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CARE AND THE PROBLEM OF PITY

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ABSTRACT

In recent years philosophers and bioethicists have given considerable attention to the concept of care. Thus we have seen important work on questions such as: whether there is a uniquely female approach to ethics, whether ethics should be partial or impartial, and whether care must be supplemented by justice. Despite this valuable and extensive work, however, some important distinctions have gone largely undiscussed. This paper tries to fill a gap left in our understanding of the concept of care itself by distinguishing between compassion and two kinds of pity. While all three are kinds of caring, we should not give them similar moral evaluations. Consequently, the distinction between compassion and different kinds of pity gives us an important insight into the question of whether we can consider care a virtue for health care professionals.

INTRODUCTION

In this article I distinguish between three types of caring – fearful pity, aloof pity, and compassion. The distinctions have their roots in Buddhist psychology, but they are also useful for the question of whether we should consider care a virtue. Because both fearful pity and aloof pity burden patients, we cannot plausibly consider them virtues for health care professionals. Compassion, however, avoids the problems associated with both kinds of pity and remains a plausible ideal. We do not, therefore, merely want health care professionals to care about their patients, but rather we want them to care about their patients in a particular way.

DEFINING CARE

Some of the most interesting philosophical work on the ethics of care has been work defining the notion of care itself. Nancy

Jecker and Donnie Self describe a crucial distinction when they differentiate 'caring for' and 'caring about.' A health care professional cares for a patient when she 'engages in a deliberate and on going activity of responding to the patient's needs.'[1] Since the duties of some health care professionals do not involve patient contact, not all health care professionals should 'care for' patients. Nonetheless, this kind of caring is unquestionably part of medicine. Health care professionals whose jobs involve patient contact certainly should care for their patients in the sense of providing for them.

While the notion of 'caring for' creates little philosophical controversy, Jecker and Self's second sense of care creates much. Health care professionals can 'care about' their patients as well as 'care for' them. Here Jecker and Self follow Stanley Hauerwas and suggest that 'caring about' involves an 'attitude, feeling, or state of mind directed toward the person or circumstance.'[2] Helga Kuhse argues similarly that this kind of caring involves an 'emotional response' to the patient.[3] It is at this point where most of the philosophical controversies arise over caring in medicine. An emotional response is a broad term open to a wide variety of interpretations. What kind of emotional response should we call caring, and what conclusions should we draw about the moral status of this emotional response?

The most well known answer to this question comes from Nel Noddings. Noddings argues that caring involves 'engrossment', 'the one-caring is engrossed in the other.'[4] Many philosophers have interpreted this literally, and Noddings' citation of Martin Buber's *I-Thou* relationship encourages this interpretation. She states, 'When I receive the other, I am totally with the other. The relation is for the moment exactly as Buber has described it in *I and Thou*.'[5] We will look at possible alternative interpretations later in the paper, but for now we should note that this common interpretation of engrossment would make it problematic as a goal for health care professionals. To mention just one potential problem, the idea that health care professionals should be

[1] N. Jecker and D. Self. Separating Care and Cure: An Analysis of Historical and Contemporary Images of Nursing and Medicine. *Journal of Medicine and Philosophy* 1991; 16: 295.

[2] Ibid. p. 62.

[3] H. Kuhse. 1997. *Caring: Nurses, Women, and Ethics*. Maldon, MA. Blackwell Publishers: 146.

[4] N. Noddings. 1984. *Caring: A Feminine Approach to Ethics and Moral Education*. Berkeley, CA. University of California Press: 33.

[5] Ibid. p. 32.

engrossed in their patients' lives seems unrealistic. It is not clear how a health care professional could develop this kind of relationship with all of her patients. Given this difficulty, it seems counterproductive to consider this kind of caring a goal for health care professionals. As Kuhse points out, exhorting health care professionals to strive for this kind of caring sets them up for failure.[6]

While literal engrossment is problematic as a virtue for health care professionals, not all philosophical interpretations of 'caring about' would require a health care professional to become engrossed in her patients. Howard Curzer suggests that caring means to 'have a liking for' which involves a kind of 'emotional attachment.'[7] This interpretation leads us down a very different path in our attempt to fill out the rather vague phrase 'emotional response.' Health care professionals could have a liking for their patients without having to develop a relationship as intimate as engrossment. Thus, if we think that caring means to have a liking for, we might avoid the problem of unrealistic expectations.

This new interpretation of caring, however, has its own problems. In fact, Curzer claims that it has so many problems that it should be considered a vice. Caring as emotional attachment leads to bias, burnout, injustice and inefficiency. It leads to bias because health care professionals cannot care equally about all patients. 'The fine talk of caring for patients as individuals conceals a nasty reality. To accept it is to endorse and encourage favouritism in health care. In practice, such talk encourages the [health care professional] to take care of patients only insofar as the [health care professional] likes the patient.'[8] It leads to burnout because the sharing of sorrow is taxing. Health care professionals will be greatly burdened by attempting to share in the suffering of their patients and in addition they may 'feel guilty about their inability to care for all of their patients equally.'[9] It leads to injustice and inefficiency because health care professionals will elevate the interests of their patients above the interests of other individuals in the community.

