
Regulating for compassion?

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In 2009, the Health and Disability Commissioner considered whether a right to be treated with compassion should be added to New Zealand's Code of Health and Disability Services Consumers' Rights. Before making his recommendation, the Commissioner explored the nature of compassion, its place as a virtue in medicine, and the implications of the proposed law change.

INTRODUCTION

Coriolanus, the legendary 5th century BC warrior who turned against his native city for banishing him, is painted by Shakespeare as the paragon Stoic warrior. Physically strong and detached, at home in the battlefield, he is the military man par excellence. Fearless, he sheds few tears. But the turning point in Shakespeare's play comes when Coriolanus remembers how to weep. He admits that "[i]t is no small thing to make mine eyes sweat compassion".¹

According to a petition from the Auckland-based Centre for Compassion in Healthcare, all health professionals, care workers, and organisations providing health care in New Zealand should be required to treat patients with compassion. 529 people (including many nurses and doctors, and even one former Director-General of Health) signed the petition, urging that the right to be treated with compassion be added to New Zealand's *Code of Health and Disability Services Consumers' Rights* (the Code). They submitted that every consumer should have the legal right "to have services provided with compassion, including a prompt and humane response to suffering".

This article discusses the nature of compassion and the implications of the proposed law change. The context of the debate is the recent review of the *Health and Disability Commissioner Act 1994* (NZ) (the Act) and the 1996 Code, which the Commissioner is required to undertake every five years, leading to a report with recommendations which the Minister of Health must table in Parliament.

WHAT IS COMPASSION?

Compassion has several shades of meaning. This was evident at a consultation meeting early in 2009, when sign language was used to ask deaf consumers about a right to compassion. It prompted a strong, negative reaction: some interpreted it as pity, others as passion or sex! Nobody wanted it.

"Compassion" can be traced to its Latin roots: "cum" (with) and "patior" (to suffer). (Note that this is also the root of the word "patient".) This meaning is well captured in the *Oxford English Dictionary*, which defines compassion as "suffering together with another" or "fellow-feeling".²

For Christians, compassion is inextricably bound up with Christ's suffering for humanity on the cross – taking the suffering of the world upon himself. In scripture, we often read that Jesus was "moved with compassion"³ and, in the parables, this response is mirrored in the story of the return of the prodigal son: "But when he was yet a great way off, his father saw him, and had compassion, and

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¹ Shakespeare W, *The Tragedy of Coriolanus*, Act V, Scene III, cited in Sherman N, "It is No Little Thing to Make Mine Eyes Sweat Compassion": APA Comments of Martha Nussbaum's Upheavals of Thought" (2004) 68(2) *Philosophy and Phenomenological Research* 458.

² *Oxford English Dictionary* (2nd ed, Oxford University Press, Oxford, 1989).

³ *King James Bible*, see eg Mark 6:34, Luke 7:13 (Cambridge University Press, London).



ran, and fell on his neck, and kissed him.”⁴ Compassion is presented as a virtuous response: “But whoso hath this world’s good, and seeth his brother have need, and shutteth up his bowels of compassion from him, how dwelleth the love of God in him?”⁵ In the Christian faith, the stirring of compassion prompts a response.

Compassion also plays a central role in many other faiths, including Buddhism. The Dalai Lama calls it “the universal message of all traditions” and sees it as the key to global happiness.⁶

Modern philosophers offer a different slant on compassion. Nussbaum draws on the Stoics in her account of compassion in her major treatise, *Upheavals of Thought*.⁷ She defines it as “the painful emotion caused by the awareness of another person’s undeserved misfortune”.⁸ It has three cognitive elements: that the harm suffered is serious; the misfortune is not the person’s fault; and the object of compassion is worthy of the concern of the bystander.⁹

I am troubled by Nussbaum’s notion of deserts.¹⁰ I can see that some inconsequential harm (the grazing of a knee) may move us to sympathy, without arousing compassion. But when, as a rehabilitation worker, I meet a newly paralysed young man, is my fellow-feeling only to be characterised as compassion if he has been injured in a motor vehicle accident, rather than in a rugby game or a failed suicide attempt?

I will leave it to the philosophers to debate Nussbaum. I want to turn to compassion in health care. Robin Youngson, the Auckland anaesthetist who has led the campaign to add the right to be treated with compassion to the Code, defines compassion as “the humane quality of understanding suffering in others and wanting to do something about it”.¹¹ This is close to the *Oxford English Dictionary* definition of compassion as “the feeling or emotion when a person is moved by the suffering or distress of another and by the desire to relieve it”.¹² The focus is on the feelings and motivations of the practitioner.

