Daring to Care: Is Spirituality Sustainable in Organizations Providing Healthcare?

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ABSTRACT

Healthcare workers are challenged to dare to care enough to provide a service that is holistic. This involves being in tune with their own spirituality and the spiritual needs of their patients or clients. Spirituality and compassion are important concepts in the ministry of nurses and other health professionals. Compassion also has links with mercy, although there is debate as to whether mercy is the same as compassion for deserving or undeserving sufferers. However, healthcare workers need to care for sufferers even if their suffering is not deserved, where such compassion is intrinsic and/or out of duty. It involves acting altruistically. Faith-based organizations are best equipped to undertake this holistic ministry but as they are becoming increasingly reliant on government funding to help finance expensive health services they encounter rationalistic pressures from these funding sources may restrict the way they deliver these services. Decision and policymakers are encouraged to embrace altruistic values rather than the egoistic values of economic rationalism, not least because the nature of healthcare has an inherent emphasis on altruistic emotions, especially compassion.

Key Words: altruism, compassion, economic rationalism, faith-based organizations, holistic ministry, mercy

Introduction

Spirituality is an important component of cultural identity and is recognized in disciplines beyond simply theology and sociology. In education, for instance, Tisdell (see Tisdell, 2006) studies the connection between spirituality and cultural identity, and links it to a search for the best teaching method that is responsive to cultural differences in society. In this sense, spirituality is a compilation of formative influences that define one’s disposition towards others as well as “The Other”. The pervasiveness of spirituality suggests a theological transcendence that can be understood as the “subjective conditions which shape our every mental and physical act … on which our awareness focuses” (Endean, 2001, p.115).

Spirituality and religion are very relevant during significant events in life. Many people value religion and spirituality in their everyday lives, but it “may be especially potent during times of loss” (Wortmann & Park, 2008, p.703). For example, individuals not claiming a formal belief in God, may consider themselves to be spiritual at times of bereavement, and may even acknowledge belief in an afterlife (Wortmann & Park, 2008; Zinnbaur & Pargament, 2005; Zinnbaur et al., 1997). Similarly, near-death experiences often result in life changes for some people that can include changed beliefs of which some relate to religion as well as spirituality (Long, 2002). Near-death experiences are just one of the ways in which boundary conditions of spirituality in management can be examined. Such an examination would encompass the altruistic elements of compassion and caring. Both of these elements are valued as the essence of the nursing profession.
More specifically, this paper argues that a holistic ministry of healthcare is emerging in a secular context and gaining recognition, although the rationalist pressures of accountability and oversight need to be handled carefully to ensure faith-based organizations keep working towards their mission. The holistic ministry with its championing of altruism as an alternative approach, can be seen to stimulate conceptions of spirituality in nursing, where compassion is required to be applied irrespective of the patient’s suffering. It is in this altruistic approach that emphasizes the need to make decisions without regard for self that differentiates the ideologies of faith-based organizations from many secular organizations that tend to make decisions and formulate policies based on self-interest (c.f. Gates & Steane 2009).

Daring to Care – Health Healing and Wholeness – Faith-Based Health and Welfare.

There are many challenges for healthcare in the Western world as increased development and availability of technology, increasing community expectations, and a more threatening environment, places great demands on the delivery of these services. There are increasing medico-ethical problems that arise as an outcome of secularization and, possibly, these raise even more problems for Christian healthcare as diminishing levels of religious staff make it more difficult to continue its ministry.

In an increasingly secular environment many of the spiritual concerns of patients and their relatives, formerly addressed by religious medical staff, are being referred to chaplains appointed by the various churches. Chaplains, in particular, are called upon to respond to patients’ questions about the reasons for their infliction with a serious illness or a temporary remission from a life threatening disease. These raise significant issues which Studer (1982, p.286) argues require a theological acceptance of “the witness of empirical science about what is in the material world”, complicating the relationships between science and theology. Indeed, this secular context has often raised the profile of a holistic ministry of healthcare that has emerged.