While Curzer has identified some real and some potential problems with caring, there are also serious problems when health care professionals do not care about their patients. The

[6] Kuhse, *op. cit.* note 3, p. 149.
[7] H. Curzer. Is Care a Virtue. *The Journal of Medicine and Philosophy* 1993; 18: 54.
[8] Ibid. p. 58.
[9] Ibid. p. 59.

most obvious problem is that patients typically want – and sometimes need – care. It can be quite distressing to interact with someone who does not respond emotionally, especially when one is in the vulnerable position of being ill. Merely acting in a beneficent way may not be enough to put a patient at ease.

Second, there are good reasons to think that 'caring about' is a necessary part of 'caring for.' In an interesting observational study conducted by Mina Mills, Huw Davies and William Macrae, for example, health care professionals who did not 'care about' their patients did a particularly poor job of providing palliative care for the dying. While some of the patients in the study did receive an acceptable standard of care, many did not. Those patients who received substandard care received poor oral hygiene, often did not have their thirst quenched, were given little encouragement to eat, and were isolated at the end of their lives. The authors found that these deficiencies in palliative treatment correlated with medical professionals who did not show characteristics of caring about their patients. The professionals who did give adequate care 'showed characteristics that identified them as ''caring'' people: for example, they spent time with a patient, addressed the patient by name, established eye contact, touched the patient, and asked open ended questions and waited for an answer.'[10] In other words, when patients were 'cared for' by medical professionals who exhibited characteristics of 'caring about' them, they received an acceptable standard of care. When patients were 'cared for' by medical professionals who did not exhibit characteristics of 'caring about' them, they typically did not receive an acceptable standard of care. This really should not surprise us. In many cases empathy may be the only way that a health care professional can understand patient needs. For example, if a patient has a hard time verbally expressing his thirst, then empathy may be the only way that a nurse will know he wants water. Thus, even though it may be useful to make a conceptual distinction between 'caring about' and 'caring for', there are times when these two senses of caring cannot be practically separated. Sometimes 'caring for' requires a kind of 'caring about.'

Finally, in many cases it will be impossible for the health care professional not to have some sense of 'caring about', not to have some emotional response to the patient. To hold up the ideal of emotional separation may be as unrealistic as engrossment. We

[10] M. Mills, H. Davies and W. Macrae. Care of Dying Patients in Hospital. *British Medical Journal* 3 September 1994; 309: 584.

typically do have emotional reactions to others' suffering. While health care professionals can become hardened, there are few, if any, who never have an emotional response to a patient. So if we tell health care professionals that caring is a vice, then we have set them up for a different kind of failure. Now we have made the unreasonable demand that they avoid emotional responses to death and suffering.

It is possible, of course, that there is no good solution to this problem. Like many issues in medicine, the emotional response of health care professionals may constitute a true moral dilemma where we must choose between two or more less than satisfactory options. We should not, however, jump to this conclusion too quickly. We need to consider whether there is any emotional response that we would consider to be caring, and that can avoid the problems of engrossment and attachment. If we can find such a response, we might be able to avoid our dilemma.

Helga Kuhse makes a suggestion that holds promise. She suggests that we should understand caring as a responsiveness and sympathy toward the patient, but one that does not constitute complete engrossment. This understanding of care, she suggests, would avoid the problems that we encounter with Noddings' idea of engrossment. 'The nurse would care, as nurse, about the patient's health status in the wide sense, but not ordinarily about his unhappy love affair, or the fact that the horse he backed came last.'[11] In other words, Kuhse suggests that health care professionals can avoid the problems of engrossment by having responsiveness and sympathy for a patient's health only, 'an entry into the health-related life space only.'[12] Kuhse's understanding would also seem to avoid the problems of emotional attachment. One can have an empathetic understanding of another's health problems without being biased toward that individual's interests. Because sympathy need not be partial, it could easily avoid Curzer's charges of bias, injustice and inefficiency.

SYMPATHY AND PROBLEMS WITH PITY

Before we continue exploring the idea of 'caring about' as sympathy, we should give further consideration to what sympathy means. Sympathy and empathy are often used interchangeably to mean 'feeling with' another. Sometimes, however, the two are

[11] Kuhse, *op. cit.* note 3, p. 150.
[12] Ibid. p. 150.

distinguished. Douglas Chismar, for example, argues that sympathy is sometimes used to designate a specific class of empathy. 'To empathise,' he states, 'is to respond to another's perceived emotional state by experiencing feelings of a similar sort. Sympathy, on the other hand, not only includes empathising, but also entails having a positive regard or a non-fleeting concern for the other person.'[13] If we accept this distinction then it is sympathy and not empathy that should be built into our analysis of what it means for a health care professional to 'care about.' Instances of empathy that are not sympathy would be instances where health care professionals experience feelings similar to their patients but lacked a positive regard for their patients. We could imagine, for example, a health care professional who so disliked one of his patients that he took delight in her pain. This is not a plausible virtue.