TREATMENT WITH COMPASSION

Shifting gear, what is *treatment* with compassion? The petitioners for change proposed a “right to be treated with compassion”, to be defined in law as “the right to have services provided with compassion, including a prompt and humane response to distress, pain and suffering”.¹³

Few would quarrel with the notion that health practitioners and institutions might be required to respond promptly and humanely to distress, pain and suffering (subject to some sort of reasonable limits defence). Note that this is not the same as a right to have suffering relieved, something that may be unattainable. The focus is simply on the swiftness and humanity of the response. As discussed below, the duty of care enshrined in the Code is already broad enough to require services to be delivered in a way that minimises harm to the patient.¹⁴ But is this the same as requiring services to be provided “with compassion” – with fellow-feeling for the patient? Is this susceptible of proof? And even if it is, can it sensibly be legally mandated?

⁴ *King James Bible*, Luke 15:20 (Cambridge University Press, London).

⁵ *King James Bible*, 1 John 3:17 (Cambridge University Press, London).

⁶ See Chatenever R, “Compassion at the Center”, *Maui News* (Hawaii, 26 April 2007), <http://www.dalailama.com/news/post/113-tibet-dalai-lama-compassion-at-the-center> viewed 6 August 2010.

⁷ Nussbaum M, *Upheavals of Thought: The Intelligence of Emotions* (Cambridge University Press, Cambridge, 2001).

⁸ Nussbaum, n 7, p 301.

⁹ Nussbaum, n 7, p 306.

¹⁰ Nussbaum qualifies her account by recognising that if the harm suffered is “beyond” or disproportionate to the fault, it may still prompt compassion: Nussbaum, n 7, pp 311-314.

¹¹ Centre for Compassion in Healthcare, *Add “Compassion” to HDC Code of Rights Petition*, <http://www.petitiononline.com/compassn/petition.html> viewed 6 August 2010.

¹² *Oxford English Dictionary*, n 2.

¹³ Centre for Compassion in Healthcare, n 11.

¹⁴ *Code of Health and Disability Services Consumers’ Rights*, Right 4(4).



The Centre for Compassion in Healthcare submits that a lack of compassion will usually be obvious, because an ordinary person would judge that the consumer has suffered unnecessarily. I am reminded of United States Supreme Court Justice Potter Stewart's definition of "hardcore pornography": "I know it when I see it."¹⁵ Leaving it to the judiciary to decide what is art and what is pornography is problematic enough; asking a Commissioner to decide whether a consumer has suffered unnecessarily strikes me as a potentially vexed exercise. It would entail asking: How much did this person suffer? How much of their suffering could have been alleviated? What steps should the practitioner have taken out of compassion to relieve their suffering? These are deep waters.

THE VIRTUE OF COMPASSION IN MEDICINE

Compassion has long been identified as an essential virtue in Eastern and Western medicine. The 7th century Chinese physician Sun Simiao describes the Ideal Physician as one who develops "a heart of great mercy and compassion" which prompts him to respond thus:

Seeing the patient unwell, a physician should feel as if he himself had been struck down. With deep sympathy welling up from the bottom of his heart, a physician should not merely appear to have done his best but get involved wholeheartedly.¹⁶

The 12th century Jewish philosopher-physician Maimonides also identified the need for fellow-feeling in the medical practitioner. He prayed, "May I never forget that the patient is a fellow creature in pain. May I never consider him merely a vessel of disease."¹⁷ Skipping forward to 1927, Boston physician Francis Peabody famously wrote: "One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in *caring for* the patient."¹⁸

The image of the caring doctor has been mirrored in the views of patients. In *Middlemarch*, George Eliot portrays a typical Victorian view of the good doctor:¹⁹

Many of us looking back through life would say that the kindest man we have ever known has been a medical man, or perhaps that surgeon whose fine tact, directed by deeply-formed perception, has come to us in our needs with a more sublime beneficence than that of miracle-workers.

