"Dissecting Bioethics," edited by Tuija Takala and Matti Häyry, welcomes contributions on the conceptual and theoretical dimensions of bioethics.

The section is dedicated to the idea that words defined by bioethicists and others should not be allowed to imprison people's actual concerns, emotions, and thoughts. Papers that expose the many meanings of a concept, describe the different readings of a moral doctrine, or provide an alternative angle to seemingly self-evident issues are therefore particularly appreciated.

The themes covered in the section so far include dignity, naturalness, public interest, community, disability, autonomy, parity of reasoning, symbolic appeals, and toleration.

All submitted papers are peer reviewed. To submit a paper or to discuss a suitable topic, contact Tuija Takala at tuija.takala@helsinki.fi.

Kindness, Not Compassion, in Healthcare

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"Respect, Integrity, Compassion . . . when a healthcare organization is committed to these values, the whole community benefits."[1] This recent advertisement in the *Journal of the American Medical Association* (*JAMA*) caught my eye. I wondered, "What do they really mean by 'Compassion'?"

A brief, nonsystematic survey of the mission, vision, and values statements of various hospital and healthcare organizations makes it impossible to miss the moral term "compassion" in one literary formulation or another.[2] Compassion is something we in Western society value as a virtue. We implore our physicians, nurses, and other healthcare personnel to "practice compassion." We try to train our medical and nursing students to "be compassionate." Compassion has become the *modus operandi* of how care should be delivered.

Who could argue with desiring compassionate care? When we are ill we believe we would like compassionate care. We want healthcare professionals to attend to our physical and emotional needs—to show us they deeply care about our problems and are striving as best they can to fix them. And we seem to think the best way for them to do this is by showing compassion, a "suffering with" us, with an urge to act in our total best interests.

Does this make sense? Do I want my doctor "suffering with" me? If I do, why not get that other "suffering with" care, *sympathetic* care? Or, alternatively,

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empathetic care? *Kind* care? Or even care that is *merciful* or with *pity*? Often in healthcare and bioethics we use hyperbole to emphasize arguments. Are we doing the same thing by using the term "compassion," which in lay language seems to carry with it a utopian feeling related to caring?

How we use terms influences how we act, how we think about situations, and how we set expectations. In this paper, by examining the meaning of compassion and where it sits in the spectrum of beneficence, I hope to provide convincing arguments that compassion is misused—it is the wrong adjective for the ideal type of interaction that should characterize the care we encourage be delivered in medical settings. In the spectrum of beneficence we should not aspire to *compassionate* care; instead we should aspire to *kindness in* caregiving. *Kind* care is more realistic, more comforting, and ultimately of greater utility than *compassionate* care.

Beneficence Means . . .

Those who choose to enter the health caring professions take on a "specific beneficence" obligation to help those who are accepted as patients, whether friend or stranger.[3] For the purposes of this discussion I use the term "helping others" or "beneficent acts" broadly to mean promoting the welfare (best interests) of those with whom we have established a professional healthcare relationship. I also assume that beneficent acts are being provided with benevolent intent to (1) those in need of some type of healthcare assistance and (2) with their voluntary consent; that is, the normal route of request for medical help and voluntary entering into a provider–patient relationship has occurred, including for those who cannot request by themselves, but for whom we agree that providing help is appropriate—with proxy consent or under emergency presumed consent circumstances.

Beneficence in healthcare is not solely the act that results in helping others; it includes the need to examine *how* we act. As Pellegrino states in listing the virtues essential to a healthcare professional who has *phronesis*, "If the patient is to be healed in the fullest sense, the physician or nurse must have compassion—i.e., the health professional must be able to feel something of the patient's experience of the predicament of illness."[4]

It is certainly possible to provide services to patients in a totally dispassionate way: You have a sore throat. I, as your doctor, hear your complaint, do a quick test for strep, determine you need antibiotics, give you a prescription, advise you to gargle and take aspirin for symptomatic relief, and leave the room. No unnecessary words are exchanged; I don't inquire into the welfare of your family or how you "feel" about your illness. I don't make small talk or act amiably. I am robotic in my receipt and dispensing of information. I provide what is often referred to as a "cold" clinical encounter, a type of dyadic interaction lacking in some sense of caring.[5]

Generally we expect more from our healthcare providers than cold "clinicism." At the same time, such a cold, dispassionate (or perhaps better, *a*-passionate) encounter is not the worst of how we can treat patients. Instead of just being neutral we could be derogatory or abusive—for example, providing care with disdain or insult: While determining the strep nature of your sore throat I could tell you pejoratively that you are fat, or smell, or are evil, or did something to deserve your painful malady. I would still be attending to your physical health, but I would not

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be nice—I wouldn't be treating you with common respect and civility, perhaps what Kahn calls "Etiquette-Based Medicine,"[6] and I certainly wouldn't be relating to your discomfort. I would be providing services in an uncaring (even mean-spirited) way—even if I was accurate with my diagnosis and treatment, even if your health improved. Such continued vicious or, in a sense, *anti-passionate* behavior would likely result in losing my patients, my practice, my hospital privileges, and perhaps my healthcare license.