There is a second and very different way that empathy and sympathy are sometimes distinguished. As Nancy Snow points out, we sometimes use empathy to mean 'feeling with' while reserving sympathy to mean 'feeling for.'[14] This distinction certainly marks two importantly different emotional responses. One might send a sympathy card to a grieving widower because one felt sorry *for* him, but without feeling any emotions similar to the widower, without feeling *with* him. The moral implications of emotionally understanding another's condition and feeling sad that another has to experience something are different.

We will return to the importance of this distinction shortly, but now we should recognise that it is not the one that Kuhse means when she suggests that 'caring about' involves sympathy. Kuhse seems to intend the same meaning of sympathy that Chismar uses. Sympathy is a response that is both empathetic and benevolent. If we consider sympathy to be an empathetic and benevolent response, should we consider it to be virtuous? I do not believe that this understanding of mere sympathy should be considered a virtue for health care professionals. While some instances of sympathy appear to be virtuous, others appear problematic. Consider four cases.

Case 1: Imagine an ER doctor caring for a patient who, in a drunken stupor, fell out of a second story window. The patient is disoriented and in considerable pain. The doctor feels sorry for the patient and does all she can to both treat the patient's

[13] D. Chismar. Empathy and Sympathy: The Important Difference. *The Journal of Value Inquiry* 1988; 22: 257.
[14] N. Snow. Empathy. *American Philosophical Quarterly* January 2000; 37: 66.

injuries and ease the patient's psychological distress. Her relationship to the patient, however, is emotionally distant. She does not experience similar emotions to her patient and she does not imagine that she could find herself in a similar situation. When the doctor finishes treating the patient she thinks to herself, 'Poor bum. It must be horrible to live a life like that.'

Case 2: Imagine a nurse's aid who is caring for a patient with emphysema. When he sees the patient suffer he feels a tightening in his chest and throat, recognises the fear and anxiety in the patient's eyes, and imagines what it would be like to have emphysema. The nurse's aid finds all of these reactions unpleasant and unsettling. He then thinks to himself, 'Her condition is the result of a life long habit of smoking. It's a good thing I never smoked; I'll never have to experience that pain.' When he reminds himself of this fact, he responds less emotionally and finds his tasks easier.

Case 3: Imagine an ICU nurse caring for a patient in the advanced stages of AIDS. He can see the pain and suffering in his patient and can clearly identify with it. He does all that he can to make his patient comfortable and to extend his patient's life. This nurse, however, is not at peace with the condition of his patient. He is uncomfortable with the idea of a patient dying in the prime of her life; he is uncomfortable with his patient's physical symptoms; and he is uncomfortable with the idea that it would be possible for him to die in the same manner. He does not, however, have any thoughts that make him feel immune from his patient's experiences. Instead, he recognises and fears his own vulnerability. At times he finds himself thinking, 'I hope my life does not end this way.'

Case 4: Imagine a paediatric nurse who is about to give a child a vaccination. She can and does empathetically understand the fear and pain that her patient is experiencing. She is not, however, distressed by identifying with her patient because she is not distressed at the idea of receiving shots herself. If she needed to be vaccinated, she would accept the unpleasant sensations without aversion. She also realises that given the current state of science, the pain of vaccination is something that is in her patient's best interest; it is a price that must be paid for health. When she is about to vaccinate the child, she empathises with him, soothes him as best she can, and does her duty without recoiling.

What would Kuhse's account say about these cases? Kuhse does not focus on the distinction between 'feeling with' and 'feeling for', so there is more than one possibility. She could consider

both 'feeling with' and 'feeling for' as empathy. If so, then all four cases would be cases of caring about. All four cases have instances of either 'feeling with' or 'feeling for' coupled with a benevolent attitude. She might, however, see an important difference between the two and only consider 'feeling with' to be empathy. If this is so, then Case 1 is not a case of caring about, but Cases 2, 3, and 4 are. Unlike Cases 2, 3, and 4, in Case 1 the health care professional does not feel any emotion similar to her patient. The ER doctor merely 'feels for' her patient. Regardless of which interpretation we give to Kuhse's analysis, however, it will not provide us with an adequate account of a virtue for health care professionals. Both interpretations suggest that Cases 2, 3, and 4 are cases of caring about, but there are important moral differences among those cases.

The three cases differ according to the emotional distance, fear, and equanimity that accompanies 'caring about.' In Case 2, for example, we see caring coupled with emotional distance. The nurse's aid initially empathises with his patient, but he feels uncomfortable with his empathy. He deals with the uncomfortable feelings by creating emotional distance. He consoles himself that the suffering is a result of a habit he does not have. Thoughts such as this serve to transform 'feeling with' into 'feeling for.' So, in Case 2 the health care professional both 'feels with' and 'feels for.' He begins with experiencing an emotion similar to his patient and then distances himself from that experience. After distancing himself he merely 'feels for' the patient.