In Western countries, hospices and, later, hospitals were first developed in the fourth century and in the nineteenth century Catholic congregations in the United States emphasized holistic concerns. Mary Aikenhead founded the Sisters of Charity in Ireland in the early nineteenth century and they were established in the United States, Australia and other countries shortly afterwards. In addition to their vows of poverty, chastity and obedience, the sisters in this order took a fourth vow of
service to the poor. Adherence to this vow motivated them to attend to all of the spiritual and temporal needs of the poor wherever they were to be found. Such care conforms with the World Health Organization’s 1948 definition of health as cited in Locker (1997, p.244). WHO regards health as “a complete state of physical, mental and social well-being not merely the absence of disease and infirmity” (see Arbuckle, 2000, p.154).

Scholars from most Christian traditions have a position on holistic ministry. Beardsley (2002), for instance, claims that there is a link between healing and integration and that the Vision of the Valley of Dry Bones (Ezekiel 37:1-14) “is a prophecy of the resurrection and points to eschatological wholeness of persons, society, and the earth made new” (p.355). She argues that this vision illustrates the healing power of God’s Spirit and argues that we can still experience wholeness with the healing of our brokenness and the restoration of health. Integration is accomplished because the healing brings harmony between parts as in her illustration of the orchestra that she cites from Wong (2002). She emphasizes Wong’s statement: “For the Christian, God through his Spirit, is the conductor to integrate all the dimensions of our being into the state of wholeness to which we aspire” (Wong, 2002, p.187 cited in Locker, pp.354-355). Other Christian traditions providing active holistic health and welfare include the Baptists (Stubblefield, 2005) and the Seventh Day Adventists (E. G. White, 1942).

Holistic care is very demanding and the authors argue that faith-based not-for-profit organizations are well-positioned to provide holistic care. However, there are many barriers that mitigate the efforts of faith-based healthcare organizations to achieve their desired goals, presenting challenges to spirituality in management, especially healthcare management.

**Daring to Care – Barriers to Holistic Health and Welfare Provision – Economic Rationalism**

The process of secularization and the demands for the professionalization of the workforce are significant barriers to the delivery of health and welfare services. These include a shortfall in the numbers of qualified religious personnel available for employment. Despite increased levels of philanthropy in developed countries many services require significant levels of government financial
assistance and this comes with greater calls for accountability and for the way the services are delivered.

The first amendment of the United States constitution provides for the separation of church and state. However, the recent government policy changes in the United States sometimes impact significantly on the very societies in which the new policies apply. For instance, Fording and Berry (2007) claim that the ambitious social policy initiative of the ‘war’ on poverty, in the United States during the 1960s, has had a most controversial impact upon American Society because of “the dramatic expansion of public assistance programs for the able-bodied poor and their children” (p.37).

Some significant changes to welfare policy occurred during Bill Clinton’s Presidential Term. The Charitable Choice Amendment of the 1996 Temporary Assistance for Needy Families (TANF) legislation is an example of more recent policy changes that enable the federal government, despite the constitutional provision for the separation of Church and State, to provide funding so that “sectarian congregations and agencies” could access such funds but still retain “their religious character”. Immediately upon taking office President George Bush established the White House Office of Faith-Based and Community Initiatives and this “generally encourage[d] an enhanced role of religious providers in service delivery” (Sosin & Smith, 2006, p.533). By 2004 at least ten federal agencies promoted the delivery of services by religious organizations. This new policy suggests, as Cnaan et al (2002) argue, “care for the neediest members of our society will be encouraged to come from local-based organizations…” (Cnaan et al., 2002, p.6). Church Congregations, some for the first time, were now in a financial position to engage in significant welfare activities in their local area.

New government funding procedures bring new responsibilities for Faith-Based agencies (Sosin & Smith, 2006). Non-profit agencies, including faith-based agencies, have a responsibility to their mission and need to be careful that they don’t contract to undertake government funded programmes that conflict with their own mission. For instance, The Salvation Army (in the USA) receives government grants to help pay for food at their summer camps for young people and for some of the costs of running various social service programmes but the contracts do not allow “it to proselytise as...
a part of the programme or as a requirement for admittance or continuance in the programme” (Ward, 2007, p.6). They are allowed to undertake the services in accordance with the way they are constituted legally as a Church with no separate entity for social work as there is in Australia or in separate foundations as is the case in France and the Netherlands. Indeed, faith-based organizations now have to be careful not to sign contracts that could hinder them in fulfilling their mission.

