassionate care leave to take care of a dying spouse, no one checks to see if the care is actually rendered with compassion. Similarly, while the phrase *compassionate use trials* has been used to advocate for this kind of investigational drug research, the term *expanded access trials* is more typically used by legal authorities and researchers.

Another shared attribute of these four phenomena is the fact that they all involve activities that would be considered legally or ethically unacceptable or at least controversial by at least a significant proportion of people without being labeled as compassionate. Most people have pretty negative responses to the term *homicide*, but *compassionate homicide* seems like it might be a lot better. Convincing authorities that a centre to distribute marijuana would be a valuable asset to the community might be difficult, but the concept becomes at least somewhat more palatable when it is linked to compassion. By attaching the concept of compassionate motivation to each of these acts, they are portrayed as an unassailable good. Of course, recognizing this fact

does not imply that that they cannot be motivated by compassion or that they are inherently bad ideas. It merely suggests that we need to examine them more carefully.

Pharmaceutical companies may be motivated by pure compassion in expanding access to investigational drugs, but in other concepts, the use of compassion or compassionate may be promoting purely profit motives. Euthanasia of a disabled child or ailing spouse may be performed with compassionate intentions in some cases and selfish intentions in others. In both examples, there may be even more situations in which motivations

are neither purely compassionate nor purely selfish. Furthermore, it is dangerous to assume that compassionate motivation necessarily results in a desirable outcome. For example, when 11-year-old Ian Carmichael was killed by his father in 2004, it was discussed as a case of compassionate homicide by news reporters and ethicists (e.g., Singer, 2004). At the trial, however, it was determined that his father's compassionate motivation was the result of his own psychotic delusions and not his son's suffering (e.g., Huffman, 2006). Even when mental illness is not an issue, research studies consistently demonstrate that both healthcare professionals



and the general public overestimate the suffering and underestimate the quality of life of individuals with severe disabilities. As a result, genuine compassion can be based on false assumptions, and compassionate homicide may be motivated by these false impressions.

Pragmatically speaking, compassion is commonly used to validate practices and ideas in healthcare and related spheres. It adds a positive spin when attached to concepts that might be otherwise controversial. Of course, the fact that the concept of compassion is used to promote other ideas and practices does not negate the fundamental importance of

compassion. Compassion is and hopefully will continue to be an essential pillar of our healthcare system. Nevertheless, these concerns do require us to examine the use of the concept of compassion more carefully to determine its relevance and value in assessing the actions to which it is being linked.

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## Upcoming Events

### Dossetor Centre Health Ethics Seminars:

#### 17 February 2012

Ethical and Legal Implications of Workplace Drug Testing

**Charl Els, MBChB, FCPsych, MMedPsych (cum laude), ABAM, MROCC**

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**Diane Kunyk, RN, PhD**

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Assistant Adjunct Professor, John Dossetor Health Ethics, University of Alberta

#### 9 March 2012

Ethics and Technology: Technics of Touch in the Neonatal Intensive Care Unit

**Michael van Manen, MD, FRCPC**

Neonatal-Perinatal Subspecialty Resident R7,  
Neonatal-Perinatal Medicine, Department of Pediatrics, University of Alberta

#### 23 March 2012

Experimental Therapies in Pediatric Care, Medical Freedom Acts and Medical Ethics: Who Has the Last Word?

**Ireh Iyioha, LLM, PhD**

Visiting Professional, John Dossetor Health Ethics Centre, University of Alberta

All seminars take place in Classroom F (2J4.02), Walter Mackenzie Health Sciences Centre, University of Alberta, 12:00 – 12:45 pm. Seminars available via Alberta Health Services' Telehealth Videoconference.

To subscribe to the seminar mailing list, please e-mail: [dossetor.centre@ualberta.ca](mailto:dossetor.centre@ualberta.ca)

### Dossetor Centre Health Ethics Symposium:

#### 13 June 2012

Details TBA

Please check the John Dossetor Health Ethics Centre website at [www.ualberta.ca/BIOETHICS/](http://www.ualberta.ca/BIOETHICS/) for complete details.

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