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ARTICLE

Compassion in health emergency management in Sri Lanka

Novil Wijesekara · K. Rashmini Wasana Priyashantha · Lahiru Kodituwakku Thushara Kamalrathne · Asanka Wedamulla · Samiddhi Samarakoon

Abstract: Compassion, defined as awareness of suffering, empathic attunement, and action to alleviate it, has been widely recognized in health care yet seldom examined systemically within Health Emergency Management (HEM). In Sri Lanka, recurrent crises provide a unique context for understanding how compassion is experienced, enacted, constrained, and sustained across the emergency management system.

A constructivist grounded theory study was undertaken through 23 semi-structured interviews with professionals across national, district, and divisional levels, including health staff, administrators, pre-hospital services, security forces, disaster managers, civil society, disability activists, and community representatives. Online interviews were conducted in Sinhala and English, recorded with consent, and analyzed using open, axial, and selective coding with constant comparison and iterative memoing.

Findings indicated broad recognition of compassion as essential in health emergencies, yet fragile in the face of stress, rigid rules, poor leadership, and resource shortages. Compassion emerged through interconnected layers: individual roots of upbringing, education, faith, and prior adversity; organizational stems shaped by resources, adaptive policies, and leadership culture; systemic flows of reciprocity between leadership, staff, patients, and communities; and cultural-philosophical traditions such as the Brahma Vihāras and Sangraha Vasthu that infused humanitarian practice with deeper ethical grounding. While some respondents perceived tension between compassion and humanitarian principles, narratives demonstrated that compassion reinforced and animated these principles when supported by organizational flexibility and cultural ethics. Instances of compassionate problem-solving contrasted sharply with harms caused by rigid application of insensitive rules.

The Lotus of Compassion in Health Emergencies Model synthesizes these findings, depicting compassion as seeds of innate potential, roots of individual formation, stems of organizational support, leaves of everyday practice, and flowers of visible expression in crises, nourished by leadership as sun and sustained by beneficiary reciprocity as bees and air. Compassion in Sri Lanka's HEM is thus not an intangible or abstract value but a systemic quality that strengthens resilience and operationalizes humanitarian principles in practice.

Keywords: compassion, health emergency management, resilience, disaster risk management, Sri Lanka

Novil Wijesekara
Disaster Preparedness and Response Division,
Ministry of Health, Sri Lanka
novil.wijesekara@gmail.com

1. Introduction

1.1 Understanding in compassion—global evidence

Compassion is understood as the combination of being aware of others' suffering, empathizing with their experience, and taking meaningful steps to alleviate it (World Health Organization, 2025). In recent literature, compassion is widely described as an essential dimension of health care (Addiss et al., 2022; Malenfant et al., 2022; Sinclair et al., 2016). Within primary health care (PHC), research consistently underscores that compassion improves quality of care, strengthens trust between providers and patients, and promotes equity in health outcomes (Burridge et al., 2017; Hordern, 2017; World Health Organization, 2025). Compassionate leadership and organizational cultures are identified as critical for embedding compassion into PHC systems, consistent with global commitments articulated in the Alma-Ata and Astana Declarations. Neilson & Syed (2026) highlights the need for having an interface for compassion with the existing public health approaches. Nevertheless, barriers such as time pressure, burnout, and hierarchical structures frequently limit its practice, prompting strategies to raise awareness, strengthen capacity, and influence policy (World Health Organization, 2025).

Addiss et al. (2023), in a review of epidemiology of compassion identify a wide range of demographic, psychological, experiential, circumstantial, and organizational "risk factors" for compassion, while emphasizing that compassion is highly context-dependent, relational, and shaped by organizational and environmental factors, yet is too often treated as an individual trait rather than a systemic phenomenon, calling for a broader examination and application of compassion (Addiss et al., 2022, Wodnik et al., 2026). New dimensions of compassion through concepts such as microkindness have been explored Lomas & VanderWeele (2026)