In Case 3, caring is not coupled with emotional distance, but rather it is coupled with fear. The ICU nurse empathises with the patient and is benevolent toward her. Like Case 2 the ICU nurse finds his experience distasteful. But unlike Case 2 he does not respond by creating emotional distance. Instead, the unpleasant feelings of empathy create fear.

Finally, in Case 4 we see caring coupled with neither distance nor fear. The paediatric nurse is able to identify with her patient's experiences, but she does not find them distasteful. Consequently, she does not respond to them by either creating emotional distance or feeling fear. Instead she responds with a kind of acceptance. I believe the differences between Cases 2, 3, and 4 are morally significant.

In Buddhist terminology the paediatric nurse has equanimity. Equanimity may have different levels of meaning in Buddhism, but there is a single clear sense that is relevant for our discussion. One is equanimous in the face of suffering when one accepts

suffering that one cannot – or might not be able to – relieve. The kind of acceptance involved in this equanimity is both cognitive and affective. In cases where suffering is unavoidable, cognitive acceptance occurs when one believes it to be unavoidable. Thus, one would cognitively accept a terminal condition when one moved past the stage of denial and believed that the condition was terminal. In cases where suffering might be unavoidable, cognitive acceptance occurs when one believes that it might be unavoidable. Thus, one would cognitively accept the risks involved in a major operation when one fully understands and assumes those risks.

Cognitive acceptance, however, is not sufficient for equanimity. One might intellectually accept some unavoidable suffering but remain motivated to try to relieve it. A patient, a family member or health care professional might, for example, realise that no medical treatment would help a patient's condition, but nevertheless ceaselessly ruminate over ineffective options or even feel compelled to request futile tests or procedures. Likewise, in cases where there are unavoidable risks one might cognitively accept those risks without affectively accepting them. One might realise that things could go wrong in a major operation and then have deep and recurring fears of that possible outcome. Here the agent being unsettled about, and averse to, the prospect of a possible future, marks the lack of affective acceptance.

Just as cognitive acceptance is not sufficient for equanimity, neither is affective acceptance. They are both necessary. Equanimity occurs when cognitive acceptance triggers affective acceptance. It is the realisation that a certain kind of suffering is unavoidable, or a certain kind of risk is unavoidable, that causes one to refrain from ineffectual action and useless worry. One is motivated to take actions that will help, but one realises that no action will help. If affective acceptance occurred without intellectual acceptance it would be a case of indifference rather than equanimity. When affective acceptance occurs without cognitive acceptance, suffering produces no motivation to help. Affective acceptance that is not triggered by cognitive acceptance would be a case where one simply did not care.

Now that we have a sense of what equanimity is, we can return to the question of whether it is morally significant. Does the paediatric nurse respond in a way that is morally better than the other cases? We might be hesitant to say this because equanimity in the case of the paediatric nurse would be so much easier than the other cases. It is easier to accept, intellectually and affectively,

the pain of an inoculation than the suffering associated with a painful disease or a debilitating addiction. The ease of developing equanimity in some circumstances – and the difficulty of developing it in others – is an important point to which we will have to return. These varying degrees of difficulty may affect whether we want to hold equanimity up as a virtue for health care professionals. Our focus now, however, should be on how the presence or absence of equanimity results in importantly different kinds of caring.

According to Buddhist theory there is an important difference between the paediatric nurse and the other cases. The paediatric nurse feels compassion while the ER doctor, the nurse's aid, and the ICU nurse feel pity. Compassion is a combination of empathy, benevolence, and equanimity. In other words, compassion is an empathetic understanding of another's suffering, an equanimous holding of any suffering or risk of suffering that cannot be relieved, and a determination to relieve any suffering that can be relieved. Pity is also an emotional and benevolent response to suffering, but it does not involve equanimity.

In some cases the distinction between compassion and pity is similar to the one drawn by Nancy Snow between empathy and sympathy. The Buddhist nun Ayya Khema uses this idea to distinguish between the two concepts.

> Pity is called a near-enemy because it seems so similar. It is very close and yet it is an enemy. Pity arises when we are sorry *for* someone. Compassion is when we are sorry *with* someone … Compassion arises when one realises the suffering, the unsatisfactoriness exists within oneself.[15]

Compassion requires us to 'feel with' someone, not merely 'feel for' someone. Compassion involves more than merely feeling with someone, so it would not be the same concept discussed by Snow, but the feature which differentiates compassion from this kind of pity would be the same one that Snow claims divides empathy from sympathy. This kind of pity is more emotionally distant than compassion. The person who pities another in this way either never empathetically understands the other (as in the case of the ER doctor) or uses thoughts to create emotional distance (as in the case of the nurse's aid). Because emotional distance characterises this kind of pity, I will refer to it as *aloof pity*.

[15] A. Khema. 1987. *Being Nobody Going Nowhere: Meditations on the Buddhist Path*. Boston, MA. Wisdom Publications: 45.

