What's wrong with 'compassion'? Towards a political, philosophical and theological context

Dr. Joshua Hordern

University Lecturer in Christian Ethics, Harris Manchester College, University of Oxford

Abstract

In some popular and political discourse, 'compassion' is commonly conceived as a simple or 'given' aspect of the world. And yet public discussion also focusses on whether 'compassion' has gone wrong in some way, suggesting that there might be various more or less satisfactory versions of compassion. At the same time, some thinkers doubt whether compassion should any longer be expected of those working in healthcare. This article draws on philosophical and theological resources to argue that the conceptual context which forms compassion is crucial for determining the ethos healthcare. The discussion explores three themes – politics, suffering and responsibility – which must be addressed in order to understand what is wrong with compassion, to identify lines of future investigation and to develop possible remedies.

Keywords

Compassion, suffering, meaning, politics, responsibility, resilience, self-compassion

Introduction

In some popular and political discourse, 'compassion' is commonly conceived as a simple or "given" aspect of the world, like an element in the periodic table. For example in 2013, UK government proposals to alter training of nurses with a preparatory year of hands-on ward-work seem to have this quality of thought, depicting compassion as an item to be added to employees along with their IT training. And yet, public discussion also focusses on whether 'compassion' has gone wrong in some way, suggesting that there might be various more or less satisfactory versions of compassion. The argument here will draw on philosophical and theological resources to explore three themes – politics, suffering and responsibility – which must be addressed to understand what is wrong with compassion and identify possible remedies.

1. Politics and training

First, there is the political dimension. The ethos of liberal political culture is strangely ambivalent towards compassion. On the one hand, compassion is commonly reckoned a central quality of

liberal democracies. Martha Nussbaum, for example, regards it as basic to the mature interdependence of citizens amidst the vulnerability and upheavals of life. Compassion operates at the frontiers of citizens' relationships and responds to the harms which politics is created to prevent and police.[1] But to others, a requirement for compassion in healthcare places unreasonable weight on citizens' interactions in modern democracies. Smajdor, Stöckl and Salter articulate the problem by critiquing demands that healthcare practitioners, especially doctors, show 'empathy' and arguing instead for training in 'etiquette'.[2] They reject the assumption that empathy, 'the ability to appreciate the emotions and feelings of others',[3] is essentially good since 'Doctors who can enter into patients' distress, pain or embarrassment might take pleasure from this ability.' Only empathy *joined with* goodness could provide beneficial motivation in the practice of healthcare.[4]

However, they also believe that a requirement for goodness is a hangover from a bygone age which held that 'doctors ought to be better than other people'. In such a culture 'patients show gratitude' to doctors since 'patients are supplicants' seeking 'more than they are entitled to…a supererogatory performance' from their physicians. Such 'expectation of gratitude does not harmonise well with the principle of respect for patient autonomy…Medicine is no longer the domain of arcane and mysterious rites. Everything is rational and explicable.' This development 'fundamentally alters the relationship' between patient and practitioner. The patient is better informed than before, no longer a quasi-child but now a responsible sharer in decision-making. Citizens encounter each other now in healthcare with no great knowledge imbalance and, typically, as strangers. This renders the 'idea that the provider of information and services must feel and empathize with the consumer/patient…excessive and incongruous.'[5] Instead, what is required is 'etiquette' which 'enables people who are not in intimate relationships to interact without having to enter into each others' [sic] subjective experiences, desires and values.'[6] As such, medical practitioners are more like pharmacists or other providers of goods and services. Thus Smajdor et al. argue that empathy, more precisely 'good' empathy', is no longer necessary in modern healthcare's encounters between strangers. Autonomy and information are taken to have fundamentally abrogated the need for gratitude and 'good' empathy.