Sublime beneficence. Small wonder that across the Atlantic in 1847, the American Medical Association in its first *Code of Ethics* could be emboldened to stipulate, as a *patient* obligation, that "a patient should, after his recovery, entertain a just and enduring sense of the value of the services rendered him by his physician; for these are of such a character, that no mere pecuniary acknowledgement can repay or cancel them".²⁰ Fildes' iconic 1891 painting of "The Doctor" was intended "to put on record the status of the doctor in our time".²¹

Much has changed in "the silent world of doctor and patient",²² not least in the recognition of patient autonomy as a cornerstone of the relationship. But the pendulum swings. In recent years there has been a re-emergence of emphasis on an ethic of caring. In part this is a response to the sterility of

¹⁵ *Jacobellis v Ohio* 378 US 184 at 197 (1964). The United States Supreme Court held that the *Constitution* protected all obscenity except "hard-core pornography", of which Stewart J famously said: "I shall not today attempt further to define the kinds of material I understand to be embraced within that shorthand description; and perhaps I could never succeed in intelligibly doing so. But I know it when I see it." The court ruled that the State of Ohio could not ban the showing of the 1958 French movie *Les Amants* in a Cleveland Heights theatre.

¹⁶ Simiao S, *Beiji Qianjin Yaofang*, Lun Dayi Xiye, cited in Paul C, "A Question of Compassion" (15-21 August 2009) 220(3614) *New Zealand Listener*, <http://www.petitiononline.com/compassn/petition.html> viewed 6 August 2010.

¹⁷ Cited in Lown B, *The Lost Art of Healing* (Houghton Mifflin, Boston, 1996) p xix.

¹⁸ Peabody F, "The Care of the Patient" (1927) 88(12) *JAMA* 877 at 882.

¹⁹ Eliot G, *Middlemarch* (London, 1874) p 720.

²⁰ American Medical Association, *Code of Ethics of the American Medical Association* (American Medical Association Press, Chicago, 1847) Art 2.10.

²¹ "Doctors and Surgeons in Art", *The Times of London* (17 March 1959) p 13, cited in Verghese A, "The Gordon Wilson Lecture: 'The Doctor in Our Own Time': Fildes' Famous Painting and Perceptions of Physician Attentiveness" (2008) 119 *Transactions of the American Clinical and Climatological Association* 117 at 119.

²² Katz J, *The Silent World of Doctor and Patient* (Free Press, Macmillan Inc, New York, 1984).



focusing on patient autonomy in a narrow, legalistic way. It also reflects a sense that patients are overlooked in the world of high-tech medicine. Doctor and anthropologist Cecil Helman writes of the paradox that “modern society ... pays lip service to individualism, while at the same time reducing individuals themselves to standardised, impersonal, disposable entities”.²³ Hospitals, he says, have become factories that “turn us from people into products at a very crucial time in our lives, a time of anxiety and ambiguity, where the very threads that hold our sense of personhood together are in danger of being torn apart”.²⁴

Boston physician Bernard Lown describes medicine as having indulged in a Faustian bargain. A three-thousand year tradition, which bonded doctor and patient in a special affinity of trust, is being traded for a new relationship. Healing is replaced with treating, caring is supplanted with managing, and the art of listening is taken over by technological procedure ... The distressed human being is frequently absent from the transaction.²⁵

A cardiologist, Lown calls upon doctors to listen to their patient’s heart, in a book entitled *The Lost Art of Healing: Practicing Compassion in Medicine*.

On the patient’s side, the yearning for compassion is beautifully evoked by essayist and a former editor of the *New York Times Book Review* Anatole Broyard, who writes of the psychological and spiritual challenges in facing metastatic prostate cancer. “I’d like my doctor to scan me, to grope for my spirit as well as my prostate. Without some recognition, I am nothing but my illness.”²⁶ Broyard wishes that his doctor would “give me his whole mind just once, be bonded with me for a brief space, survey my soul as well as my flesh”.²⁷ Note his use of the word “give”.

The absence of compassion in health care is increasingly remarked upon. “Help Me, Nurse” – “The Lost Art of Caring” was the cover story of a 2009 issue of the *New Zealand Listener*.²⁸ The calls for compassion in health care have struck a chord, both in the local campaign and in movements abroad. In the United States, the Kenneth B Schwarz Center sponsors “compassion rounds”: multidisciplinary forums in which caregivers discuss difficult emotional issues that arise in caring for patients.²⁹ In Lord Darzi’s June 2008 review of the National Health Service in England, compassion is identified as a core value, described as follows:

We find the time to listen and talk when it is needed, make the effort to understand, and get on and do the small things that mean so much – not because we are asked to but because we care.³⁰

Yet the shiny new NHS Constitution, issued in January 2009, distinguishes between values (including compassion), which should “guide” the health service, and rights (including treatment with dignity and respect), to which patients are legally entitled.³¹

CONTEMPORARY CODES OF ETHICS

What of health professional codes of ethics? There is no mention of compassion in the Hippocratic Oath, which dates from the 4th century BC, but it does appear in several contemporary codes of ethics. The American Medical Association’s *Code of Medical Ethics* (2001) states, as its first principle,

²³ Helman C, *Suburban Shaman: Tales from Medicine’s Frontline* (Hammersmith Press, London, 2006) p 167.