Most patients want to be treated warmly, as if they weren't just another of hundreds of patients I see every month, but are unique individuals about whom I care. They may want to know that I understand what they are experiencing and that I feel badly that they feel that way. Most patients certainly don't want anti-passionate care and generally object to a-passionate care as well; they want some type of emotional component attached to it. Does that mean it must be *com*passionate care, or are there other types of beneficent acts that might fit the bill—ways we can show we care without having to be fully compassionate?

Compassion

There are many words we use to describe beneficent acts: nice, kind, compassionate, charitable, sympathetic, empathetic, merciful, and even heroic. What is it that distinguishes these *types* of beneficent acts? To simplify matters, I will assume that those toward whom healthcare beneficent acts are directed have some need—that in some way their medically related welfare can be enhanced. This includes those who enter into the healthcare system who are not always aware of their needs, for example, with undiagnosed, asymptomatic hypertension, and those who may not want help to alleviate those needs, such as an unrepentant smoker. I exclude acts intended to help those not in need because often (though not always) in healthcare to take an act to help someone who doesn't need help results in harm.[7]

Because compassion is such a pervasive term used in healthcare today, it is a good starting point for examination. Consider the definition presented by Nussbaum, as a derivative from Aristotle's term *pity*: "Compassion is a painful emotion occasioned by the awareness of another person's undeserved misfortune."[8] Aristotle's necessary components of compassion include (1) the belief that another has experienced a serious (not trivial) suffering, (2) the suffering was undeserved, (3) it creates in us a "painful emotion" that partially arises because we believe the misfortune (4) can "befall us soon."[9] That is, that we are also vulnerable to the misfortune.

Hence we must, through our own perception and understanding, realize that a comrade's ailment is serious and undeserved—he cannot be blameworthy or deserving of his suffering. Further, to determine if something is serious we need to somehow put ourselves in the shoes of the sufferer, for the sense of seriousness must come from the sufferer's perspective. However, in contradistinction to Aristotle, Nussbaum argues that compassion does not require that we feel the *same* thing as the sufferer, only that we can *understand* what the suffering is about and recognize that it is antagonistic to the well-being of the sufferer.

It is this last component—something that is antagonistic to the well-being of the sufferer—that Nussbaum means when she talks about the need for us to make a "*eudaimonistic* judgment" about the sufferer. The compassionate person has to make a judgment about

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the welfare of the sufferer from the sufferer's point of view, "even when that may differ from the judgment of the person [sufferer] herself."[10]

She thereby alters Aristotle's definition by claiming that his fourth component, of suffering that can "befall us soon," is not a necessary component of compassion, though it may be a helpful component. Although evaluating suffering as something that can "befall us soon" can be useful in forming our *eudaimonistic* judgment (it helps to put us in the sufferer's shoes—a sense of "commonness" with the sufferer), it is not a complete way to inform a *eudaimonistic* judgment—according to Nussbaum we don't need a sense of fear to have compassion, but instead a sense of vulnerability "in the person of the other." We often do this by attaching the sufferer's predicament to one we've experienced. We need to know how to assess the sufferer's problem and how we can release her from her suffering, and help her flourish (beyond release). We do this even when it may seem to go against the sufferer's own assessment, because sometimes sufferers' judgments are clouded by the pain and maladaptive behaviors that can go along with suffering.

The desire to release another's suffering is the fifth necessary component of compassion: our acute need to do something to relieve the suffering. It is not that we always *can* do something about it, but we *want* to cure the ill. This motivational component is, for some, a necessary fifth component of compassion.[11]

The third component of Aristotle's definition incorporated by Nussbaum is propounded by David Hume and Adam Smith in their notion of sympathy in their moral sentiment theories. As Solomon points out, "Hume and Smith were struggling to formulate a more sociable sense of human nature, one in which mutual affection and approval are more important than self-interest as such, one in which *shared emotions and feelings* for others are more important than acquisitive desires."[12] Without this *shared* or *fellow-feeling* component, compassion would simply be a logical process of evaluation of another's predicament, one that could be done with (or without) any kind of feelings or emotional content at all. All we would need to do is use a simple algorithm that would be inclusive of vulnerable, undeserved, anti-*eudaimonistic* suffering for which we would be spurred to action.