In the example of The Salvation Army again, for the fifteen southern states and the District of Columbia (see Howes, 2007, p.271), the Social Services Department reviews about US$90million worth of government contracts each year comprising “about fifteen hundred contracts for residential housing or temporary shelter or feeding programs or after school programs – a variety of things from youth to adults to homeless to senior citizens” (C. White, 2007, pp.7-8). Senior staff often have to be careful to ensure that even for admission to and participation in these programmes, the contracts do not require that religious symbols be removed from buildings or that clients are prohibited from accessing church services (Gates & Steane 2008). Where such stipulations are included in the contracts the offer of funding for the programme is declined.

There is a different approach in Australia where one outcome of public management reform during the past ten years has been the shift from the traditional welfare models administered by the state towards a partnership with private organizations to deliver the welfare services. Participating organizations function both for-profit as well as not-for-profit. As is the case in the United States, Australian faith-based organizations are prominent amongst the not-for-profit group and they are atypical of a neoliberal preference for markets and business processes (c.f. Camilleri & Winkworth, 2005; Cleary, 1994; Harinath & Matthews Jr., 2004; Melville & McDonald, 2006; Vidal, 2001). A process of deregulation as well as privatization in industries, utilities and services has enabled transparent procedures and accountability frameworks, traditionally the domain of public administration, to be transferred or devolved to other organizations.

In Australia there have been many developments in the voluntary sector that have enabled faith-based organizations to win contracts for services over other types of organizations such as for-
profit corporations. Arguably, this responsiveness under economic pressure is indicative of the resilience of faith-based organization but it could also be argued that the values of economic rationalists in government and other large corporations have been replicated by decision and policymakers in the faith-based organizations. The faith-based organizations may need to realise that they have become contract providers (Bennett, 2008) rather than providers of a service because of their compassion for people in need. In the process they may be negotiating with politicians and government officials who are not altruistic (Sørensen & Bay, 2002). This raises the question as to whether policies are formulated out of self-interest rather than the needs and wellbeing of clients. The unresolved and mounting tension between faith-based ideologies and economic rationalism also suggests a need for decision and policymakers, in each of the three sectors, to adopt an alternative approach to their decision and policymaking.

**What is Altruism? Is this a New Approach to Health and Welfare Provision that Decision and Policymakers Dare to Adopt?**

Arguably, faith-based organizations daring to care about the wellbeing of their clients will embrace altruistic values in their decision and policymaking. Social scientists, such as Eisenberg (1986) and Staub (1978) define altruism as “prosocial actions intended to benefit others that are not motivated by the desire for self-benefit” and thus can include internalized principles of justice and other moral motives that Eisenberg (1991, p.128) claims are not always accepted by some other social scientists in the field. Such social scientists claim either, that acting out of self-interest is the norm of social life, or it is a self-fulfilling concept (c.f. Derlega & Grzelak, 1982; Hobbes, 1991; A. Kohn, 1990; M. Kohn, 2009; Lerner, 1980, 1982; Miller, 2010; Schwartz, 1986; Adam Smith, 1791). This suggests that adopting a self-interest framework in decision and policymaking would reward a few whose self-interests are served by the decisions but would leave many others comparatively worse off. Arguably, a just solution would involve the decision and policymakers following an alternative path to one of egoism. This path is one of selflessness or altruism, rather than egoism or selfishness.
`Altruism’ was coined originally by Auguste Comte - ironically the ‘Father of Positivism’ - in the mid-nineteenth century and given academic confirmation a century later by Sorokin and others. Before 1852, ideologies, actions and views of morality were expressed by words such as love, beneficence or Christianity. Dixon (2008, p.1) also adds “sympathy, philanthropy, [and] utilitarianism”. To Comte, ‘altruism’ is a religion in which self-centredness is eradicated and “replaced by selfless love and devotion to society” (Midlarsky & Kahana, 1994, p.12). In England, John Stuart Mill adopted a similar philosophy of secular altruism that Raeder describes as “selfless concern for the good of the whole over the concern for a particular and personal salvation centered on the ‘miserable individuality’ of the average person” (Carey, 2002, p.116 ; Raeder, 2002).

Arguably, altruism is a Kantian supreme moral principle associated with idealistic good will (Kant, 1981; Norheim Jr., 2004, p.115). Altruism and similar social virtues in constructivist Kantian philosophy are claimed to be “means for self-interested aims” (Norheim Jr., 2004, p.119; O'Neill, 1996, Chapter 7).