²⁴ Helman, n 23, pp 160-161.

²⁵ Lown, n 17.

²⁶ Broyard A, *Intoxicated by My Illness: and Other Writings on Life and Death* (C Potter, New York, 1992) p 45.

²⁷ Broyard, n 26, p 44.

²⁸ Boland M, “Help Me, Nurse” (11-17 April 2009) 218 (3596) *New Zealand Listener*, http://www.listener.co.nz/issue/3596/features/13106/help_me_nurse.html viewed 6 August 2010.

²⁹ See *When Caregivers and Patients Connect, Everybody Feels Better*, <http://www.theschwartzcenter.org> viewed 6 August 2010.

³⁰ Darzi A and United Kingdom Department of Health, *High Quality Care For All – NHS Next Stage Review Final Report* (Stationary Office, Norwich, 2008).

³¹ United Kingdom Department of Health, *The NHS Constitution – The NHS Belongs to Us All* (21 January 2009), http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613 viewed 6 August 2010.



that “[a] physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights”.³² In New Zealand, compassion appears as a principle in the New Zealand Medical Association’s *Code of Ethics* (2008): “Practise the science and art of medicine to the best of your ability with moral integrity, compassion and respect for human dignity.”³³ It forms part of the “underlying philosophy” identified in the New Zealand Nurses Organisation’s *Code of Ethics* (2001), which describes “caring” as the moral foundation of nursing, and notes that it encompasses “the concepts of compassion, commitment, congruence, confidence, conscience, culture, collaboration, communication and consultation *amongst others*”³⁴ (those nurses sure know how to hit the high Cs!). The Australian Medical Association’s *Code of Ethics* (2006) goes a step further, and expects the doctor to “treat your patient with compassion and respect”.³⁵ This ethical mandate comes very close to the proposed legal requirement in New Zealand.

THE SCOPE OF THE NEW ZEALAND CODE OF CONSUMERS’ RIGHTS

What rights are recognised in the New Zealand legislation? The *Code of Health and Disability Services Consumers’ Rights* is a regulation made under the *Health and Disability Commissioner Act 1994* (NZ).³⁶ It prescribes 10 rights (actually nine, since one is really an application provision, extending the rights to participation in teaching and research),³⁷ and all open with, or contain, the words “every consumer has the right”. In true Hohfeldian spirit, every right is matched by a correlative duty. Clause 1(2) of the Code states, “Every provider is subject to the duties in this Code.”

All the duties are overlaid with a standard of reasonableness: it is a defence for providers to show that they took “reasonable actions in the circumstances”.³⁸ Providers are required to “inform consumers of their rights” and “enable consumers to exercise their rights”.³⁹ Failure to fulfil their legal duties may result in a provider being subject to a complaint to the Health and Disability Commissioner. This may lead to a formal investigation and finding that the provider breached the consumer’s rights, opening the way to a civil claim before the Human Rights Review Tribunal (with a limited power to award damages) and, in cases of significant failure, to professional discipline.⁴⁰ In other words, these rights are not merely aspirational statements of the sort found in codes of ethics, or even in charters of patients’ rights, such as the recently promulgated *Australian Charter of Healthcare Rights*.⁴¹ The New Zealand rights are legally enforceable.

The rights in the New Zealand Code are confined in scope by the authorised ambit of the enabling statute. Section 20 of the *Health and Disability Commissioner Act* requires the Code to contain rights relating to the principle of informed consent, measures to enable effective communication, complaint procedures, and the provision of services of an appropriate standard, in a manner that respects the dignity and independence of the individual, and that takes into account the needs, values and beliefs of different cultural, religious, social, and ethnic groups. Two observations in passing: these are rights *in*

³² American Medical Association, *Code of Medical Ethics* (17 June 2001).

³³ New Zealand Medical Association, *Code of Ethics* (rev 2008), Principle 4.

³⁴ New Zealand Nurses Organisation, *Code of Ethics* (rev 2001) p 11.

³⁵ Australian Medical Association, *Code of Ethics* (2004, rev 2006) at 1.1(b).

³⁶ *Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996* (NZ), made pursuant to the *Health and Disability Commissioner Act 1994* (NZ), s 74(1).