Not all cases of pity, however, involve emotional distance. The Buddhist writer Steven Levine focuses on a different distinction when he contrasts compassion and pity. He states, 'When you meet the pain of another with fear, it is often called pity . . . When you're motivated by pity you're acting on the aversion you have to experiencing someone else's predicament. You want to alleviate their discomfort as a means of alleviating your own. Pity creates more fear and separation. When love touches the pain of another, it is called compassion.'[16] The distinction here helps us illuminate the case of the ICU nurse. The ICU nurse does not respond to his patient with emotional distance. He empathises with his patient's condition and does not construct thoughts that distance himself from those empathetic feelings. But he does find the empathetic feelings uncomfortable and as a result he fears that his own life will turn out the same. I will call cases like these cases of *fearful pity*.

In Buddhism, the differences between these cases are significant. While Buddhism considers compassion a virtue, it does not consider pity a virtue. Pity is considered the 'near enemy' of compassion. It is 'near' because it is easily mistaken for it, and it is an 'enemy' because it is something that prevents us from dwelling in the virtue of compassion (or more precisely, it prevents us from dwelling in the 'divine abode' of compassion).[17] The idea that each Brahma-vihara has a near and far enemy also has a long history in Buddhist thought. The idea can be traced back at least as far as the 5th century monk Buddhaghosa.[18]

[16] S. Levine. 1982. *Who Dies? An Investigation of Conscious Living and Conscious Dying*. New York, NY. Anchor Books: 168.

[17] There are four Brahma-viharas: compassion (karuna), loving-kindness (metta), sympathetic joy (mudita) and equanimity (upekkha). Those states are sometimes discussed independently where compassion occurs when we feel and are moved by our own or another's suffering; loving-kindness occurs when we wish ourselves or another well; sympathetic joy occurs when we rejoice at our own or another's joy; and equanimity occurs when we have a kind of balance or acceptance in the face of suffering. If we wanted to keep these virtues separate then my argument would be that caring involves both compassion and equanimity. It is suggested in Buddhist writings, however, that the Brahma-viharas are interrelated. Compassion without equanimity is actually not a virtue or a divine abode. The Brahma-viharas and their interrelations are discussed frequently in both the Pali Cannon and secondary Buddhist literature. For a discussion in the Pali Cannon see, for example: *The Long Discourses of the Buddha: A Translation of the Digha Nikaya*. Translated by Maurice Walshe. 1996. Suttas 1–16. Boston, MA. Wisdom Publications.

[18] See: B. Buddhaghosa. 1976. *The Path of Purification*. Translated by Bhikkhu Nyanamoli. Berkeley, CA. Shambala.

The distinction between compassion and the two forms of pity is also important for modern health care professionals.[19] We cannot plausibly consider either form of pity a virtue in medicine. Fearful pity, for example, would create a serious problem of burnout. The health care professional who experiences fearful pity seems even more likely than the professional who experiences emotional attachment to become burned out. To continually empathise with an experience that one fears would be exhausting, if not overwhelming. It is not hard to imagine that the ICU nurse who has many AIDS patients and is afraid of AIDS will not last long as a caring professional. It would simply be too difficult to continue in this state. Eventually we want to look at possible solutions to this problem, but right now it is important to simply recognise this as a problem. This professional is caring in a way that cannot be sustained.

Notice that Kuhse's response to the burnout generated by engrossment is not helpful here. Kuhse suggests that health care professionals should have a limited entry into the life space of their patients. She suggests that the health care professional should only be sympathetic and responsive to the patient's health care needs. In many cases, however, the patient's health care needs are exactly where the problem lies. The dying patient needs to be comforted as the inevitable end nears. Entering that part of the patient's life space is going to lead to burnout unless the health care professional has come to an emotional

[19] Since I am suggesting that a distinction within Buddhism is important for health care ethics, it would be natural to wonder whether health care workers in Buddhist countries utilise the distinction and find it helpful. Modern health care practices in Buddhist countries like Thailand have been strongly influenced by western medicine, so I am uncertain as to whether the distinction is utilised. We would need an empirical study to answer that question. We do, however, have good reason to believe that health care workers have used the distinction in the past. The *Vinaya*, the part of the Pali Cannon that outlines rules for monks, has a specific instruction that monks should attend to the sick. Perhaps as a result of this instruction much of the medical care in Southeast Asia during the early years of Buddhism was administered by Buddhist monks. We can assume that these monks were familiar with basic Buddhist concepts like the Brahma-viharas, and thus that they would have been aware of the distinction between compassion and pity. For a discussion of contemporary Bioethics in Thailand see: D. Ratanakul. Bioethics in Thailand: The Struggle for Buddhist Solutions. *Journal of Medicine and Philosophy* 1988; 13: 301–12. For the Buddha's instruction to attend to the sick see: J. Kornfield (ed.). 1996. *Teachings of the Buddha*. Translated by F. L. Woodward. New York, NY. Barnes and Noble: 110–111. For a discussion of Buddhist monks in the history of Asian medicine see: K. Zysk. 1991. *Asceticism and Healing in Ancient India: Medicine in the Buddhist Monastery*. Oxford. Oxford University Press.

acceptance about his own inevitable death. Entering the life space of a patient in a great deal of physical pain is going to lead to burnout unless the health care professional has come to an emotional acceptance about his own unavoidable pain. Kuhse and others are right that it would be too difficult for health care professionals to become friends with every stranger who walked in the door, but in many cases it may be even more difficult for the health care professional to sympathise with the physical and emotional pains that arise from a patient's illness.