Several conceptual claims are operating here: that duty and gratitude are mutually exclusive; that greater equality of information undermines the significance of empathy between practitioner and patient; that the heightened patient responsibility such information brings makes empathy less appropriate; that, in modern society, it is not reasonable that substantial notions of goodness should be expected to inform the empathy of healthcare practitioners. Ann Bradshaw takes another view, observing that compassion is being demanded of nurses and doctors just as the Judaeo-Christian context of compassion is being stripped away and replaced by a government-written script. Nurses and doctors are like actors, widening their smiles to ensure that boxes are ticked and complaints are down. This is 'the "have a nice day" nurse…[the] McDonaldised

[1] Nussbaum, M., *Upheavals of Thought: The Intelligence of Emotions*, CUP, 2001
[2] Smajdor, A., Stöckl, A., Salter, C., 'The limits of empathy: problems in medical education and practice', *Journal of Medical Ethics*, 2011, 37:380-83
[3] ibid. 381
[4] ibid. 382
[5] ibid. 382
[6] ibid. 383

approach.'[7] Ironically, this is what Smajdor et al. *recommend*, suggesting that because 'we lack the resources to be truly empathetic', what is now necessary is 'more akin to the McDonalds style 'You have a nice day now' [rather] than to a rich nuanced and individualised conception of empathy'.[8]

By contrast, Bradshaw describes how the 'moral basis and thus the content and direction of care' have 'a foundational assumption…an altruistic compassionate love [*agape*] concerned with the needs not only of the cheerful, helpful and grateful patient or client, but also of people who may be unattractive, ungrateful, unhygienic, awkward and demanding. "As you did it to one of the least of these my brethren you did it to me.' (Matthew 25:40)".'[9] For Bradshaw, such an ethics of care is available and essential for humane nursing. Compassionate love, rooted in historic Christianity's *agape* tradition, fostered nursing before and may renew it again.

Three observations follow from this interchange. First, while importantly related, there is a conceptual distinction between empathy and compassion. The two, as Smajdor et al. know, do not mean the same thing – the understanding of the empathic person is not necessarily oriented benevolently towards the person in need. Second, there are significant philosophical and theological traditions, ancient and modern, which complexify the disagreement between Smajdor et al. and Bradshaw. For example, Bradshaw's glossing of *agape* as 'altruistic compassionate love' raises further questions. For example, is self-love excluded by such *agape*? In healthcare systems where burn-out is common, such questions must be addressed.

Third, the political environment shapes encounters between people in healthcare and the training for such encounters which medical and nursing students receive. Addressing a group of healthcare practitioners in the 1980's, Oliver O'Donovan observed that:

> Compassion is the virtue of being moved to action by the sight of suffering – that is to say, by the infringement of passive freedoms. It is a virtue that circumvents thought, since it prompts us immediately to action. It is a virtue that presupposes that an answer has already been found to the question 'What needs to be done?', a virtue of motivation rather than reasoning. As such it is the appropriate virtue for a liberal revolution, which requires no independent thinking about the object of morality, only a very strong motivation to its practice.[10]

Such 'compassion' suffers from liberal political culture's indeterminacy about the human condition and the nature of reality ('the object of morality'). This indeterminacy renders compassion a mere reaction rather than a dimension of reasoned activity concerning a determinate, value-laden reality. The liberalism which O'Donovan criticises lionises compassion but simultaneously removes the content necessary to make coherent a 'good' empathy.

Compassion's modern political fate is basic to a diagnosis of what has gone wrong. Compassion's role in healthcare is formed by political beliefs and those beliefs should be

---

[7] Bradshaw, A., 'Measuring nursing care and compassion: the McDonaldised nurse', *Journal of Medical Ethics*, 2009, 35:465-68, 468

[8] Smajdor et al. 'The limits of empathy', 383

[9] Bradshaw, A., 'Yes! There is an ethics of care', Journal of Medical Ethics, 1996; 22: 8-12, 11-12

[10] O'Donovan, O., *Begotten or Made?*, OUP, 1984, 11

explained and defended. Whether or not O'Donovan's precise critique of liberal politics is correct, both Smajdor et al. and Bradshaw must explain how their expectations for healthcare workers correlate with the political context. Should the encounter between patient and practitioner in contemporary liberal democracies be a transaction in which neither a good form of empathy nor a thick moral communion between sufferer and carer should be expected? To answer this, it is necessary to consider philosophical and theological traditions which preceded and still shape modern politics.