In summary, as a synthesis of Nussbaum's modified assessment of Aristotle and Solomon's approaches toward compassion, I assert that the following five necessary components, when all are present, create the sufficient condition for compassion: (1) serious suffering, (2) undeserved, (3) a fellow-feeling, based on a (4) *eudaimonistic* judgment, (5) motivating to action (relief of suffering).

Is this fivefold definition of compassion too strict? Are any of these criteria expendable? Suppose we remove "serious suffering" as a criterion and simply replace it with "suffering?" Perhaps the modifier "serious" can be removed, but can "suffering" be removed? We certainly can have compassion for someone who is suffering from less-than-serious circumstances. The modifier "serious" emphasizes that this cannot be "trivial." So some level of gravitas is required. Otherwise we would be missing Nussbaum's *eudaimonistic* judgment—if the suffering is not of significance then it is not impacting on the broadly construed *eudaimonia* of the individual. Similarly, it may not (and often doesn't) spur us to act, other than perhaps in superficial ways. Such beneficent impulses may be more on the line of sympathetic than compassionate.

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Although there may be some tolerance for minor modifications of these criteria, removing any one of the broad five categories would substantially change the meaning of the term "compassion" to one of the other common terms of beneficence such as sympathy, mercy, or kindness. More on this later.

Compassion in Healthcare

One way of understanding whether compassion is the appropriate type of beneficent act for healthcare is to see how each of the five necessary conditions applies.

Serious Suffering

Sometimes in healthcare we are dealing with people who are experiencing suffering. Oftentimes, particularly in primary care, we provide services for people with trivial problems, or even unacknowledged or pleasurable "problems," like smoking. A hospital setting is where we see the more serious problems, although many hospitals provide primary care in their outpatient clinics. This criterion of serious suffering, then, is often met in hospital settings and sometimes in outpatient settings. Healthcare providers are obligated to provide services, whether trivial or for severe suffering, perhaps except in emergency triage circumstances, where those with more serious sufferings are attended to over those with trivial concerns.

Because it is hard to evoke compassion for trivial problems, should we promise to provide compassionate care when it may not be possible to be compassionate? If so, then we need to eliminate the "serious" condition I've defined as part of compassion. Alternatively we could be more honest in our promises to our patients: In cases of trivial (nonserious) suffering we won't provide compassionate care. Perhaps our mission statement would be qualified: "We provide care that is compassionate in seriously suffering patients. If you are not suffering from a *serious* condition, we will provide you with all the appropriate and necessary health services, without compassion but with ______ care."

Undeserved

Although we might understand some contributing causative factors toward some diseases, most illness occurs without a comprehensive understanding, and we can't tell most patients how to prevent most diseases.[13] Take something as simple as a sore throat. Whether it is viral or strep, although we know some of the conditions that predispose toward the invasion of viruses or bacteria, we don't know why some people will colonize asymptomatically whereas others will be infected. Similarly, with smoking, why do some get lung cancer and others don't? Until we can answer these questions with certainty it is difficult to think that the illness is deserved.

But sometimes it is clear that the suffering is not undeserved. We treat trauma victims who significantly contributed to the cause of their trauma by, for example, drinking and then driving. Healthcare professionals' codes of ethics would consider it bad form to interact with such persons in a blaming way—we expect doctors, nurses, and others to treat such patients with some form of gentleness and respect, even if we may not be feeling such gentleness and respect because they got us up in the middle of the night to treat the consequences of their irresponsible behavior. We provide care for them in spite of their self-caused (read: not undeserved) suffering. Because our definition of compassion requires that

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the suffering be undeserved, then how do we characterize the caring treatment we provide in those with *deserved* or at least *blameworthy* suffering? In theory, it should not be with compassion, but with something else. Would it be without passion at all, with simple tolerance,[14] or with some other type of care?

Of course, we might be able to feel something for the person while disapproving of her choice that directly attributed to her suffering.[15] Would this be a compassionate feeling? Some would argue that we should try to feel compassion even for those who caused their own suffering. At times this takes the form of a question-begging argument: They caused their own suffering, no one would do such a thing purposefully, therefore it was an accidental cause and thus undeserved. Or: They caused their own suffering, no one would purposefully work against their own *eudaimonia*, therefore there must be something wrong with them psychologically that caused them to do this. We can't blame those who are not in their right minds, so their suffering is undeserved. Although there may be rare times when this latter argument may apply, I find the former argument unconvincing, as it requires that we suspend the notion of agency whenever a wrong or bad result obtains.