The problem of burnout suggests that we cannot plausibly hold as a goal that health care professionals regularly feel fearful pity. We might, however, try to avoid the problem of burnout by having health care professionals only aspire to feel the emotion occasionally. Some might find this idea attractive once they realise that patients may want this kind of pity. A patient may want fearful pity because on some occasions its expression may bring comfort. A patient may find it easier to deal with his pain if he can think of himself as carrying a great burden. Imagine a young man who has just been in a car accident and has broken both of his legs. The physical pain of his injuries may be difficult to deal with, but social and psychological suffering may be greater. He faces a quite different kind of social existence while his injuries heal. He will have an extended period where he will be unable to leave his bed and then another extended period where he will be unable to walk. It may be psychologically easier for this patient to deal with his situation if others express both care and fear of his condition. If his present condition is pitiful then his recovery marks a great accomplishment – a transformation from the pitiful to the normal. The patient has born a burden that brought fear to the hearts of others. Of course, not all patients will react in this way, but at least some patients may.

Despite the possibility of patients welcoming fearful pity, it remains implausible as a health care virtue. We have already begun to see the problem when we realise that only some patients would welcome fearful pity. To be pitied is to be judged as pitiful, and many patients would find this distasteful under any circumstance. The health care professional who is afraid of temporarily losing the use of his legs, and transmits that fear to a patient who has temporarily lost the use of his legs, will often burden the patient further.

The problem with fearful pity is more than merely a problem of some patients wanting it and others not wanting it. We are more likely to feel fearful pity for those who do not want it than

for those who do. We are most likely to want pity from others when we suffer from a temporary condition from which we expect recovery. We are most likely to feel pity for others, however, when they suffer from an irreversible condition. If we fear the temporary loss of the use of our legs, we will certainly fear permanent loss. Patients who have permanently lost the use of their legs, however, are less likely to want their condition pitied. When they are pitied for their condition, they are pitied for something that will not change. To be pitied for a permanent condition is to become permanently pitiful. In these cases, pity conveys the judgement of unchanging tragedy. The problem with fearful pity therefore is that it is quite likely, perhaps more likely than not, to burden patients by subjecting them to negative social judgement.

In other cases, fearful pity may make it more difficult for patients to deal with their physical pain. Steven Levine describes the problem:

> Much of our pain is reinforced by those around us who wish us not to be in pain. Indeed, many of those who want to help – doctors, nurses, loved ones, therapists – because of their own fear of pain project resistance with such comments as, 'Oh, you poor baby!' Or a wincing around the eyes that reinforces the pain of those they are treating.[20]

Here the problem is not the suffering associated with negative social judgement, but rather the suffering associated with unpleasant physical sensations. Imagine being given a vaccination by a nurse who is afraid of shots. The nurse may deeply sympathise with your position and she may do as much as she can to make you comfortable, but her fear itself may be upsetting. Her fear may colour your own experience and leave you distressed. The same problem would apply to other cases of fearful pity. There are some pains that medication is unable to treat, and individuals who suffer from such pains must find a way of accepting the sensations as best they can. When health care professionals have fearful pity for this pain, they can inadvertently make that task more difficult. Thus, we have at least three reasons to think that fearful pity is not a virtue for health care professionals: it can burden patients by making it more difficult for them to deal with unpleasant physical sensations, it can burden patients by subjecting them to a negative social judgement, and it can contribute to professional burnout.

[20] Levine, *op. cit.* note 16, p. 118.

Aloof pity shares some of the same problems as fearful pity with fewer benefits. Aloof pity occurs when an agent sympathises with the experience of another but also feels emotional distance. While the individual who feels fearful pity recognises the suffering of another and fears it may happen to him, the individual who feels aloof pity recognises the suffering of another but never believes it could happen to him and never feels connected to it. The person who experiences aloof pity for patients sees them as separate and demeaned. Like fearful pity, this would burden the patient with a negative social judgement. Unlike fearful pity, however, aloof pity is unlikely to ever be welcomed by patients. A patient might feel comforted by the idea that they are able to endure something that others fear, but it is hard to imagine a patient welcoming the marginalising gaze of aloof pity. Aloof pity is not plausible as a virtue.