³⁷ *Code of Health and Disability Services Consumers’ Rights*, Right 9.

³⁸ *Code of Health and Disability Services Consumers’ Rights*, cl 3.

³⁹ *Code of Health and Disability Services Consumers’ Rights*, cl 1(3).

⁴⁰ *Health and Disability Commissioner Act 1994* (NZ), ss 49, 50.

⁴¹ Australian Commission on Safety and Quality in Healthcare, *Australian Charter of Healthcare Rights* (22 July 2008), <http://www.health.gov.au> viewed 6 August 2010.



health care, rather than rights *to* health care, so the Code cannot include a right to access services;⁴² and it is doubtful whether a right to be treated with compassion falls within the permitted scope of the Code, so the Act itself would probably need to be changed to authorise a specific new right.

In an interesting exercise of participatory democracy, the first Commissioner was required to conduct a national consultation and solicit “a wide range of views” on the specific rights to be codified, and to forward a draft Code to the Minister of Health for tabling in Parliament and enactment (subject to any revisions, which, if “material”, had to be justified in a statement of reasons, also tabled in Parliament).⁴³ The need for treatment with respect and dignity appears to have loomed large in consultations with the public about the Code, but there is no mention of the desirability of regulating for compassion in the consultation documents.⁴⁴ Perhaps it was not high on the priority list in the mid-1990s, although I suspect that the crisis of compassion was already evident in the health sector at that time. More likely, it was not seen as a permitted or even an appropriate subject of regulation.

The Code was enacted in 1996. It contains specific rights relating to effective communication,⁴⁵ to be properly informed⁴⁶ and to give or withhold consent,⁴⁷ to be free from discrimination and exploitation,⁴⁸ to have support,⁴⁹ and to make a complaint and get a reasoned response.⁵⁰ Three rights are conceptually more akin to the proposed right of treatment with compassion:

- Right 1, “the right to be treated with respect”;
- Right 3, “the right to have services provided in a manner that respects the dignity and independence of the individual”; and
- Right 4, which can be summarised as the right to “due care”.

The component parts of what I have called “due care” are interesting. It encapsulates not only the common law requirement of “reasonable care and skill”,⁵¹ but also compliance with “professional, ethical, and other relevant standards”⁵² (thus an ethical duty may become a legal obligation); and even service provision “in a manner that minimises the potential harm to, and optimises the quality of life” of the consumer.⁵³ But wait, there’s more! The New Zealand Code actually defines “optimise the quality of life” to mean “to take a holistic view of the needs of the consumer in order to achieve the best possible outcome in the circumstances”.⁵⁴ Might this not come close to Broyard’s plea to his doctor to grope for his spirit?

So, to summarise, the Code requires both technically competent care and adherence to basic principles of respect and dignity, and it comes close to a duty to *care for* the patient; but it falls short of requiring treatment with compassion.

⁴² Arguably a right of access by disability services consumers may be permitted by s 20(2)(a) of the *Health and Disability Commissioner Act 1994* (NZ), which authorises the Code to provide for “[a]ny matter relating to the rights of disability services consumers that the Commissioner considers is of particular importance to such consumers”.

⁴³ *Health and Disability Commissioner Act 1994* (NZ), s 19.

⁴⁴ Health and Disability Commissioner, *A Proposed Draft Code of Rights for Consumers of Health and Disability Services: A Resource for Public Consultation on the Proposed Draft Code* (1995); and Health and Disability Commissioner, *Draft Code of Health and Disability Services Consumers’ Rights: Consultation Analysis*, discussed in Skegg P, “The New Zealand Code of Health and Disability Services Consumers’ Rights” (1997) 5 JLM 124.

⁴⁵ *Code of Health and Disability Services Consumers’ Rights*, Right 5.

⁴⁶ *Code of Health and Disability Services Consumers’ Rights*, Right 6.

⁴⁷ *Code of Health and Disability Services Consumers’ Rights*, Right 7.

⁴⁸ *Code of Health and Disability Services Consumers’ Rights*, Right 2.

⁴⁹ *Code of Health and Disability Services Consumers’ Rights*, Right 8.

⁵⁰ *Code of Health and Disability Services Consumers’ Rights*, Right 10.

⁵¹ *Code of Health and Disability Services Consumers’ Rights*, Right 4(1).

⁵² *Code of Health and Disability Services Consumers’ Rights*, Right 4(2).

⁵³ *Code of Health and Disability Services Consumers’ Rights*, Right 4(4).

⁵⁴ *Code of Health and Disability Services Consumers’ Rights*, cl 4.