2. Suffering and meaning

For a discussion of politics introduces the issue of how the interrelation of suffering and meaning makes a difference to 'compassion'. Suffering requires some kind of response. Such response commonly involves simple, silent presence with those who suffer. But alongside this, politics is expected actively to ameliorate suffering. In modern polities, such action typically involves no apparent reference to meaning, the preserve of individual citizens who *make* meaning for themselves.

Note that it is not that contemporary politics *necessarily* renders suffering meaningless. One could imagine such an interpretation namely that (a) since suffering frustrates individual choice and the construction of meaning, rendering choosing subjects increasingly incapacitated in their choices until their deaths end choice altogether, and (b) since these are the goals whose protection is the ostensible rationale for the establishment of liberal democracies, therefore (c) the political imperative for safeguarding choice mandates putting 'compassion' into technical overdrive in its use of treatment, seeking above all to preserve some level of patient consciousness and choice.

While this sketch correctly foregrounds choice, the actual picture is more complex than this both in terms of patient experience and the range of contemporary political responses. It seems true that contemporary politics does thrust healthcare practitioners into a vortex of demands for compassion without any adequate common agreement on suffering's meaning. The result is that a heavy load of imaginative expectation is placed upon healthcare employees from whom 'compassion' is expected. It is small wonder that, with such an uncertain target, compassion is routinely and often unfairly perceived to be absent. However, participants in political life, including patients and healthcare practitioners, are better than official political pronouncements and seldom conceive of themselves as bare choosers but rather in ways which are textured by more complex personal, philosophical and theological commitments and by basic connections to family, friends and neighbours.

The interaction of two philosophers, Martha Nussbaum and Roger Crisp, casts light on the interpretation of suffering and clarifies what is wrong with compassion by introducing some older, occluded traditions of thought.

Nussbaum, drawing on Stoic and Aristotelian sources, has proposed a cognitive notion of compassion as central to political life, including healthcare. By 'cognitive' she means that compassion is, in part, an emotion which is constituted by three beliefs that are necessary and sufficient for the emotion to be present. Such compassion is a judgment constituted by beliefs

that, first, another's suffering is serious, not trivial; second that the suffering is undeserved rather than the sufferer's own fault; third, that the suffering can be imagined to be one's own and that it has some bearing on one's own flourishing (or, in Greek, *eudaimonia*).[11]

Crisp rejects this approach to compassion as too narrowly prescriptive, especially its cognitivist approach to emotion, concluding that compassion is morally relatively unimportant.[12] Crisp's critique works by counter-examples which show that each of compassion's alleged constituent features is in fact unnecessary. For Crisp (i) there is no reason why we should not feel compassion for someone with a minor stapler injury as well as for someone whose leg is crushed by a car, both of whom could require medical treatment. But Nussbaum seems to rule the former out because it is not serious. Similarly (ii) visitors may reasonably feel compassion for prisoners even though such prisoners deserve some punishment. In a surprise theological aside, Crisp employs the illustration that even the God of the Old Testament feels compassion for those upon whom he has mercy, that is, those deserving punishment.[13]

For Crisp, the problem with Nussbaum's (and Aristotle's) seriousness and desert requirements is that they are unnecessarily unparsimonious in multiplying forms of emotion depending on whether certain features of the object of compassion are present. Appealing to Adam Smith, Crisp believes only one instinctive natural emotion is at stake, fellow-feeling, and that this simpler, undifferentiated emotion is more plausible than Nussbaum's cognitivist construction. Compassion for Crisp is not judgment but pain – perhaps primal as when a baby recognises the pain of another baby, perhaps far more sophisticated, as when someone explores the sorrows of a Greek tragedy – but pain nonetheless.

Lastly (iii) over against the third requirement, Crisp describes someone who, though terminally ill, yet feels compassion for those suffering a natural disaster. The terminal sufferer cannot reasonably see such sufferers as part of her flourishing since she is about to die; nor can she imagine suffering what they suffer since she will not live long enough to do so. And yet she still feels compassion. Accordingly, he rules this judgment not to be constitutive of compassion either. With all three dismissed, Nussbaum's account falls apart.[14]