This is not to reject the idea that some health professionals will, à la Hume and Smith, suffer with a sufferer simply because of the infectious nature of suffering or because of the predisposition of the professional. Some people just cannot avoid taking on the emotional pain that comes with someone else's physical or mental suffering, no matter the cause or the sufferer's responsibility. As noted earlier, this may or may not be healthy for the health professional, but the more cogent issue is whether we should encourage such behavior or even promise it in our mission or vision statements. Would encouraging a compassionate response in a healthcare professional for someone who doesn't deserve such a response also encourage wrong behavior or work against *phronesis*?

A Fellow (Shared) Feeling

Providing care to someone with undeserved suffering, even with a sense of vulnerability, might mean that there are shared feelings of pain and suffering, or it might not. In talking with a close friend who conveys to me how in winter he walked to the end of his icy driveway, fell, and severely fractured his ankle I wince and shiver. I imagine his pain, but perhaps more so I imagine my pain were I similarly to fall. I express my sympathy for his pain and disability, for his ordeal of surgery and rehabilitation, and for his probable lifelong fear of icy surfaces. I offer to help him get groceries, cook meals, or provide a ride to synagogue. This is a complete picture of compassion: my fellow-feeling and motivation to act for an undeserved, serious, anti-eudaimonistic condition.

But suppose I do all of the same things except wince and shiver—that is, absent of the fellow-feeling? Suppose my imagination is limited and I can't conjure up my friend's pain and disability other than cognitively knowing that he will have a long road to hoe?[16] Suppose my friend were, instead, my orthopedic patient, and that my wincing and shivering would mean I couldn't properly operate on him because of the instability of my hands, or the adrenalin-induced fast heart pumping, or my confusion because I become depressed at how this has changed his life for the next few months? Because of my compassion I

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may render myself incapable of taking necessary action on behalf of my patient. My potential compassion-motivating beneficent act instead becomes impotence.

We certainly don't advocate such total shared or imaginative feelings when we talk about wanting our healthcare service providers to have compassion. Indeed, it would bring the provision of services to a standstill. An emergency room physician or nurse who took on such total compassion would soon be fired. An orthopedist would lose his referral base.

Our common notion of compassion does not require, expect, or countenance such paralysis in situations like these. But also, certainly during our lifetimes as healthcare providers, we encounter patients who are in their spiral to death, or in constant pain, or in other intractable forms of distress or disability. Were we to use our imaginations to such an extent of Aristotelian sympathy or Humean fellow-feeling we might not be able to live anything other than incapacitated or compromised lives. This is not the case, of course: We learn to live our lives while feeling for our fellows. We learn to ignore or suppress the strength of feelings of our patients so as to provide needed services. We are concerned without being disabled. We advocate a type of *phronesis* of feeling—a studied, cautious, mild, proper form that incorporates just the right amount of shared feeling at just the right time while maintaining an ability to act as objectively as possible in providing care for the patient.

Many healthcare workers who attend to patients in severe suffering, such as nurses and physicians in neurotrauma intensive care units, often need "debriefings," a type of psychological decompression that helps them deal with their intense feelings and frustrations when providing compassion to their patients. The problem of job-related stress and burnout in intensive care and other hospital units is a common one.[17] Such emotional exhaustion partially is a result of our demand to have our healthcare workers provide care with the fellow-feeling component of compassion.

Eudaimonistic Judgment (or Befall Us Soon)

One good reason Nussbaum rejects Aristotle's "befall us soon" criterion for the more robust *eudaimonistic* judgment is because Aristotle's concept of vulnerability is too narrow:

> Those who think evil may befall them are such as have already had it befall them and have safely escaped from it; elderly men, owing to their good sense and their experience; weak men, especially men inclined to cowardice; and also educated people, since these can take long views. Also those who have parents living, or children, or wives; for these are our own, and the evils mentioned above may easily befall them.[18]

It is certainly possible that healthcare professionals can appreciate the pain and suffering that others are experiencing even if the providers themselves have not so suffered. We could still strive to see every patient's suffering and needs within the context of their own goals and projects and filtered through putting oneself imaginatively in the vulnerability of the other.

