



- interdisziplinären Gespräch*, ed. Günter Thomas and Isolde Karle (Stuttgart: Kohlhammer, 2009), pp. 274–89 WA TR2, No. 2194 b.
25. See e.g. WA 8, *Eyn trew vormanung Martini Luther tzu allen Christen, sich tzu vorhuten fur auffruhr unnd emporung* (1522), p. 685.
 26. WA 23, p. 363f.
 27. WA TR 1, pp. 151–2.
 28. WA TR 1, pp. 151–2.
 29. In later traditions, physical health would be emphasized as a *precondition* for repentance.
 30. WA 6, p. 459.
 31. Jean Calvin, *Commentaire de l'Épître aux Romains*, 1540.
 32. *Institutes* I.17.3.
 33. Letter to the wife of Admiral Coligny, cited in Klein, *Krankheitsdeutung*, p. 280.
 34. Cited in Volker Wels, *Manifestationen des Geistes: Frömmigkeit, Spiritualismus und Dichtung in der Frühen Neuzeit* (Göttingen: Vandenhoeck & Ruprecht, 2014), p. 96.
 35. Klein, *Krankheitsdeutung*, p. 284, cit. Ralf-Dieter Hofheinz and Ralf Bröer, 'Zwischen Gesundheitspädagogik und Kausalitätstheorie: Melanchthons "Theologie der Krankheit"', *Fragmenta Melanchthoniana*, Vol. 3 (2003), pp. 69–86.

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Compassion and responsibility for disease: Trump, tragedy and mercy

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Abstract

Thinking about compassion helps to illuminate what is pernicious and beneficial about emphasizing personal responsibility for health. This article considers whether it is 'compassionate' to see someone's disease as an embodiment of past faults. Two traditions, one Aristotelian-tragedic and the other Thomist and merciful, yield two ideas of compassion. The argument is that disease should not be conceived as something for

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which one is responsible in a way which risks the possibility of receiving treatment. But preventive medicine is conceived as a moral endeavour intertwined with the pastoral care of the sick, with discretion as to the manner and timing of any focus on responsibility.

Keywords

Aquinas, collaborative deliberation, compassion, disease, mercy, responsibility, tragedy

Introduction

Donald Trump's 2017 choice to lead Medicare and Medicaid was Seema Verma who claimed that her Healthy Indiana Plan (HIP)

... melds two themes of American society that typically collide in our health-care system, rugged individualism and the Judeo-Christian ethic. HIP combines these diametrically opposed themes by promoting personal responsibility while providing subsidized health protection to those who can least afford it.¹

What should be made of this? Personal responsibility to oneself and one's neighbours arguably belongs to *some kind of* 'ethic' rather than to a mere rugged individualism. But an ethic that emphasizes personal responsibility is, she believes, 'diametrically opposed' to a 'Judeo-Christian' ethic that privileges concern for those 'who can least afford' health protection.

Is this how a Christian ethic, at least, should conceive of personal responsibility in healthcare? The parable of the good Samaritan might give some support to this. The 'one who had mercy/compassion upon' the injured man is commended but this key parable raises no question of whether the injured man was irresponsible in taking the Jericho road, putting himself in harm's way. This is hardly an endorsement of an ethic of patients' personal responsibility but rather of taking responsibility *for others'* well-being. So perhaps Verma is both right *and* wrong on what Christian wisdom offers to US healthcare.

Focusing on responsibility presses the question of how disease should be conceived. Is disease, its prevention and its cure, in any sense rightly conceived as the patient's responsibility? If so, does this in some way reformulate what compassion means in everyday clinician practice and patient experience, whether in the USA or the NHS?