Comte’s ‘altruism’ met with strong resistance and ridicule, at first, even though acceptance of the new word:

made it possible to experience oneself and the world in new ways, to communicate new ethical concepts, and to create new moral and religious identities (Dixon, 2008, p.1).

Despite its poor acceptance in the second half of the nineteenth century, Dixon (2008, p.360) claims that the concept of ‘altruism’ made a significant advance into religious and theological circles in a conference in St. James’s Hall, London, led by the Reverend Hugh Price Hughes, on 30 December 1900. Hughes, a Wesleyan social preacher, devoted to Green’s philosophy of idealism (see Green, 1999; 2003), endeavored to include secular philosophy into Christian service. Hughes saw Christian truth in the positivism of Comte as well as in the evolutionary ethics suggested by Spencer. Arguably, the fashionable new ‘altruism’ ethos could be embraced by Christianity as well as, to some degree, philosophies such as positivism, determinism, idealism and Darwinian evolutionary theory (Dixon, 2008).
There are levels of altruism (Schmidtz, 1993). As a generalization, some people are self-orientated and do not show concern for other peoples’ welfare. These can be described as self-regarding people. Concerned people care about others’ welfare, respectful people place restrictions on their behaviour towards others; but, at a higher level, altruistic people are motivated largely by regard for others. Altruism is an unconditional and conscious process, translated into action, and directed towards another’s welfare (Monroe, 1996). Despite its infrequent application and exhortations that it should be manifested more, altruism plays a significant role because it challenges dominant beliefs that pursuing individual self-interest is natural. That is, these levels of concern and respect shown to others, motivated by non self-regard, form an interesting category from a rational choice perspective (Schmidtz, 1993). Some social scientists have explored other characteristics of human behaviour, such as ‘sympathy’ (Adam Smith, 1759) and ‘mutual aid’ (Kropotkin, 1902), which, although beneficial, are not strictly altruistic but may be termed neo-altruistic.

The above categories of altruism and neo-altruism can be seen both across sectors and within each sector of the healthcare industry. The next section explains why many caring and compassionate persons become nurses and remain in the healthcare workforce.

**Daring to Care in Health Care – Spirituality in the Nursing Profession**

Perceptions of scientific professionalism in medical care have restricted the focus on spiritual dimensions within public health services. However, Ellis and Naraysasamy (2009) investigated an increasing demand for holistic care within the United Kingdom National Health Service. They argue that spiritual care can be provided by nurses who are aware of their own and their patients’ spirituality. Miner-Williams argues that nurses need to be competent in providing spiritual care as well as providing care spiritually – “caring for the person in addition to caring for the patient”. She claims that nurses who are comfortable with their own spiritualities are best able to provide nursing care spiritually. Miner-Williams (2006, p.813) cites 13 of the numerous definitions of spirituality applicable to nursing including: connectedness, meaning, transcendence, values and beliefs, energy and emotion (p.811). Such concepts are outside the level of knowledge and experience of many
secular nurses who, in acknowledging their lack of expertise make appropriate referrals. Nurses need to recognize when patients do not wish to have certain life issues, especially of a religious nature, addressed. In such circumstances “care must be taken to document spiritual needs and plans to address them, including making chaplain referrals” (Miner-Williams, 2006, p.819).