COMPLAINT DECISIONS

The published decisions of the two Commissioners have put flesh on the bones of the Code. As Commissioner from 2000 to 2010, I saw many complaints fuelled by the absence of compassion. Yet I never felt constrained, by the lack of a specific right to compassion in the Code, from holding a provider to account for callous conduct.

In some well-publicised decisions, I found providers in such circumstances in breach of the Code: for example, Capital and Coast District Health Board, for the neglectful care of a 50-year-old man who struggled for breath as he lay dying at Wellington Hospital in 2004.⁵⁵ I stated (p 106):

Patients who have been admitted to hospital because they are acutely unwell are especially in need of care, comfort and compassion. As well as suffering from their present illness, they are likely to be frightened by the unfamiliar hospital environment and fearful for the future.

The District Health Board was held in breach of its basic duty of care under Right 4 of the Code.

Sometimes the rights to respect and dignity are found to be breached, as was the case for three elderly patients left waiting in an overcrowded emergency department at North Shore Hospital in the winter of 2007. In my inquiry report in April 2009, I commented:⁵⁶

All hospital patients, especially acutely unwell senior citizens, deserve clean facilities, comfortable waiting areas, and responsive services. A lack of hygiene and long waits in uncomfortable conditions are an affront to patient dignity and a breach of legal rights.

Waitemata District Health Board was found in breach of Rights 1 and 3 (respect and dignity).

Cases of neglect, disrespect and indignity clearly fall within the ambit of the Code, and subject to adequate proof of the offending conduct, will lead to some form of formal or informal sanction. But what of more intangible but no less significant wrongs? The Centre for Compassion in Healthcare petition cites situations “when consumers are addressed with unfeeling detachment, when emotional needs are brushed aside, when apology or support is denied, and when hope is needlessly extinguished”.⁵⁷ Is a law change necessary to address these shortcomings?

The Commissioner’s office (HDC) sees cases like this. Two come to mind. First is the case of the fearful middle-aged woman who consults a general surgeon in private about a procedure to confirm whether she has pancreatic cancer, recently diagnosed by her local specialist. The diagnosis is later confirmed when she has the procedure, following frustrating delays and miscommunication. But at the heart of her complaint⁵⁸ lay two thoughtless acts by the surgeon. He interrupts the consultation to take a long telephone call about a business matter. And he says that he will be away for all of January, commenting: “If I don’t have a holiday, I might die.” The first act is clearly disrespectful, and the second is grossly insensitive. This is the sort of conduct that Arthur Frank examines in an essay entitled “How Can They Act Like That?”⁵⁹ There is no evidence here of “the humane quality of understanding suffering in others and wanting to do something about it”.⁶⁰

In the second case, a mother receives a telephone call that her adult son (whom I will call Peter) is very ill in a hospital at the other end of the country, having been found in a motel (while away on a work trip), unconscious from a massive brain bleed. She gets the first flight and within a few hours is at her son’s bedside, with his wife. In her own words:

⁵⁵ *Capital and Coast District Health Board: A Report by the Health and Disability Commissioner* (Case 05HDC11908, 22 March 2007), <http://www.hdc.org.nz/decisions--case-notes/commissioner's-decisions/2007/05hdc11908> viewed 6 August 2010.

⁵⁶ *North Shore Hospital March to October 2007: A Report by the Health and Disability Commissioner* (Case 07HDC21742, April 2009), <http://www.nzdoctor.co.nz/media/6463/NorthShoreHospital.pdf> viewed 6 August 2010.

⁵⁷ Centre for Compassion in Healthcare, n 11.

⁵⁸ Health and Disability Commissioner, Case 08HDC03160 (18 June 2008, unpublished).

⁵⁹ Frank A, “How Can They Act Like That?” *Clinicians and Patients as Characters in Each Other’s Stories* (2002) 32(6) *Hastings Center Report* 14.

⁶⁰ As “compassion” is defined by the Centre for Compassion in Healthcare, n 11.



On arrival ... we were informed by my other son that Peter was on life support. We were treated with respect and caring by the staff. At 7pm there was a change of staff. A new doctor introduced himself – a big man, brusque and arrogant. Shortly after he introduced himself, we were informed that very shortly staff would be disconnecting the life support.

The withdrawal of life was then bungled, and the family witnessed a horrific scene before being ushered away. The letter of complaint⁶¹ stated: “None of us, to this day, can forget the incident. We felt the doctor showed no respect for Peter.”