Responsibility in healthcare

Questions of responsibility characterize the collaborative relationships between patients and healthcare staff which have largely replaced paternalist attitudes. Patient choice, values and beliefs are central. In shared decision-making (SDM), 'clinicians and patients make decisions together using the best available

evidence...[and] patients are encouraged to think about the available screening, treatment, or management options and the likely benefits and harms of each'.²

Such SDM requires 'collaborative deliberation', rooted in a relational notion of autonomy 'where the two (or sometimes more) parties "dance together", figuring out who leads, and in what direction'. Collaborative deliberation 'requires that clinicians are curious about and respectful of *patients' informed preferences*, recognizing that this process should incorporate insight about emotions, gut feelings, and biases'.³ It thus 'serves as an underpinning framework for empathic clinical practice'.⁴

But 'informing and exploring preferences is not enough'.⁵ SDM should involve 'an existential journey aimed at fostering patient autonomy with the curating help of physicians who are attentive to patients' informational, emotional, and relational needs'. This relational autonomy aims to avoid both paternalism and abandonment to 'bear the burden of self-blame if things go poorly'.⁶

For collaborative deliberation might over-correct paternalism to thrust unwanted responsibility onto highly vulnerable people. Disease then transforms into the occasion of becoming a 'health-care sinner' because of poor past behaviour and ill-judged choices for future treatment, adding burdens of guilt and worry on top of the disease itself.

Thinking about compassion helps to illuminate what is pernicious and what is beneficial about personal responsibility for health. Compassion is almost universally commended as basic to healthcare. But what one thinks about responsibility in healthcare will shape the compassion one espouses. Understanding compassion in relation to responsibility will enable an at least partial diagnosis of how disease is conceived both by the one experiencing the disease and by other parties. Is it compatible with compassion to conceive of someone's disease as a consequence and embodiment of past faults and poor decisions?

Compassion in two traditions

Two classic traditions yield two ideas of compassion: *eleos* and *misericordia*. Contrasting them sheds light on how responsibility and disease should be associated.⁷

Compassion-*eleos*

Compassion-*eleos* in Aristotle and in Greek tragedy provide useful counterpoints to the Christian traditions considered below. For Aristotle's *eleos* (ἐλεος; often translated as 'pity'), *desert* is central:

Pity may be defined as a feeling of pain caused by the sight of some evil, destructive 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.⁸

Those who deserve their bad condition – including those causally responsible for their bad condition – are unworthy of ‘pity’. They may be dubbed the ‘undeserving sick’ – their sickness is so identified with their just deserts that they are undeserving of *eleos*.

This bracing option seems frankly naïve about distinguishing different causes of disease. Martha Nussbaum nuances Aristotle’s account through narratives concerning desert ‘in Homeric and tragic appeals for compassion’.⁹ She recounts how Philoctetes, an expert archer, en route to the Trojan War, trespasses on a sanctuary. The gods punish him with a snakebite which develops into a painful, pus-filled and smelly leg-wound. Being thus generally unpleasant as a companion, he is abandoned by the Greeks on an island for ten years. However, realizing they cannot defeat the Trojans without him, the Greeks return to pick him up. After various treacherous twists, Neoptolemos, conflicted about Philoctetes’ abuse and suffering, resolves to help him.

Nussbaum’s nuance is that it is

not inconsistent with [Aristotle’s] account to have compassion for people for things they do out of their own bad character or culpable negligence – so long as one can either see the suffering as out of all proportion to the fault *or* view the bad character or negligence as itself the product of forces to some extent excusably beyond the person’s control.¹⁰

Moreover, in a passage oddly neglected by Nussbaum, Philoctetes bitterly rejects the assistance offered. And so Neoptolemos addresses him thus:

Men must bear the fortune given them by the gods. But those who are set upon by damage that is of their own doing, such as yourself, it is just neither to have sympathy for them, nor to pity them. You have become an animal, and refuse all advice: if someone, thinking on your behalf, does give advice, you hate him, you consider him an enemy.¹¹

In collaborative deliberation, such *eleos* would entail compassion for misfortune but not for patients who reject help, making their condition worse. The unjustly treated if ‘undeserving sick’ receive compassion; but not the apparently subhuman and ‘obstinate sick’.

In summary, there is some discretion for how compassion relates to responsibility and desert. Compassion-*eleos* is ‘a painful emotion occasioned by the awareness of another person’s undeserved misfortune’.¹² Those responsible for their suffering – those who have ‘brought it on themselves’ – are not deserving of compassion-*eleos* although certain factors may mitigate this. In particular, compassion-*eleos* is not appropriate to those who reject help to address their current suffering or to prevent future suffering.