Not infrequently situations exist where one caregiver (e.g., a nurse) disagrees with another caregiver's (e.g., a physician's) "orders" for care because the nurses' *eudaimonistic* judgment of the patient differs from the physician's. In these cases usually, though not always, the nurse still provides the care ordered by the physician based on the power hierarchy in the

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health delivery system, not based upon the *eudaimonistic* judgment of the nurse. Can such care provided by the nurse be considered compassionate care, even if given begrudgingly or under protest when the nurse believes it is not in the flourishing interests of the patient? In such a case we might be able to say that the physician is *ordering* compassionate care, whereas the nurse cannot *provide* compassionate care, because the care she is providing is contrary to what she believes to be in the best *eudaimonistic* judgment for the patient.

Motivating to Action

This is perhaps the easiest of the compassion criteria to fulfill in healthcare, because, as noted above, by placing ourselves in the position where we project to the community our willingness to care for those in healthcare need, we have explicitly stated our willingness to act, no matter our motive. By accepting licensure we have put ourselves in the position of obligation to act, even if putting ourselves in harm's way—a duty to care.[19]

There are times we act simply out of duty—we are motivated not by the patient's needs, but by our chosen profession, our self-image, the call in the middle of the night to which we mechanically respond, a desire for a higher income, or our need to obtain one more case for our research. Our acting is not out of compassion, but out of duty or self-interest. Assuming we have still done the right and good thing for the patient, then we still haven't provided what was promised in the mission statement—compassionate care—only duty without a motivation to act for that one individual, or perhaps the fellow-feeling contained in compassion.

Perhaps an even stronger reason to avoid compassion as the emotion we demand in providing healthcare services is because it explicitly requires several moral judgments, of which we often attempt to neutralize ourselves when providing care: about the intrinsic value of suffering and desert and the extrinsic value of external goods associated with *eudaimonia* of the suffering individual. Were we to make these judgments at the time of providing services we may compromise our ability to offer the best care because we judge, for example, that the murderer in our care does not deserve to live or should suffer more for what she did. Throughout our medical education we are told that we should treat without judging or at least not expressing our judgment. Yet judging is required for compassion. As Nussbaum says: "Compassion seems to be, as standardly experienced, a reasonably reliable guide to the presence of real value."[20]

In the analysis of each of the five compassion criteria we can see how, in various healthcare contexts, one or more of the necessary conditions may not be present. Certainly there are times when compassion is both applicable and appropriate. But perhaps just as often either it isn't appropriate (e.g., with trivial or deserved problems or purposeful emotional distancing), or perhaps it just doesn't apply (e.g., motivation to action is by duty, not through compassion).

Perhaps the necessary criteria for compassion are too strictly applied in this discussion? Maybe when we talk about compassionate healthcare we don't need such intensity of fellow-feeling. Maybe one person deserves our deep emotional fellow-feeling and another deserves only a passing ache. This may be saying that we need to exhibit a *phronesis* of compassion, that we provide just the *right amount* of compassion in healthcare. Perhaps this

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implies that compassion isn't present or absent, but is present in different amounts or forms. Certainly when it comes to the nature of the fellow-feeling this may be the case—deep feelings versus emotional shudders. But still the fellow-feeling is present for undeserved serious suffering. When such conditions do not apply, though, what is it that we provide? A lesser form of care, or a different form of care? Or something that isn't *care* at all? If we mitigate our shared feelings or the other of the five necessary criteria are not present, then I argue that we are not providing compassionate care. If so, what should we claim to be delivering?

Other Acts of Beneficence

To claim in mission and values statements that we are providing compassionate care is to claim too unrealistic a standard. If this is the case, what type of *caring* would work better? There are some types of beneficent acts we can eliminate rather quickly.

Pity

We likely wouldn't want our mission statements to claim we provide care *with pity*. Although pity was the term used by Aristotle to convey the idea of compassion (*pitié* also is the French term for compassion used by Rousseau in *Émile*), in today's parlance pity connotes a sense of condescension and/or gloating. We wouldn't want to give the impression that our hospital or long-term care facility treats its patients condescendingly or gloatingly.

Mercy

Care given *with mercy* connotes a power differential through leniency—God can be merciful to his flock; a judge can give a less-than-standard, lenient sentence to a convicted criminal; a father can exact a more gentle punishment to his wayward son. Healthcare given mercifully connotes a paternalism and/or control that the profession has been trying to eliminate over the past 30 years. Certainly many patients these days do not want to lay themselves in the hands of their physicians and nurses without question; they want their autonomy respected. Furthermore, to ask for mercy often is to acknowledge some level of blameworthiness. Finally, mercy provided usually requires an acknowledgment of thanks that can lead to an obligation of reciprocity, something that may be encouraged by hospital fund-raisers, but certainly is inappropriate at the time care is delivered; rarely do patients wish to deal with such issues when they are suffering.