To Crisp's first two criticisms we will return. But Nussbaum understands the requirement pertaining to imagination and flourishing more subtly than Crisp allows, with important implications for healthcare. For example, one's life and one's flourishing might involve deep concern for sufferers such as children in neo-natal intensive care. Damage to such sufferers affects one's sense of one's life purpose (or 'vocation'). The cancer sufferer does not need the tsunami victims for *her* flourishing but rather her life purpose may have involved serving such victims even though such service is now impossible. Similarly, a retired neo-natal nurse or doctor, concerned about the quality of neo-natal intensive care, might feel continued compassion

[11] Nussbaum, M., *Upheavals of Thought*; 304-16; cf. Aristotle, *Rhetoric*, 1385b13ff. For a more detailed critique of Nussbaum's approach, see Hordern, J., *Political Affections: Civic Participation and Moral Theology*, OUP, 2013, 41-59 and passim; for an application of Nussbaum's thought to medical education cf. Leget, C., 'Avoiding evasion: Medical ethics education and emotion theory', *Journal of Medical Ethics*, 2004, 30:490-93

[12] Crisp, R., 'Compassion and Beyond', *Ethical Theory and Moral Practice*, 2008 (11) 233-46

[13] ibid. 235-6

[14] ibid. 237

for sick new-borns and their nurses and doctors, a compassion rooted in her life commitment to the specialty even though she is no longer working herself. This formulation seems plausible and Crisp's rebuttal of Nussbaum unconvincing. The important result is that compassion and a sense of life purpose are interwoven both during a life working in healthcare and afterwards. As the case of neonatal care shows, this is obviously not because a practitioner will receive neonatal intensive care herself but rather because of life purpose. Vocation is a matter of the meaning one's life has and so, inasmuch as it shapes the medical and nursing practice, especially when it comes to 'compassion', meaning can hardly be simply a private matter.

On the first two claimed cognitive dimensions of compassion – seriousness and desert – Crisp's criticisms are more powerful but for other reasons than he thinks. Crisp's account is itself *unnecessarily parsimonious*, depending upon implausibly under-specified notions of suffering and its meaning. In a footnote Crisp asserts that 'suffering is what is bad for a person'[15]. This footnote is given to clarify his forceful claim that the 'heart of compassion as an emotion is what we feel at the misery or suffering of others.'[16] Superficially, these claims seem unproblematic – of course suffering is bad for a person and compassion is about the misery and suffering of others. But on three further levels, there are difficulties which develop the earlier political discussion and press the need for traditional insights and wisdom for understanding and practising compassion.

First, from whose perspective is the suffering bad? By rejecting the cognitivist interpretation of compassion Crisp seems not to allow that multiple perspectives on suffering may form compassion's nature. However, if there can be some debate about whose perspective is important, this suggests that compassion is more than pain. One person's perception of suffering is not another's. And yet compassion seems necessarily related to more than one person, at least the sufferer and the one encountering the sufferer. This means there must be some cognitive content which differentiates the perspectives on the suffering. This implies that there may be a process shared by sufferer and carer by which the suffering is evaluated. To claim baldly that 'suffering is what is bad for a person' and that compassion responds to this badness pushes the questions towards 'bad in what way' and 'bad in whose eyes', questions which are unintelligible outside the cognitive notion of compassion.

Second, how are empathy and compassion interrelated? If compassion's multi-perspectival quality points towards a cognitive approach, then Smajdor et al.'s argument that empathy is an unreasonable demand for training in healthcare must, *a fortiori*, entail that demands for compassion are unreasonable too since, on any reasonable cognitive conception of compassion, an ability to understand the other's perspective is basic to grasping the way that the suffering is bad *for this person* and so to the constitution of compassion. If empathy cannot be expected, then neither can compassion. As already argued, such an approach depends on a contested notion of politics. But it also depends on a conceptual mistake. Smajdor et al. give a specific reason for not promoting empathy, namely that empathy is inappropriate in the operating theatre since a 'doctor who flinches as he makes an incision will be a worse surgeon.'[17] This observation illustrates an unfortunate lack of interaction between philosophical theory of emotions and

[15] ibid. 237n15
[16] ibid. 237
[17] Smajdor et al. 'The limits of empathy', 381

healthcare ethics. William James' late nineteenth sensualist theory that emotion is always constituted by physical change was immediately challenged and has been in retreat for some time.[18] Cognitivist theories, such as Nussbaum's, in which emotions which constitute empathy are forms of cognitive judgment, have control of the field. The reasons for this are manifold but, most relevant here is the observation that a flinch cannot be a necessary feature of empathy, as suggested by Smajdor et al. For no physical reaction can individuate any particular emotional state. Physical change type conceptions of emotion cannot *sufficiently* account for why anger is different from grief and why both are different from compassion since the same physical feeling or change may occur with all three emotions. The more reasonable position is that empathy is a necessary constituent feature of the compassion whereby another's state is evaluated.