It is premature to characterize scientific professionalism and spiritual care in nursing as mutually exclusive. While the former has specificity and is instrumental in attaining a health goal, the latter is general and inclusive of broader dimensions of humanity in attaining a holistic goal in health. They can be complementary. Arguably, perceptions of exclusivity can be attributed to the omission of concepts of spirituality in theoretical models of holistic care taught in nursing academies. Oldnall lamented such omissions either completely or he referred to them “only implicitly in certain elements of their conceptual framework thus rendering this fourth important dimension of holistic care ‘null and void’ or, at its best, incomprehensible” (Oldnall, 1995, p.417). Public Sector health professionals in multi-faith communities face many challenges if they hold to a particular belief system (e.g. Christianity) and endeavour to “offer the ideal of spiritual care to patients who hold other quite different beliefs” (Fawcett & Noble, 2004, p.136). Van Loon in her research discovered that patients often receive spiritual care from nurses but “it is hidden in the ordinary taken-for-granted aspects of the nurse/patient relationship and consequently it often goes unrecognized” (van Loon, 1995, 2001a; 2005, p.266). Although the International Council of Nurses (ICN) Code of Ethics (1973) provides for spirituality in its practice codes, Ross (1994) claims the practice was not defined. Likewise the Australian Nursing Federation’s Standards of Nursing Practice (1989) and the (Australian Nursing Council’s (ANC) guidelines (2000) include spirituality “as an implicit component of holistic nursing care” (Ormsby & Harrington, 2003, p.322) However, Ormsby and Harrington claim that the provision of spiritual care is the responsibility of individual professional nurses. Mental health nurses have a special role to play in the delivery of spiritual care to their patients in each of the government, private and faith-based not-for-profit sectors alike (Wilding et al., 2006). The Australian Defence Force is a significant provider of public sector healthcare in Australian society and it identifies
“spirituality as a distinct entity within holistic nursing practice” (Director of Nursing Services Australian Defence Force, 1996; Ormsby & Harrington, 2003, p.322). While secular nurses may not be equipped, educationally and experientially, to provide such spiritual care, nurses, adhering to a belief-system may find it easier to undertake such a role in a faith-based environment (Grosvenor, 2006; MacKinlay, 2008; van Loon, 1998, 1999, 2000, 2001a, 2001b).

**Spirituality and Religion**

Many nurses in the health system can hold allegiance to a religious tradition. Others are agnostics or do not acknowledge religious beliefs at all. Cline (2008) identifies three distinctions between religion and spirituality. First, religion as an institution was established by humankind who exercises control and designates god a minor place in their every-day activities but spirituality involves every aspect of human life. While spirituality is chosen, religion can be forced. Second, religion can be defined as a human phenomenon: “a manifestation of the flesh” but spirituality is more transcendent as a manifestation of the Transcendent. Third, spirituality is more a perspective that influences behavior as a way of loving or accepting or relating to the world, which is less deterministic than behavior expected through religious practices. These distinctions may seem minor, associated with individual and civil “mystical experiences” (Zinnbaur et al., 1997), but signify the divergence of views about attempts to see spirituality and religion as synonymous, . Generally, while spirituality has had strong foundations within organized religion in shaping faith experiences and beliefs, the actual manifestation of spirituality is unique for each religious tradition, finding different expression in each one as well as in civil and non-church religions of a political nature.

Even though health professionals do not have a religious role in public sector healthcare in secular countries such as the United States and Australia, they can still exercise a spiritually caring role. Historically, although secularism had limited the impact of institutionalized religion upon public service over a long period, the removal of spirituality and other forms of humanness from nursing practices had, in effect, been profoundly detrimental. A change came, however, with the eclectic and unorthodox spirituality of Florence Nightingale, a Tuscan-born Nurse of an Unitarian religious
tradition and her 38 trainees engaged in a ministry of caring for British soldiers during the Crimean War in 1854 (Boykin & Dunphy, 2002; Winderquist, 1992). To Nightingale “the universe was an embodiment of a transcendent God” (Boykin & Dunphy, 2002, p.15). Macrae cites her thus “human consciousness is tending to become one with consciousness with God” (Macrae, 1995, p.9).

Nightingale’s nursing corps activities led to the development of nursing as we know it today. Such expressions of spirituality and compassion whilst performing extremely emotional tasks on the Crimean battlefield equipped Nightingale’s nurses and subsequent generations to cope with highly emotional episodes that, perhaps too frequently, are the lot of nursing professionals.

**Spirituality, Compassion and Emotional Labour**

This awareness of spirituality and recognition of the importance of compassion has parallels with the emotional labour and emotion regulation theories and models in other fields of management. The original conceptualization of emotional labour refers to a worker’s endeavor to display emotions according to embedded social and cultural norms rather than what he or she actually feels (Hochschild, 1983). Emotional labour can be seen to have two dimensions: nurses’ autonomous response and their work persona strategies (i.e. surface or deep acts). From a pragmatic perspective, nurses confront human suffering on a daily basis and are expected to provide genuine caring to alleviate patients’ distress rather than simple task-oriented responses (McCreight, 2005). Many nurses perform emotional labour, while realizing that their actual feelings are not consistent with the caring emotions expected of them professionally (P. Smith & Lorentzon, 2005).