Compassion-misericordia

Aquinas interprets the *eleos* Jesus commends and the inner, bowel-level response of the Samaritan to the injured man (ἐσπλᾶγχνίσθη, *esplanchnisthē*) in terms of *misericordia*.¹³ Developing but qualifying some of Aristotle's insights and building on Augustine, he writes that:

...mercy is heartfelt compassion for another's misery, a compassion which drives us to do what we can to help him. Indeed the Latin word for mercy, *Misericordia*, comes from one's heart being miserable (*miserum cor*), at the sight of another's distress. Now misery is the opposite of happiness. But it is of the essence of beatitude or happiness that a man gets what he wants: *Happy the man*, says Augustine, *who has everything he wants and wants nothing that is evil*. Hence misery, on the other hand, implies that a man suffers against his will.¹⁴

Aquinas is thinking through how virtues proper to human life relate to joy and the hope of a stable, loving friendship with God. Happiness is not simply getting what you want but wanting that which is good – that is, friendship with God – and getting it. So how are compassion and responsibility interrelated? Aquinas argues that:

...there is a sense in which fault itself is punishment, in so far that there goes together with it, something against the will of the sinner, and in this way it can be considered deserving of mercy...¹⁵

...mercy is a kind of sadness. Now the reason for sadness is always some weakness; that is why...sick people become sad more easily than others. It follows that the reason why one person has mercy on another is because he himself suffers some weakness.¹⁶

The reason given elsewhere for this claimed propensity to sadness among the sick is that harms suffered by those already sick are felt more grievously.¹⁷ Thus Aquinas claims that the conditions people experience on account of their faults are suffering enough: something is happening against their will to be happy (even if, as Aquinas allows, happiness is not conceived as friendship with God). This thwarting of the will is, he thinks, punishment enough for any fault which has contributed to their condition.

Mercy or *misericordia* emerges as sadness which arises because of weakness: weakness, generally speaking, in the one exercising *misericordia* just as much as the one receiving it; weakness, specifically, in the form of disease, which may or may not be linked to some specifically *moral* weakness. The conception is not of the undeserving or obstinate sick but rather of the 'sad sick'. But to talk of the sad sick is not necessarily to dismiss issues of responsibility regarding any sin which engenders sickness and sadness.

An experienced hospital chaplain comments that

...the relationship between a person's way of life, sin and disease in many cases is obvious and often lurks in the background of conversation with patients. ...[exoneration is not] a theologically proper or humanly helpful answer to the question concerning some one's own responsibility for the event of having become sick.¹⁸

Sin is to be reckoned with, not treated as a category inapplicable to disease. Honestly examining responsibility rather than inappropriately ignoring it (exoneration) makes conceivable a compassion-*misericordia* in which responsibility for disease is treated with leniency. This attitude stems from God's providence, justice and mercy, which aims to restore sinners to friendship with God. It accompanies an understanding of human weakness, negligence and deliberate fault. This in no way implies downplaying the accidental conditions of life and diseases which simply come upon us. However, questions concerning those matters for which we are, more or less, responsible are not neglected.

This merciful mental process, properly routinized, will cultivate an attitude of *compassionate candour* in collaborative deliberation with those who suffer disease, engaging in past faults and future responsibilities where relevant and appropriate. Disease is not necessarily an alien intrusion unrelated to the subject's agency but may somehow be interwoven with it. At the same time, compassion-*misericordia* rejects a judgementalism which ignores other party's faults and responsibilities, underplays environmental factors or requires more strength than people can muster. What emerges is an ethos of lenient if searching accommodation of persons in their weakness, failure and faults amidst the accidents of life.

If fault is reckoned with and yet treated with the heartfelt sadness of mercy, what follows for the subjective self-awareness of the sufferer, the *self-conception* of disease? The chaplain comments that:

Disease, insofar as it is experienced as a life crisis, can awaken a person to a dimension of sin which encompasses and determines his life as a whole, and which cannot be limited to a moral guilt in view of singular actions.¹⁹

Such awakenings hardly imply that suffering or its likely onset always makes people 'come to their senses' and change their lives. Evidence suggests that taking responsibility for healthy behaviour change is seldom primarily associated with understanding one's genetically informed risk profile. Indeed, connecting health and disease with more subtle sources of self-understanding seems a more psychologically plausible way to encourage responsibility taking.²⁰