Third, what is it for a person to suffer? Over against the extreme liberal political notion that suffering necessarily involves the eclipse of meaning, commitments about what O'Donovan called 'the object of morality' will substantially shape the experience of one's own and others' suffering. If, with the moderate liberal Nussbaum but *contra* Crisp and, apparently, Smajdor et al, cognition is constitutive of compassion, as suggested by the multi-perspectival and empathic quality of compassion, then beliefs about reality and the human condition must enter into compassion.

This brings back onto the table the seriousness and desert aspects of compassion but not now simply in Nussbaum's terms but as an open question: how do interpretations of the world and the human condition form compassion as a cognitive evaluation of suffering? In this light, Crisp's theological aside regarding God's mercy and compassion is important. For, whether or not God is invoked, the framework for compassion determines its nature. Such a framework might incorporate themes such as joy, sadness, fear, memory, death and personhood, to name but a few.[19] What it is for a person to suffer or to feel compassion is contextualised, often within more or less recognised traditions of moral thought. A failure to give either critical or approbatory attention to these traditions is a large part of what is wrong with 'compassion'.

The truth, therefore, of Smajdor et al.'s critique is that empathy disconnected from a wider moral outlook is insufficient for moral training. Good empathy is what is needed. This is precisely why older traditions of thought – whether Nussbaum's neo-Stoic Aristotelianism or some explicitly theological account – offer necessary substance to the debate about compassion. 'Compassion' is not simply a given, like an element in the periodic table but rather gains its nuanced meaning in relation to other moral and political concepts and a view of the human condition. Crisp, for his own reasons, concludes that 'Compassion on its own…is unlikely to provide a secure source of insight into our obligations regarding the suffering of others.'[20] Cognitivist views rooted in substantial philosophical and theological moral visions provide better reasons for this conclusion.

---

[18] James, W., 'The physical basis of emotion', *Psychological Review* 1.5 (1894), 516-29; Baldwin, J.M., 'The origin of emotional expression', *Psychological Review* 1.6 (1894), 610-623; cf. James, W., 'What Is an Emotion?', *Mind* 9, 1884, 188-205. Note that this is not to say that physical change plays *no* part in affective experience but only that it is not a sufficient explanation of it.

[19] For these themes more generally in moral and political experience, cf. Hordern, *Political Affections*, esp. chapters two and three.

[20] Crisp, 'Compassion and Beyond', 245

3. Responsibility and resilience

The final element of this analysis of what is wrong with compassion concerns how responsibility and fault are related to compassion. This may be addressed briefly here but requires a longer treatment. If compassion is a kind of evaluative cognition related to a person's vocation in healthcare, their sense of their purpose, the question of responsibility takes form in at least two ways.

First, on Nussbaum's view, compassion will be less appropriate towards those who suffer through their own fault than those who suffer some calamity. There is a problem here for the healthcare practitioner who desires the same quality of care for the person suffering cancer principally or even only partially because of lifestyle, and the one who suffers from an idiopathic cancer. The notion that those who have more responsibility for their illnesses should be less the objects of compassion is liable to capricious and ill-informed distortions. This concern applies also to Smajdor et al.'s notion that the information which patients have diminishes the significance of gratitude and empathy and increases their responsibility.

Second, there is the healthcare practitioner's responsibility for patients' health, sickness and dying. Their sense of responsibility *may* be underdeveloped but is more commonly, especially in conscientious practitioners, over-emphasised. This might seem operationally useful since it drives the nurse or doctor towards detailed attention. But it may be psychologically damaging not to say untruthful about the responsibility any one practitioner has for patients. Just as assignation of individual responsibility may be untruthful thereby distorting self-perception and leading to compassion-fatigue, so an institutional culture informed by inappropriate assignations of blame may undermine the resilience of compassion.