The compassionate care of Florence Nightingale and her team is a quality to which to aspire, with Nightingale being called a ministering angel. However, Burnell (2009) argues that it is a topic not always included in nursing scholarship and contemporary care delivery models. Indeed, there have also been calls for the more limited and pragmatic approach toward emotional labour and emotion regulation to be included in nursing preregistration training (Huynh et al., 2008). Such approaches contrast with earlier models of emotion, such as valence, that highlight the negative and positive aspects of emotion (c.f. Ekman & Davidson, 1994; Frijda, 1994a, 1994b; Solomon & Stone, 2002; D.
Watson & Clark, 1984). On the other hand Zeelenberg and Pieters (2006) propose a pragmatic approach to emotional labour that they call ‘Feeling-Is–For-Doing’. They claim that an emotion is indicative of a problem and a behavioural plan is needed to deal with the problem. They argue that their pragmatic approach is superior because “it focuses on behavioral effects of specific relevant endogenous emotional experiences” (Zeelenberg & Pieters, 2006, p.129). Their pragmatic approach benefits from the research of Decartes (1989), Jevons (1871/1965), James (1907/1995) and others (c.f. Frijda, 1986; Zeelenberg & Pieters, 1999, 2004). An apparent absence of a deeper acknowledgement of the role of compassion suggests the need to investigate the nature of compassion that guides people who dare to care for suffering humanity and to raise the profile of a spiritual approach to healthcare. Such an approach would increase the caring component that is the basis of the nursing profession.

**Daring to Care – Exercising Compassion to Suffering Humanity**

It is rare for human beings to experience care from others who have immersed themselves “into the pain, brokenness, fear, and anguish of another, even when that person is a stranger” (Burnell, 2009). This rarity may be an outcome of the unbalanced coverage of human suffering by the media through their continual and explicit rehashing of incidents portraying other humans’ vulnerability, anguish and powerlessness (Höijer, 2004). Suffering includes a long list of painful and destructive evils that, in accordance with Aristotle’s summary, includes death, physical injuries, disease, lack of food and loneliness (van der Cingel, 2009). Christianity has always accepted the mystery of suffering as it was significant in Christ’s mission (1 Peter 4:12-13) as exemplified in Christ’s willingness to submit to suffering and death to redeem sinful mankind.

In the face of this rarity of compassion ‘The American Nurses Association Code of Ethics for Nurses’ “calls for the nurse to practice with compassion and respect for every individual” (Milton, 2003, p.301). Caring is valued as the essence of the nursing profession (J. Watson, 2005). Compassionate care is argued to be “nursing’s most precious asset”, although there are concerns that “nursing discourse featuring the profession’s altruistic ideals is not only scarce, but lukewarm at
In their response to the Norwegian Nurses’ Association’s inclusion of “compassion as one of the basic values in nursing care” Hem and Heggen (2004) questioned if compassion is essential to nursing care. Their research argued that although “compassion is a radical idea, with a critical potential” it is “demanding in practice and as an ideal” and that although it is necessary as an ethical guideline it is not a necessary “condition for the radical step of taking a patient’s distress seriously” (Hem & Heggen, 2004, p.28). These arguments suggest that if these ideals are to be achieved the nurse will need to understand what ‘compassion’ means.

**What is Compassion? Is it Merely Pity?**

The concept of pity is attributed to Aristotle’s *Rhetoric* first written in 350BCE (Aristotle, 1941). Nussbaum (1996, p.31) limits Aristotle’s concept of pity (1941, 1385b13ff) to that of a painful emotion relating to the suffering of others depending upon its seriousness, lack of recipient culpability and the sufferer having similar values to that of the pitier. Such restrictions do not accord with Carr’s (1999, p.411) claim that “pity and compassion are altruistic emotions”.