Thus, such awakenings are potentially significant pastoral matters inasmuch as they concern the perception of the self's responsibility for disease. A distinction is important here. Awakening to responsibility in SDM as a *prospectively* oriented

activity differs from self-perceptions informed by a solely *retrospective* introspection about one's responsibility for disease. In SDM the dangers lie principally in a perhaps unwanted level of patient choice and that 'burden of self-blame if things go poorly'.²¹ Nonetheless, pastorally speaking, a psychologically plausible process of collaborative deliberation must incorporate *some* retrospective consciousness of how past unhealthy ways of life may contribute to a poor outcome to any prospective treatment decision made.

So how should compassionate, candid, collaborative deliberation incorporate, with pastoral sensitivity, this complex self-awareness regarding responsibility both for disease and its treatment? Self-consciousness is associated with conscience in Christian thought – a self-conception which may involve both approving and disapproving thoughts. To give rise to a bad conscience but then fail to support change – pastorally, clinically and environmentally – seems as irresponsible as denying the possible benefits of a troubled conscience is implausible.²²

To develop this pastoral line, Aquinas cites St Augustine to demonstrate that what he calls fraternal correction is itself a feature of compassion-*misericordia*:

it is...the discretion of charity that makes us spare evil-doers, not rebuking them or chiding them on the spot, but waiting to find a more favourable occasion; or again because we fear that it will only make them worse, or cause them to hinder and oppress others who are weak and need instruction in a life of goodness and piety, even to the extent of turning them away from the faith.²³

What it is pastorally wise to say and do is again seen against the horizon of friendship with God through faith. Wisdom involves picking your moment or, in some cases, avoiding any reckoning with responsibility altogether. At the same time, there may be real benefit through an early, pastoral engagement with responsibility for disease. This may be particularly relevant when others are directly affected by one's actions. I think of the mother I heard movingly describe her daily self-reproach for the wrong she thought she had done her child by smoking during pregnancy.

Pastorally speaking, while giving space for acknowledgement of personal responsibility, Christian thought recognizes that circumstances which cause ill health are commonly complex. This clearly matters for how disease is conceived. The Reformed Protestant tradition, for example, emphasizes that sin is both personal and environmental – people's health is buffeted by forces and factors not simply within their control.²⁴

Similarly, over against Aristotle's perhaps naïve view, disease is only rarely attributable to a single cause. Accordingly, since causal factors are so conflated, while there is a willingness to get down to granularity about personal responsibility for health and disease, for many Christian thinkers, there is also a deeper unwillingness to link such responsibility to sanctions – e.g. the refusal to provide treatment. Moreover, precisely because people's experience of ill health may itself be

psychologically debilitating, the tendency narrated by Sophocles to regard the obstinate sick as subhuman is guarded against.

On this, Ruth Groenhout warns that

The language of sin often doesn't arise in the healthcare context... When it does arise it lends itself easily to fairly simplistic types of individual blame and shame.²⁵

This admittedly deep problem of attributing responsibility for disease in ways which are sophisticated with respect to causality and human psychology does not make the attribution of responsibility an inappropriate activity in every circumstance – just a very difficult one. It is not that sin does not exist with respect to health but rather that finding appropriate ways of identifying it and *enabling liberation from it*, thereby limiting its destructive nature, requires immense pastoral wisdom.

In summary, any attempt to interrelate retrospective and prospective reckoning with responsibility requires the discretion and pastoral insight of compassion-*misericordia*. Engaging sorrowfully with the sad weakness, negligence and deliberate fault of patients as responsible citizens, amidst the accidents of life, is not only permissible but commonly necessary. However, it is hemmed in very tightly indeed by pastoral sensitivity to self-awareness defined by conscience and to alertness to how those who shape the structures and environments which surround health are also bearers of responsibility. As Scott Rae puts it, writing from a US perspective,

While still taking personal responsibility seriously, it is often difficult to hold someone fully responsible for choices that have been impacted by the systemic components of sin. This is why as a society we have been reluctant to give much weight to the concept of desert as a criterion for the distribution of healthcare resources... However, if one's lifestyle makes them non-cooperative as patients and unwilling to contribute to their care, that may be a factor in their future course of treatment.²⁶