These two points focus on two ways in which compassion may lose its resilience by operating on the basis of a distorted view of human responsibility, detached from the subtleties of historic traditions of moral thought. Two theological observations point towards how moral resilience may be sustained.

The first is counter-intuitive and addresses Smajdor et al.'s points about moral superiority and thankfulness. Their analysis vacates the space empathy and, therefore, compassion occupy but leaves it to be filled with potentially damaging concepts of responsibility and fault. Etiquette will not hold back judgmentalism; some more substantial morality is required. The claim that respect for autonomy will be sufficient seems unduly optimistic about both the universal understanding of this notion and its moral robustness in its modern formulations.[21]

Compassion, in a Christian theological context, does not entail a culture of supplication between patients and doctors. The duty of healthcare practitioners to make people aware of their responsibility for their own health is not a matter of moral superiority but is consonant with the wisdom disclosed in the suffering life of Christ, namely the frailty of all humanity. Amidst fragility, thankfulness for the stability which reliance on others enables should not create

[21] For this term, see O'Neill, O., *Autonomy and Trust in Bioethics,* CUP, 2002

supplicants but rather mutual regard and service.[22] In healthcare, sufferer and carer experience the common human condition in which thankfulness for life and fellowship in sufferings is basic. The notion that thankfulness to those who do their duty in healthcare is inappropriate mistakes being paid for a job with being called to a vocation. That vocation requires a high degree of personal, affective investment which often involves going a literal extra mile around the wards and corridors of hospitals, hospices, streets and surgeries.

The second concerns the objections of some that responsibility in the form of fault and blame is essentially antipathetic to forming compassionate cultures. Paul Gilbert's work is an example of this line of thought.[23] Recall Crisp's counter-example to Nussbaum's emphasis on desert, that prison visitors can rightly feel compassion for inmates. In this context, recent work on healthcare, compassion and criminal justice by Lacey and Pickard has argued for 'responsibility without blame', especially 'affective blame'. This proposal observes that responsibility should be distinguished from the experience of how a patient (or prisoner) realises their responsibility. They recommend a distinction between affective blame (negative and hostile) and detached blame (recognising responsibility but without hostility), a distinction to be consciously observed in healthcare and in courts and penal institutions.[24]

This recommendation seems to entail that the quality of institutions depends on the presence of multiple people whose moral outlooks avoid affective blame in favour of detached blame. In the context of human moral frailty, the questions follow: what philosophical or theological wisdom will foster and give resilience to such an outlook? What self-consciousness among those working in healthcare will enable them to distinguish, in themselves and their institutions, between the two kinds of blame?

In the Judaeo-Christian tradition to which Bradshaw pointed there are two moral streams of insight which address these questions and the challenge of over-conscientiousness among healthcare practitioners, both of which threaten moral resilience. These are addressed briefly here in hope that they can be explored more fully on another occasion.

First, there is a tradition of responding to wrongdoing in mercy: of acknowledging responsibility, assigning blame but avoiding condemnation, on the basis that all are equally in need of God's grace. The challenge in a medical context is how to sustain sufficient moral resilience to discern between modes of accountability and forms of condemnation. The Judaeo-Christian tradition has travelled this path often, with more success at times than at others. The best insights have typically involved associating the responsibility of self and others with the mercifulness of God.[25] The reversible role-taking which Nussbaum signals in her quasi-Aristotelian notion of imaginative construal is taken up but improved on by the Judaeo-Christian notion of shared confession of equal fragility and dependence on God. To return to the example given, all are in

[22] Cf. Hordern, *Political Affections*, chapter 5 for a study in fragility and service esp. 261ff

[23] Cf. for example Gilbert, P., *The Compassionate Mind,* Constable, 2010

[24] Lacey, N. and Pickard, H., 'From the Consulting Room to the Court Room: Taking the Clinical Model of Responsibility Without Blame into the Legal Realm', *Oxford Journal of Legal Studies*, Vol. 33, No. 1 (2013), 1-29

[25] This notion became familiar afresh in Martin Luther's exposition of justification by faith, for which see e.g. Luther, M., *The Freedom of a Christian*, in *Luther's Works*, xxxi, ed. Pelikan, J. and Lehmann, N. (Concordia, 1957)

need of mercy, whether or not we act in a blameworthy fashion concerning aspects of health linked to lifestyle. Such common standing is an antidote to condemnatory patterns of behaviour while preserving the truthfulness of responsibility and fault.