Although ‘pity’ has some disagreeable connotations in modern society, at the time of Aristotle and the New Testament it had a similar meaning to `compassion’. In the gospels `compassion’ is only used of Jesus and in some of the parables. Barclay claims that the phrase “‘He was moved with compassion’ ([έσπλαγχνωσθή ] splagchnisetheis) is the strongest word for compassionate pity in the Greek language”. Derived from the word splagchna (bowels) “it describes the pity and the compassion which move a man to the very depths of his being” Similarly in the Parable of the Good Samaritan (Luke 10:25-37) the interlinear rendition of [έσπλαγχνωσθή ] splagchnisetheis is “He was filled with compassion”.

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1 Words such as pity, compassion, and sympathy are employed when splagchnisetheis is translated into English. For example, Barclay (1958) translates part of Matthew 9:36 as “He was moved with compassion to the depths of His being”. It is translated ‘compassion’ in the King James Version and in Today’s New International Version, ‘pity’ in the New English Bible, ‘felt sorry’ in the Jerusalem Bible and in the New Greek-English Interlinear New Testament translation as “He felt sympathy”. In Luke 10:33 splagchnisetheis is rendered ‘compassion’ in the King James Version and the Jerusalem Bible and ‘pity’ in Today’s New International Version, the New English Bible and by Barclay (Barclay, 1965, p.164).
In his *Rhetoric* Aristotle argues that `pity’ is an aroused emotion in “the sight of some evil, deadly or painful” occurrence. Aristotle (1941, 1385b) defines `pity’ as:

> a feeling of pain caused by the sight of some evil, deadly or painful, which befalls one who does not deserve it, and which we might expect to befall ourselves or some friend of ours, and moreover to befall us soon (cited in Keaty, 2005, p.182)

These conditions for eliciting pity have some emphasis in Thomas Aquinas’ concept of Christian mercy. Aquinas (1981,ST, 11-11.30) claims that the emotion of sympathy, characteristic of mercy, is felt “for those who suffer the effects of destructive evil, for those who suffer the effects of destructive evil that occurs accidentally, and for those who suffer the effects of destructive evil undeservedly” (Keaty, 2005, p.185). Aquinas (ST, 11 11.30.1) relied upon Augustine’s definition of mercy as “heartfelt sympathy for another’s distress impelling us to succour him” (Augustine, 1984; 1998, IX, 5). Floyd (2009, p.454) adds that Aquinas understood the etymology of ‘mercy’ (misericordia) as literally meaning ‘compassionate heart’ and has as its object the unhappiness of others. Floyd argues that such accounts highlight the obligatory nature of mercy and thus we are encouraged to adopt mercy as a fixture in our moral lives (p.450).

Statman argues in a similar vein when claiming that it is “morally appropriate to feel for a person who suffers an undeserved misfortune and desire its alleviation” (Statman, 1994, p.345). He continues to argue that we can do without mercy because the moral work is accomplished by compassion and beneficence and the use of the word `mercy’ is confusing. Some other scholars argue a limited form of mercy. Smart (1968), for instance, argues a court room style of mercy that is not much more than leniency and concludes that it only made “strict logical sense in a retributivist view of punishment” (Roberts, 1971; see Smart, 1968, p.356). Smart claims acts of `mercy’ are generally “simply measures by which we ensure that the punishment fits the crime” or as benevolent means of “reducing or waiving punishment” (p.358).

An alternative view is argued in Twambley’s (1976) claim that mercy is linked with forgiveness and this places it above Aristotle’s notion of `pity’ and extends the act of compassion to undeserving sufferers. It is the type of compassion extended by an anguished father to his wayward
son in the Parable of the Prodigal Son (Luke 15:11-24, 31-32). Further, Twambley (1976) argues that humans are not compelled or obliged to extend compassion (e.g., as per the prodigal son’s elder brother), whereas Smart proposes it is an obligation. The elder brother did not have the same compassion for his returning younger brother as did his father (Luke 15:25-30).

The caring role of nurses and other health professionals is very demanding and they are frequently required to be compassionate towards those they serve even if the recipient does not deserve it. This essential element is more than mere pity.

**Can Health Professionals Care and Show Compassion in Distasteful Situations?**

Remunerated nurses and other medical staff do not have the option to be selective about whom they will care even if they undertake their tasks as a sense of duty (Kane-Urrabazo, 2007). The authors argue the exercise of compassion is not dependent on deliverers being advantaged financially through their caring actions (Cooper, 2007). Whatever the motivation, medical-staff are required to care for suffering patients even if the suffering is perceived to be deserved, for example, attending to the needs of a substance-abuse patient who has abused his body. The accident and emergency nurse needs to care for the injured drink-driver responsible for the death of an infant girl. The intensive care nurse is required to attend to the injuries of the terrorist whose activities caused the loss of many lives and extensive property damage.