Similarly, Eibach, writing from a German perspective, agrees but claims that in order to encourage the personal responsibility which will underpin 'preventive medicine'

...it should be the churches' task to make it clear once again that human life is not man's property, but a unique gift of God, and that man is responsible for his use of this gift in the eyes of God. Man can indeed become guilty with regard to his body and his life, and he must stand up for this guilt in the eyes of God.²⁷

Conclusion

The parable of the Good Samaritan is important to understanding the interrelation of compassion and responsibility. There is a basic neighbourly duty of compassion

towards the sick whatever the circumstances. Nonetheless, we need a wider view to understand the complex psychology which is at work in conceiving disease within healthcare. On one level, there is the question of the psychological attitude of compassion towards those in need. Nussbaum's attention to Aristotle and Greek tragedy draws out how compassion, both in attitude and in practical outworking, may be defined not only by past circumstances and failings but also by the present behaviour of the sick including their refusal to accept help.

However, for the Christian authors considered here, disease is not conceived as something for which one is responsible in a way which puts at risk the possibility of receiving treatment: disease is not reduced into personal agency in ways which bind burdens of responsibility indiscriminately on people's backs. Even if there is the possibility of not receiving treatment, the agent's *past* moral responsibility is not thought decisive but rather the likely benefit to the patient who is perhaps 'non-cooperative' or 'unwilling' to care for themselves. This leads to an affirmation both of preventive medicine as a moral endeavour and of the pastoral care of the sick, with discretion as to the manner and timing of any focus on responsibility.

This is neither Seema Verma's rugged individualism, nor is it simply protection for the most vulnerable, a compassion apparently pure and unalloyed by considerations of responsibility. It is a pastorally sensitive, multi-layered attention to personal responsibility, which simultaneously locates that responsibility within a complex web of responsibilities. This seems vital to a workable Christian ethic of compassion for the new shape of healthcare, in which many patients increasingly have responsibility both in decision-making and in managing their own care, both in the US system and in the UK's NHS.

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Notes

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4. Elwyn et al., 'Collaborative Deliberation', p. 162.
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6. Elwyn et al., 'Collaborative Deliberation', p. 162.

7. The exploration of compassion here sheds light on how the term should be distinguished from 'empathy' as deployed in the articles by Graham Collins and Katherine Southwood in this issue. Though the issue requires greater space than is possible here, my analysis of compassion suggests that 'empathy' is not an emotion as such (*pace* Carel as cited by Southwood), though it may partially constitute the imaginative element of compassion which Nussbaum describes (see below). For another view of 'empathy', see Jeremy Howick and Sian Rees, 'Overthrowing Barriers to Empathy in Healthcare: Empathy in the Age of the Internet', *Journal of the Royal Society of Medicine*, online publication (June 2017) <<https://doi.org/10.1177/0141076817714443>>.
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9. Martha Nussbaum, *Upheavals of Thought* (Cambridge: Cambridge University Press, 2003) p. 312.
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13. Luke 10.33–37.
14. Aquinas, *Summa Theologiae* (ST) 2a2ae 30a1resp (trans. R. J. Batten; Cambridge: Cambridge University Press, 2006); citing Augustine, *City of God* 9.1 and *On the Trinity* 13.5.
15. Aquinas, ST 2a2ae 30a1ad1.
16. Aquinas, ST 2a2ae 30a2sed.
17. Aquinas, ST 2a2ae 47a3.
18. Ulrich Eibach, 'Life History, Sin, and Disease', *Christian Bioethics*, Vol. 12 (2006), pp. 117–31 (p. 117); cf. Scott Rae, 'On the Connection Between Sickness and Sin: A Commentary', *Christian Bioethics*, Vol. 12 (2006), pp. 151–6 (p. 154).
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24. See Ruth Groenhout, 'Not Without Hope: A Reformed Analysis of Sickness and Sin', *Christian Bioethics*, Vol. 12 (2006), pp. 133–50.
25. Groenhout, 'Not Without Hope', p. 148.
26. Rae, 'On the Connection Between Sickness and Sin', p. 153.
27. Eibach, 'Life History, Sin, and Disease', p. 130.

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