Charity

Many institutions consider that they provide *charitable* care when they give services to those who otherwise cannot afford care or those whose care is reimbursed by subpar reimbursement schemes like Medicaid. However, the greater percentage of care is still paid for by those who receive it, mostly through their contracted health or social insurance companies. Further, healthcare workers in most settings do not provide care *charitably*—they are reimbursed for their services either through billing insurers or by being salaried employees of their institutions. Although charity might be an important component of the mission of some hospitals and other nonprofit healthcare institutions, for the majority of patients, care is not provided for free by either the institutions or their workers.[21] Indeed, often great resources are devoted to collecting from delinquent accounts.[22]

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Sympathy or Empathy

It seems clear that our mission statements would not work well with pity, mercy, or charity as the descriptor of the acts provided. Perhaps care with *sympathy* or *empathy* would work? Sympathy has the same etymological meaning as compassion—to suffer with. In many works of fiction and philosophy the terms have been used essentially interchangeably. If they are considered to be the same thing, then *sympathetic* care runs into the same problems as *compassionate* care. However, they are not used today in the same ways. Sympathy connotes being aware of the other's suffering without having a one-to-one correspondence of their suffering with our own experience, without an imaginative co-feeling with the sufferer. Further, one can have sympathy for someone no matter the cause of their suffering. *Empathy* requires "an imaginative reconstruction of another person's experience, whether happy or sad, pleasant or painful or neutral, and whether the imaginer thinks the other person's situation good, bad, or indifferent."[23] In common parlance, we can relate to the other's suffering because we have suffered similarly, or we can imagine what it would feel like if the same thing happened to us.

Neither sympathy nor empathy require an urge toward action (though they might), nor do they require a similar sense of vulnerability, and in these ways they differ from compassion. We can feel the other's loss or feel sorry for the other without the need to alleviate the suffering. We can evoke an emotion without having to feel the similar possibility of susceptibility to the suffering being experienced. These limitations would be healthier in some circumstances—where suffering cannot be alleviated we would not feel impotence or distress because we are unable to care for the patient.

Somewhat safely (to our healthcare personnel) our mission statements could claim we provide sympathetic or empathetic (or empathic) care. This would link the emotional component with the implicit obligation to provide services. How do we explain care provided in those circumstances, or by those individual providers, who are able to divorce their emotions from their provision of care? If we claim to give sympathetic care, then our caregivers still have to have the right feelings at the right time. If we claim to give empathic care, then our caregivers have to conjure up the suffering of the patient in every case—to have an imaginative fellow-feeling. This might work well for severely and moderately suffering patients, but wouldn't work for trivial illness or for preventive services. Further, at least in the case of empathy, we would still have the problem of healthcare worker burnout.

Kindness

Kind words can be short and easy to speak but their echoes are truly endless.
Mother Teresa

Maybe we should simply ask our healthcare workers to provide care with amiability, respect, and commonsense niceness no matter how we feel about the patient, our reaction to the patient, or the circumstances surrounding the patient's suffering. While healthcare providers are performing their routine or extraordinary tasks of care we can ask them to act as if they care and understand the patient's suffering, without taking on the stressful emotions that emanate from being compassionate or empathetic. In other words, they can be *kind*, or at the very least they can *act kindly* and with etiquette.

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What is kindness? I haven't found a treatment of kindness as comprehensive and refined as Nussbaum's or Solomon's works on compassion. Today we use kindness not as a selfless helping, but more importantly as a description of *the way* in which help is offered—with gentleness, respect, amiability, and concern; we are considerate, forbearing, agreeable, genial, and tolerant. Being kind is in *how we go about acting*, not the selflessness of charitable helping implied in Aristotle's definition. Kindness is a benevolent act with "sensitivity to the details of others' situation and needs"[24] as well as "a sensitivity to their thoughts and feelings."[25]

Further, kindness has to do with the way we *act*, not necessarily the way we *feel* while we are acting. On a practical basis, so long as patients believe that we care about them and so long as that belief can be reinforced by our continued sensitivity to the patient's feelings during the delivery of our services, we will fulfill our obligatory duty of performing needed services based upon the patient's situation. We can act as if we care, even if we have no positive or negative feelings about the patient or fellow-feelings; we can provide services without having to make judgments about how deserved the patient's suffering is.