Of the nurses in the public and for-profit sectors some will have a personal faith and endeavour to show true charity, or *agape* love to their patients and so make love possible in them (Tillich, 1968, p.191). Such modus operandi is in accord with models of psychotherapeutic healing advanced by social psychologists like Erich Fromm (c.f. Fromm, 1956; Funk, 2009). Others work with a deep sense of compassion because they, like Schopenhaur, see ‘compassion’ (‘mitleid’) as an image of goodness and a virtue (c.f. Mannion, 2002; 2003, p.219; van der Cingel, 2009, p.130). Still others, in the Kantian tradition, will regard compassion as, more or less, a duty and will act accordingly (van der Cingel, 2009). In such a situation the sufferers could be victimized (c.f. S. R. Smith, 2005, pp.76-87).
Compassion is the emotive or volitional source of the disposition to act with mercy. Arguably, compassion is a broader form of mercy, where compassion or mercy may be elicited from pity and sympathy that along with empathy “have a different tone and meaning in everyday conversations” (van der Cingel, 2009, p.130). In showing compassion healthcare workers seek to progress and alleviate the suffering of their patients whilst recognizing the moral significance of the suffering (c.f. Carnevale, 2009; Rehnsfeldt & Eriksson, 2004). In cases of terrorist attacks and other traumatic incidents, healthcare professionals will approach with compassion their role of seeking to alleviate their patients’ trauma. This could extend to the use of new psychotherapeutic strategies, such as the ‘Adaptive Information Processing (Eye Movement Desensitization and Reprocessing)’, developed by Francine Shapiro (2001) to advance the trauma healing process (c.f. Coetzee & Regel, 2005; Shapiro, 2002; Wheeler, 2007, 2008).

Although there is debate as to whether pity is present depending on whether the patient’s suffering is deserved or not, in pragmatic terms, healthcare workers often have to show compassion to some extent irrespective of whether the suffering is perceived to be deserved or not. For instance, questions are asked whether: terrorists as well as their victims should be treated (Granot & Tabak, 2002; Margalith et al., 2008; Tabak et al., 2006); intoxicated persons should be treated (Frank, 2002); or whether patients with HIV/AIDS should receive medical care (McCann, 1997, 1999; McCann & Sharkey, 1998). The authors argue that the emotions of pity, compassion and mercy are qualities possessed by many nurses and other healthcare workers but are manifested best in the holistic ministry of faith-based organizations

**Conclusion**

Spirituality may be linked to religion and as such has relevance in the life of many people. This is particularly the case during times of loss. Nurses and other health professionals frequently share the experiences of patients and their loved ones during periods of catharsis such as approaching death. Nursing professionals have a special role in the provision of spiritual care to patients in their times of
crisis. This may involve referring patients to an appropriate chaplain or, particularly if the nurse has a personal faith, to exercise the spiritual care themselves.

Nurses and other health professionals are called upon to be compassionate to sufferers. Compassion is linked to pity, a concept developed by Aristotle that only applies when the suffering is deserved. However, medical professionals are required to attend to sufferers even when the suffering is deserved. Where they are compassionate towards undeserving sufferers they are acting without regard for self and so are acting in an altruistic manner. They may never be in a position to exercise compassion with mercy that is exemplified best in the mercy of God through the vicarious sacrifice of His only Son, Jesus. However, being in tune with their own spirituality and the spiritual needs of their patients will assist them to address the holistic needs of those they serve. This may involve them undertaking a servant role in the holistic ministry of a public or a not-for-profit healthcare organization. Showing compassion to sufferers involves caring for them in a way that is an intrinsic characteristic of nursing professionals.

Faith-based organizations are the best equipped to exercise compassion through altruistic and other programmes in a holistic ministry. However, as they need to rely on some government financial assistance to provide expensive services they face many restrictions on the way they deliver services to suffering humanity. Many of these restrictions are outcomes of the economic rationalistic policies of politicians and government bureaucrats and these are encouraged to adopt altruistic values in their decision and policy making.

References


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