Second, there is a Christian theological tradition of interrelating love and self-love in complex but psychologically powerful ways. The reasonable concern for 'self-compassion' in some compassion literature might be conceptually improved by interplay with this tradition of thought. Self-love and love of others, while running the risk of overwhelming each other, are not incompatible in Christian thought in which a natural concern for the self is transfigured in the concern for the self's fellowship with God. Such a turn of mind involves an awareness that not everything, and certainly not death itself, is in one's own hands, a wisdom which is shared most naturally by those working in healthcare. Self-love is, in this sense, the way that a love for those who suffer learns not to take on more responsibility than is good either for the self or the sufferer. The crucial conceptual insight to this end is an awareness of transcendent providence.[26]

Conclusion: What is needed? A context for compassion

Contemporary public rhetoric tends to isolate compassion from the values and commitments which would make it coherent, especially those of pre-modern traditions. Thus public calls for compassion appear as crushing demands not supportive initiatives which enable healthcare workers in maintaining moral resilience. While compassion is immediately practical since it concerns the ethos of institutions of training and care, one avenue towards long-term change will involve conceptual exploration. To contextualise compassion conceptually will require undertaking an enquiry in search of the psychological, historical and, indeed, neuroscientific sources which give coherence to our human concern with health and its loss. In short, compassion on its own can neither explain nor sustain itself.

Whenever an issue has been analysed here, it has been suggested that what is decisive for compassion is its context, whether political, philosophical or theological. Compassion is not simply an undifferentiated reality in the world, which could in principle be isolated and definitively described. Compassion keeps company with other moral concepts in an individual and, though normally less coherently, in medical institutions such as hospital departments, General Practices or hospices. Much could be agreed on the behavioural requirements of 'compassion' (e.g. having a glass of water within a patient's reach) but this would not address long-term social questions about quality of care. For, in a society of many cultures, the nature of compassion will itself be a healthy point of debate since it concerns the duties of citizens, the meaning of suffering and the responsibility of patients and practitioners. These matters are difficult but rich areas for human growth and exploration. Moreover, as Bradshaw suggests, there are traditional insights and lived practices which offer assistance, not least those associated with the Judaeo-Christian tradition which gave birth to, among other things, the hospice movement and, arguably, nursing via the early church's response to famine in the Roman

[26] For this theme in classic Christian texts, cf. O'Donovan, O., *The Problem of Self-love in St Augustine*, Wipf and Stock, 2006.

Empire.[27] No good social purpose is served by occluding the questions about the nature of compassion. Indeed, much good could be attained, especially in terms of moral resilience, by taking them seriously.

Thus the bare call for compassion and blunt means sometimes recommended to induce it are unwise. They set healthcare workers impossible tasks, namely to provide an indeterminate moral attitude to suffering which is immediately responsive but lacks the substance which would support the resilience of practitioners. The basic requirement of pain relief is intelligible. But an emotional repertoire which focusses merely on pain relief is insufficient for a morally mature healthcare ethos. Pain relief could be achieved by technicians. But patients – sufferers – need more than this. If we want humane healthcare, we need something more substantial. We need a coherent context for compassion.

Acknowledgements

While the argument made here is solely the author's, I am grateful for critical discussion following two presentations of earlier versions of this paper at the Anscombe Centre for Bioethics, Oxford and the Christian Ethics postgraduate research seminar in Oxford's Faculty of Theology and Religion, especially Brian Williams, Matthew Anderson and Jim van Dyke. I also acknowledge helpful feedback from Ann Bradshaw, Thomas Miller and Claire Hordern.

[27] Ferngren, G., *Medicine and Health Care in Early Christianity*, Johns Hopkins University Press, 2009, 113-39