Because it is so easy for pity to harm both patients and health care professionals, it is not a plausible virtue. In many cases it would seem that unsympathetic benevolence would be better than pity. If the health care professionals who felt uncomfortable with death did not identify with their patients, for example, then they might avoid transmitting unease to their patients. In some cases, therefore, unsympathetic benevolence would avoid causing the emotional burden caused by pity. We should not forget, however, the problems of unsympathetic benevolence. First, in many cases it is unrealistic. A complete lack of sympathy would be impossible for many health care workers, especially those who have extended patient contact. Health care professionals may try to minimise sympathetic identification, but shutting off sympathy altogether is often not an option. Second, we must remember that limiting sympathy has serious negative consequences. A patient may be left emotionally isolated and may have his physical needs ignored. Trying not to sympathise is neither a fully realisable nor an attractive goal.

Before we turn to the ideal of compassion it will be helpful to consider a more charitable interpretation of Noddings' conception of engrossment. While some of Noddings' discussion of the meaning of care suggests literal engrossment, there are other passages that suggest a special kind of sympathy. At one point, for example, she uses the term engrossment because she claims that it does a better job of pointing to 'feeling with' than empathy.

> Caring involves, for the one caring, a 'feeling with' the other. We might want to call this relationship 'empathy,' but we

> should think about what we mean by this term. The *Oxford Universal Dictionary* defines *empathy* as 'The power of projecting one's personality into, and so fully understanding, the object of contemplation.' This is, perhaps, a peculiarly rational, western, masculine way of looking at 'feeling with.' The notion of 'feeling with' that I have outlined does not involve projection but reception. I have called it 'engrossment.'[21]

Noddings avoids using the term empathy to avoid the idea of projection. She goes on to say that we only project, ask ourselves how we would feel if we were in the other's shoes, when the more natural mode of reception breaks down. If, as Noddings suggests, we can distinguish between reception and projection as methods of simulating the experiences of others, then her claim seems to be that reception is superior. And it seems to be superior for the same type of reason that we claimed 'feeling with' is superior to 'feeling for.' On this interpretation of Noddings she uses the term engrossment to avoid a subtle kind of emotional distance.

I am uncertain whether the distinction between engrossment as reception and empathy as projection is an important one, but if it were, engrossment as reception would still not always be virtuous for health care professionals. Engrossment as reception would include instances of fearful pity. For example, Noddings says that when we care:

> We also have aroused in us the feeling, 'I must do something.' When we see the other's reality as a possibility for us, we must act to eliminate the intolerable, to reduce the pain, to fill the need, to actualise the dream.[22]

This kind of response is wonderful when we can do something about suffering, but it is tragic when we cannot. It would be problematic, for example, if a health care professional reacted to a terminal patient's impending death with the attitude that 'I must do something.' A virtuous response to unavoidable suffering or risks of suffering must include acceptance. Thus, engrossment as reception avoids aloof pity, but does not avoid fearful pity. Noddings does not make room for equanimity within caring.

[21] Noddings, *op. cit.* note 4, p. 30.
[22] Ibid. p. 14.

THE COMPASSIONATE SOLUTION

There is an attractive option – compassion. It would be best for both the health care professional and the patient if the health care professional could sympathetically understand the patient's experiences, be moved to relieve suffering when possible, but also have a kind of acceptance or equanimity for the pain and loss that the patient may experience. This is, of course, easier said than done, but it is worth recognising that if a health care professional could have this kind of reaction to the plight of his patients that it would avoid the problems we have surveyed.

Because compassion includes sympathetic understanding, it does not encounter the problems associated with unsympathetic benevolence. Unsympathetic benevolence is problematic because it may leave patients feeling isolated and ignored, and because it may lead health care professionals to overlook some of the patient's physical needs. Compassion avoids the cause of these problems.

Because compassion is infused with equanimity, it does not encounter the problems associated with pity. Compassion includes a kind of acceptance of the sympathetically understood pain and suffering. The compassionate individual does not feel afraid of, or distant from, the kind of pain and suffering that is sympathetically understood. She understands what the experience is like, realises that something similar could happen to her, and opens to that experience without fear. This kind of understanding would not harm the patient.

If health care professionals faced a simple choice between unsympathetic benevolence, pity, and compassion, it would clearly be best to choose compassion. But compassion is not something that can be cultivated with such a simple choice. Indeed, in some cases compassion may even be difficult to imagine. Sure health care professionals can develop equanimity about inoculations, but can they develop it about chronic pain, disability, and death? What should we say about the moral status of compassion, given how difficult it may be to cultivate?

THE IDEAL OF COMPASSION

Compassion avoids the problems associated with unsympathetic benevolence and pity. Consequently, it would seem ideal if health care professionals could feel compassion for all of their patients. But should we conclude that health care professionals have an obligation to be compassionate?

The claim that health care professionals are obligated to be compassionate seems susceptible to one of the criticisms Kuhse levelled against caring as engrossment. Compassion, especially compassion in the face of death and disease, is quite difficult to cultivate. If we claim that compassion is an obligation, we seem to be making an unreasonable demand on health care professionals.