This is not to preclude having a good feeling when we act kindly. If providers wish to be more emotionally attuned to patients' sufferings than simply acknowledging, respecting, and being nice and warm-hearted about it, so be it, so long as they have adequate coping mechanisms to prevent emotional exhaustion. But acting kindly does not require such emotional attachment.

Kindness can be provided purely rationally, without the judgment of emotions, but with the recipient of care perceiving a positive feeling from the caregiver. Thus the patient feels cared for no matter the caring emotions of the service provider. There can be a distinct disconnect for the services giver, so long as there is not a perceived disconnect by the care recipient.

Kindness differs from compassion both in the ability to act positively and appropriately without feeling and in our distinction of the conditions of the patient. Recall that compassion requires that the patient be in a serious suffering mode that we judge to be against the patient's *eudaimonia*. To be kind does not require a patient to be anything other than in a relationship with us; the condition of the patient, whether trivial or serious, is moot. Further, kindness is performed no matter how vulnerable or distant we feel from the patient's condition. This is particularly useful among the worried well or those we are attending for prevention reasons—where no vulnerability may actually exist or where the vulnerability is so remote as to be currently devoid of evoking a fellow-feeling response.

Finally, by not requiring an emotional attachment, kindness frees us from the concern about judging a patient even when judgment may be a natural inclination—when we need to provide care because it is our duty in the face of what might be unpleasant judgmental emotions—caring for a terrorist or a drunk driver who severely injured the patient who is suffering in the next room.

Some might argue that if our emotions are not concordant with our expressions of care, we will be incapable of providing true kindness. This certainly will be true for some. Perhaps we will need to give proper etiquette classes to our medical and nursing students so that they will be able to exhibit kindness no matter to whom, when, and how they need to deliver the care.[26] It will be an empirical finding

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as to whether teaching students to act kindly is easier or harder than teaching them to act compassionately. Our moral education, beginning in early childhood, includes instructing children to "be nice" long before it is to "be compassionate." We have more practice in being civil, considerate, and gentle. In professional education patterning occurs from mentors and authority figures in training; medical, nursing, and other students are taught to act appropriately in various clinical settings often in an unplanned way.

Another objection to using kindness as the type of beneficent care provided could be that we would be disingenuous in providing care—we would, in essence, be lying to our patients because we could be giving them the false impression that we are emotionally concerned for their welfare even if we are not. If by kind care we mean care that is respectful, amiable, sensitive, and tolerant, then a health professional need not be emotionally engaged in order to be providing honestly kind care, whereas the same person would be lying if we have promised emotionally engaging care, such as compassionate or empathetic care. Further, kindness is a less stringent standard than compassion, and therefore more easily applied in adverse circumstances, meaning that it is also more likely to be applied consistently.

Some, particularly those in religious healthcare institutions, may object to substituting kindness for compassion because compassion is a theological ideal toward which we should strive, and a vision or mission is to approach the ideal, particularly where that ideal is set in a spiritual framework. By setting the standard high we can hope that our employees will also aim high and reach the ideal as often as possible. Conceptually I agree. However, good management also requires that we not set up employees for failure and that we set appropriate expectations for our patients. By setting lofty expectations for patients and perhaps unrealistically high goals for employees, whenever we don't meet those goals we have failed, with hopes dashed and disappointment resulting. From an organization psychology perspective this is not healthy. From a customer relations perspective this does not promote goodwill. And from an individual health professional perspective this can lead to burnout.

So, if we are honest and realistic we should eliminate "compassion" from our mission, vision, and values statements. Instead our healthcare systems should be committed to *kind* care as a core value and mission of service provision. This is not to argue against compassionate care if it can be provided, but against the assertion that compassionate care is and should be the dominant and pervasive care provided. We can still encourage compassion at the right time in the right circumstances, but not widely broadcast it as what our patients should expect.

And so, I'd change the advertisement to read "Respect, Integrity, *Kindness* . . . when a healthcare organization is committed to these values, the whole community benefits."