Again, we are prompted to ask, “How can they act like that?” Let me tell you how HDC dealt with these complaints. First, we brought them to the doctors’ attention (as well as the hospital in the second case). We asked them to respond. They admitted the conduct. The surgeon was appalled by his behaviour, offered an explanation (he was tired and stressed, which is why he made such an insensitive remark, intended as a joke), apologised for his conduct, and indicated the changes he has made to ensure that his secretary holds his phone during consultations. The hospital also apologised, and provided evidence of the changes introduced to ensure that Emergency Department staff are properly trained and supported in extubation for dying patients. The ED doctor offered only a partial apology (and got the mother’s name wrong); the hospital’s chief executive officer told me that he has gone to work in Queensland.

In both cases, HDC took an educational approach to the complaint, looking for evidence of reflection, apology and change. This is how most complaints are handled at HDC. Contrary to the views of the petitioners, “the test of the Code of Rights” is *not* “in the breach”. Only 1 in 20 complaints to the Commissioner’s office results in a breach finding. The Commissioner is required to “facilitate the fair, simple, speedy, and efficient resolution of complaints”.⁶² Thus, in the year ended 30 June 2009, HDC received 1,360 complaints, but only 112 formal investigations were completed, and only 72 of these resulted in a breach finding. The majority of complaints were informally resolved, often by an educational letter to the provider, noting the shortcomings and suggesting areas for improvement.⁶³

This approach does not always satisfy the complainant. The woman with pancreatic cancer remained unhappy about the surgeon’s behaviour. But Peter’s mother did feel that her complaint had been resolved. She sent me a card of thanks, in which she wrote that the information we gathered had helped the family understand the circumstances on the crucial day: “You have eased our pain and helped all of us to move forward.”

Would it have made a difference if the Code included a right to be treated with compassion? I do not think so. It was not a matter of pigeonholing the thoughtless or callous conduct into the breach of a specific legal right. Nor was it a matter of looking into the feelings or motivation of the practitioner, and asking why the practitioner had failed to “suffer with” the patient or family. Rather, my focus was on the reflections of the practitioner on his conduct, and his willingness to respond to the additional suffering caused by his behaviour.

WHY NOT MANDATE COMPASSION?

Why not mandate treatment with compassion? Why not invoke the force of the law to compel the kind of care that some patients yearn for?

I referred earlier to compassion in religion. Sennett notes that in traditional Judaism and Islam, divine law required specific acts of charity by individuals.⁶⁴ Catholicism formulated compassion as duty. But Protestantism emphasised the spontaneous, voluntary character of providing help to others. Luther wrote that charity cannot be commanded; for Calvin, compassion is a “free gift of self”. Wordsworth’s poem “The Old Cumberland Beggar” attacks the legalism of the Catholic and

⁶¹ Health and Disability Commissioner, Case 09HDC00849 (6 March 2009, unpublished).

⁶² *Health and Disability Commissioner Act 1994* (NZ), s 6.

⁶³ Health and Disability Commissioner, *Annual Report for the Year Ended 30 June 2009* (September 2009), <http://www.hdc.org.nz/media/31143/report%202009.pdf> viewed 6 August 2010.

⁶⁴ Sennett R, *Respect: The Formation of Character in an Age of Inequality* (Penguin Group, London, 2004) p 193.



Judeo-Islamic belief in compassion as duty:⁶⁵

In this cold abstinence from evil deeds,
And these inevitable charities,
Wherewith to satisfy the human soul?

Phillips and Taylor make a similar point in their book *On Kindness*. They write: “Ordered to be kind, we are likely to be cruel; wanting to be kind we are likely to discover our generosity.”⁶⁶

Compassionate behaviour is a gift from the heart of the bystander. Broyard wanted his doctor to “give me his whole mind just once”. This is not the stuff of law. I may be deeply touched by the small act of a doctor gently touching my arm before a painful procedure; how would I feel if I knew that protocol 3.2 required this act? Would it not be robbed of something?⁶⁷

The ongoing debate about child smacking and the law in New Zealand may tell us something about the proper role of the law. The *Crimes Act 1961* (NZ) was amended in June 2007 so that parents charged with assault on their children no longer have the defence of “reasonable force for the purposes of correction”.⁶⁸ Whatever the merits of that reform (later the subject of a referendum), I think we would all accept that it is an appropriate role for the law to punish certain behaviour, including assault (though we might debate the threshold for assault). But imagine if the Children’s Commissioner proposed a new law: “All parents shall love their children.” Parents can be compelled to provide the necessities of life, and to refrain from inflicting physical harm on their children, but we cannot require a parent to love, or to perform acts of loving kindness.