Thomasine Kushner, who argues that there is an obligation of compassion, is sensitive to this critique. Kushner argues: 'Certainly it would be foolish to expect total and widespread conformity or condemn anyone who falls short. Even if we cannot be perfectly compassionate at all times, we can all come closer than we do at present.'[23] So Kushner does not argue that health care professionals have an obligation to be compassionate, but rather they have an obligation to move closer to compassion. More concretely, Kushner states: 'I would argue that our moral obligations require that we not turn away, that we identify with the suffering of others, and that identification prompts us as moral agents to act to the degree that is in our power to do so.'[24]

Our reflections on the problems of pity should make us qualify Kushner's claim. If we are obligated to never turn away, then we will sometimes knowingly cultivate pity rather than compassion. In some instances, health care professionals will be unable to feel equanimity and thus face the choice between unsympathetic benevolence and pity. In those cases, turning away may be the best option. Our ideal is to face the suffering of patients with sympathetic understanding, benevolence and equanimity. We must make room for the possibility that a health care professional may not be able to face suffering with emotional balance – that on some occasions they will not have equanimity. This does not mean they have no obligation to cultivate compassion, but there is no easy and uniform recipe for its cultivation. Consequently, we do not have a moral obligation never to turn away.

Even with these qualifications, some might consider the goal of cultivating compassion to be excessively taxing. Doesn't it require too much of health care professionals that they try to cultivate equanimity toward death and disease? If equanimity was at odds with health care professionals' interests, then we might conclude that the ideal of compassion does demand too much. But equanimity does not seem to conflict with the interests of health

[23] D. Thomasma and T. Kushner. A Dialogue on Compassion and Supererogation in Medicine. *Cambridge Quarterly of Healthcare Ethics* 1995; 4: 419.
[24] Ibid. p. 417.

care professionals. The kind of equanimity that would improve patient care is an acceptance of the health care professionals' own vulnerability to death and disease. It is merely seeing and accepting some unavoidable features of their own lives. These are difficult existential facts to face, but health care professionals are especially ill positioned to avoid them. They are daily witnesses to death and disease. Consequently, if they do not aim toward understanding and acceptance of these aspects of the human condition, their work will become a persistent, agonising, and ultimately unsuccessful attempt to deny the fragility of their own lives. At first it may seem too much for us to ask health care professionals to aim at equanimity, but ultimately the alternatives may ask even more.

CONCLUSION

It is important to distinguish between different kinds of caring. Philosophers have already done much work in this area, but one crucial distinction has gone largely unnoticed. When a health care professional sympathises with a patient's suffering, the professional may or may not relate to that suffering with equanimity. Ideally the professional will have equanimity, and thus will feel compassion rather than pity.

Given the difficulty of cultivating compassion, however, we cannot consider it obligatory that health care professionals be compassionate. We could, however, see it as a professional obligation to try to cultivate compassion. This conclusion raises an important practical question: how should professionals try to cultivate compassion? There are two types of meditation typically used in Theravadin Buddhism – vipassana and Brahma-vihara-bhavana – and both are thought to be helpful in the cultivation of compassion. In vipassana meditation (or insight meditation), one practices mindfulness or a moment-to-moment non-judgemental awareness. A greater understanding of pain, suffering and equanimity are traditionally described as some of the fruits of this type of meditation. In Brahma-vihara-bhavana (or the meditative development of the divine abodes), one silently repeats phrases associated with the divine abodes in order to cultivate them directly. Not surprisingly, this is also thought to help cultivate compassion. While other religious, philosophical, and psychological traditions may also have techniques that would be helpful, it is interesting to note that vipassana and Brahma-vihara-bhavana meditation have made inroads in Western health care in a context other than the development of professional

virtue. The Center for Mindfulness in Medicine, Health Care, and Society at the University of Massachusetts Medical Center has used both types of meditation to help patients with a variety of health care problems.[25] Two hundred and forty other stress reduction clinics have done the same.[26] The meditations have been particularly helpful for patients who have physical pain that cannot be treated with modern medicine. Perhaps they would be just as helpful for health care professionals who care for – and sympathise with – those patients.

The difficulty of cultivating compassion should also convince us that the responsibility for its cultivation should not merely fall on individual health care professionals. Part of the burden must lie with professional organisations and institutions of medical education. Instead of expecting health care professionals to develop compassion on their own, institutions should seek to provide opportunities and professional incentives to help them develop this important professional virtue. Thus, while we should not say that health care professionals are obligated to be compassionate, we should say that individuals and institutions should aim at cultivating compassion in health care.[27]

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[25] J. Kabat-Zinn. 1990. *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness*. New York, NY. Bantam Doubleday Dell; S. Santorelli. 1999. *Heal Thy Self: Lessons on Mindfulness in Medicine*. New York, NY. Random House.

[26] For a list of other mindfulness-based stress reduction clinics see the Center for Mindfulness in Medicine, Health Care and Society's website: www.umass.edu/cfm/.

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