Notes

1. Advertisement for Allina Hospitals and Clinics, *JAMA* 2006;296(1):125.
2. See, for example, Methodist Hospital in Houston, Texas ("Statement of Values"): "Compassion—We embrace the whole person and respond to emotional, ethical and spiritual concerns as well as physical needs."; available at http://www.methodisthealth.com/cgi-bin/hmdim/home/basic.do?channelId=-1073829781&contentId=536884147&contentType=GENERIC_CONTENT_TYPE (last accessed 19 Jul 2006); The Hospital for Sick Children in Toronto Values statement:

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"Excellence ... in compassionate family-centred care and service"; available at http://www.sickkids.ca/abouthsc/section.asp?s=Who+We+Are&sID=11873&ss=Vision%2C+Mission+%26+Values&ssID=231 (last accessed 24 Jul 2006); Beth Israel Deaconess Medical Center in Massachusetts: "Our expert staff provides care that is compassionate, personal, and respectful of patients and their families."; available at http://www.bidmc.harvard.edu/sites/bidmc/search.asp (last accessed 19 Jul 2006).

3. Beauchamp T, Childress J. *Principles of Biomedical Ethics*, 5th ed. New York: Oxford University Press; 2001:166–9.
4. Pellegrino ED. Toward a virtue-based normative ethic for the health professional. *Kennedy Institute of Ethics Journal* 1995;5(3):253–77.
5. Such terminology is often used in other aspects of our lives; for example, we might enter a stark, unadorned office lacking pictures on its white walls and state it has a "clinical" feeling, meaning it is devoid of warmth or friendliness.
6. Kahn MW. "Etiquette-based medicine." *New England Journal of Medicine* 2008;358(19):1988–9.
7. We certainly can be beneficent to people not in need—we can send them an unsolicited and unexpected birthday present or generously give them unsolicited tickets to a concert—just because we know they would like that, even though they are unneeding and sometimes even undeserving. Although this type of considerate or generous act is benevolent, it is not usually an act expected or encouraged within the realm of the healthcare setting.
8. Nussbaum M. *Upheavals of Thought, The Intelligence of Emotions*. New York: Cambridge University Press; 2001:301.
9. Aristotle, *Rhetoric*, Book 2 1385b12–1386a3. Chicago: Encyclopedia Brittanica; 1990.
10. See note 8, Nussbaum 2001:309.
11. Later in her book, Nussbaum implies that a sustained commitment to action, even if not possible, is an important component of compassion. She takes up the objections to compassion, one of which is the momentary desire to help without the prolonged effort needed to effect change. She concedes to this concern: "People can all-too-easily feel that they have done something morally good because they have had an experience of compassion—without having to take any of the steps to change the world that might involve them in real difficulty and sacrifice" (see note 8, Nussbaum 2001:399).
12. Solomon RC. *In Defense of Sentimentality*. New York: Oxford University Press; 2001:55 (italics added).
13. I am avoiding the often disdainfully stated controversy of whether we can or should "blame the victim" for significantly contributing toward his own illness. The politically correct view is not to do so, though I believe there certainly can be justification for blaming someone where they have persisted in habits that they know substantially contribute to the cause of their disease.
14. Gillon R. Toleration and healthcare ethics. *Cambridge Quarterly of Healthcare Ethics* 2005;14:100–6.
15. Thanks to Kelly Sorenson for this observation.
16. Or, as Kelly Sorenson suggested in a review of a draft of this paper, suppose I'm a male gynecologist.
17. See, for example, Chen SM, McMurray A. "Burnout" in intensive care nurses. *Journal of Nursing Research* 2001;9(5):152–64.
18. See note 9, Aristotle, Book 2 1385b12–1386a3.
19. Clark CC. In harm's way: AMA physicians and the duty to treat. *Journal of Medicine and Philosophy* 2005;30:65–87.
20. See note 8, Nussbaum 2001:374.
21. In some cases "charitable" care might be used to mean "providing care with love" or "from the heart" (*caritas*). Including the term "charitable" in mission statements would, most likely, produce the same objectionable issues as I posit for using "compassion."
22. See, for example, Brady P. Center blasts hospitals' debt collection policies. *Yale Daily News*, 17 Nov 2003; available at http://www.yaledailynews.com/Article.aspx?ArticleID=24152 (last accessed 27 Sep 2006).
23. See note 8, Nussbaum 2001:302.
24. Hurka T. *Virtue, Vice, and Value*. New York: Oxford University Press; 2001:106.
25. Walker ADM. Virtue and character. *Philosophy* 1989;64(249):349–62.
26. See note 6, Kahn 2008:1988–9, wherein he claims that, "I may or may not be able to teach students or residents to be curious about the world, to see things through the patient's eyes, or to tolerate suffering. I think I can, however, train them to shake a patient's hand, sit down during a conversation, and pay attention. Such behavior provides the necessary—if not always sufficient—foundation for the patient to have a satisfying experience."

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