There are other difficulties with regulating for compassion, which I have not explored. One is nicely captured by the reported response of a midwife who learnt that her husband, a general practitioner, was attending the sector meeting I convened in June 2009 to debate this issue. “A right to be treated with compassion?”, she asked as she rushed out the door to her next delivery, “How are they going to measure that?” There is understandable nervousness about making a concept that is linked to emotions and to the individual consumer’s experience of health care, the subject of a legal duty. “Legislation can direct actions but not emotions,” submitted the New Zealand Nurses Organisation. Confidence in and respect for the law is important. There was significant provider resistance when New Zealand’s *Code of Consumers’ Rights* was first enacted. I accept that the Code is a “living document” (why bother to review it every five years if it is set in stone?), but we need to think carefully before jeopardising provider confidence in the fairness and predictability of the current regime of rights.

CONCLUSION

If legislation is not the right solution, how should we promote compassionate care? Let me offer a few suggestions. As educators, we can teach trainees about the nature of suffering and the value that patients place on empathy, kindness and understanding. As health professionals, we can role model compassionate care. Regulators can play a part too. A recent King’s Fund paper notes that “[t]he professional regulators can and should provide significant leadership in relation to compassionate care; talking explicitly about what is not acceptable in terms of conduct, attitudes, and behaviours; and setting standards”.⁶⁹ We can also highlight good care, as we did in 2007 when we published patient stories in a booklet entitled *The Art of Great Care*.⁷⁰

⁶⁵ Sennett, n 64, p 194.

⁶⁶ Phillips A and Taylor B, *On Kindness* (Hamish Hamilton, London, 2009) p 50.

⁶⁷ The author is indebted to Peter Skegg for this example.

⁶⁸ *Crimes (Substituted Section 59) Amendment Act 2007* (NZ).

⁶⁹ Firth-Cozens J and Cornwell J, *The Point of Care: Enabling Compassionate Care in Acute Hospital Settings* (The King’s Fund, London, 2009) p 9.

⁷⁰ Health and Disability Commissioner, *The Art of Great Care* (2007); and Nationwide Health & Disability Consumer Advocacy Service, *The Art of Good Care* (2010), <http://www.hdc.org.nz/publications/other-publications-from-hdc/stories-about-great-care> viewed 6 August 2010.



Chochinov argues that compassion may be cultivated by exposure to the medical humanities and the arts.⁷¹ Nussbaum believes that to develop compassion in public life we must give the humanities and the arts a large place in education.⁷² She says that the imagination of poets is required, and cites Walt Whitman.⁷³ It brought to mind some Whitman lines from *Leaves of Grass*, that are inscribed above the entrance to a cavernous underground Metro station in Washington DC. Whitman recalls his experience as a wound dresser, tending to Civil War soldiers in hospital. His words, carved in stone in Dupont Circle, are a subtle but eloquent reference to an epidemic that reminded us of the importance of care in the absence of cure:⁷⁴

Thus is silence in dreams' projections,
Returning, resuming, I thread my way through the hospitals,
The hurt and wounded I pacify with soothing hand,
I sit by the restless all dark night, some are so young,
Some suffer so much, I recall the experience sweet and sad ...

EPILOGUE

On 29 June 2009, the Commissioner submitted his final report on the *Review of the Health and Disability Commissioner Act 1994 and the Code of Health and Disability Services Consumers' Rights to the Minister of Health*.⁷⁵ The Review report recommended against inclusion of a right to be treated with compassion in the Code.⁷⁶

⁷¹ Chochinov H, "Dignity and the Essence of Medicine: The A, B, C, and D of Dignity Conserving Care" (2007) 335 BMJ 184 at 186.

⁷² Nussbaum, n 7, p 426.

⁷³ Nussbaum, n 7, p 436.

⁷⁴ Whitman W, "The Dresser" in *Leaves of Grass* (New York, 1867) pp 33-34.

⁷⁵ Health and Disability Commissioner, *A Review of the Health and Disability Commissioner Act 1994 and the Code of Health and Disability Services Consumers' Rights: Report to the Minister of Health* (June 2009), <http://www.hdc.org.nz/the-act--code/review-of-the-act-and-code-2009> viewed 6 August 2010.

⁷⁶ For commentary on the Commissioner's review and final report, see Manning J, "Review of New Zealand's Health and Disability Commissioner Act and Code of Rights" in "Legal Issues" (2009) 17 JLM 314.