Beyond the PHC setting, the literature on compassion fatigue highlights the vulnerability of emergency physicians and frontline health workers, who, due to high-intensity exposure to trauma, irregular hours, and chronic stress, are at risk of diminished empathy and compassion. This phenomenon has well-documented consequences, including reduced quality of care, patient dissatisfaction, and provider burnout, and requires both individual strategies (e.g., mindfulness, boundaries, meaning-making) and organizational measures (e.g., safety, workload management, supportive culture) to mitigate its effects (Jeanmonod et al., 2024). Complementary reviews on compassionate care in the emergency department further emphasize that compassion is teachable, measurable, and linked to better patient outcomes, yet remains understudied in acute and high-stress environments (Garnett et al., 2023; Marks et al., 2025).

1.2 Compassion in the Sri Lankan context

In Sri Lanka, compassion is commonly understood and enacted as a relational and moral orientation toward suffering, shaped by cultural, religious, and social norms rather than framed solely as an individual psychological attribute. Jayasinghe, writing from the Sri Lankan medical context, distinguishes compassion from empathy and sympathy, describing it as a motivational state that arises in response to another's suffering and compels action to alleviate it (Jayasinghe, 2017). He highlights a growing public expectation for compassionate health care in Sri Lanka, alongside concerns that systemic pressures, poor role modelling, hierarchical cultures, and inadequate psychosocial support can erode compassionate practice among health professionals. At the same time, he argues that Sri Lanka possesses rich indigenous cultural and religious resources, including contemplative practices such as metta meditation, that can nurture both compassion toward others and self-compassion among health workers.

Qualitative evidence further suggests that compassion is a socially embedded and culturally mediated construct in Sri Lanka. In an exploratory phenomenological study among Sri Lankan students, Kariyawasam et al. find that participants' understanding of compassion closely aligns with Western definitions, particularly as "sympathetic consideration toward suffering," while simultaneously being shaped by religion, collectivistic values, upbringing, and social expectations (Kariyawasam et al., 2021). Notably, participants distinguish compassion toward others from compassion toward oneself, indicating that self-compassion is less readily accepted or practiced, and that social and cultural inhibitors can constrain compassionate expression. These findings underscore compassion as both relational and context-dependent, influenced by moral expectations, social norms, and perceived roles.

In applied health care settings, Sri Lankan research on respectful maternal care further illustrates how compassion is culturally articulated and operationalized. Rishard et al. demonstrated that compassion and supportive care among labor care providers can be meaningfully strengthened by grounding training in the Buddhist ethical framework of the Brahma-vihāras, namely metta (loving-kindness), karuna (compassion), muditha (empathetic joy), and upekkha (equanimity) (Rishard et al., 2024). These principles are explicitly linked to domains of respectful maternal care in a culturally sensitive manner, resonating not only with Buddhist practitioners but also with providers of other faiths, given their shared ethical foundations. This work highlights compassion in Sri Lanka as an ethical practice oriented toward dignity, respect, emotional presence, and moral responsibility, rather than as an abstract or purely technical competency.

Together, these Sri Lankan studies suggest that compassion is understood locally as a relational, value-driven, and culturally grounded phenomenon, enacted through moral duty, respect for dignity, and practical support, but also constrained by systemic stressors and organizational hierarchies. This contextual understanding provides an essential lens for examining how compassion is experienced, enacted, constrained, or sustained within Sri Lanka's health emergency management system.

1.3 Compassion in health emergency management

In disaster management research, leadership is increasingly framed in relational terms, with compassion, care, and justice viewed as ethical imperatives for reducing suffering. Crosweller (2022) argues that "relational worldviews" in leadership are more effective than "invulnerable" worldviews shaped by managerialism or insensitivity to suffering (Crosweller, 2022). Parallel sociological and psychological work on catastrophe compassion challenges disaster myths of chaos and breakdown, showing that disasters more often evoke altruistic solidarity, mutual aid, and prosocial behaviours. Community reciprocity—residents offering food, assistance, and solidarity to responders—is documented as a common and sustaining feature of post-disaster contexts ("In a Catastrophe, Compassion Rises," 2024).

The World Health Organization (WHO) often refers to Health Emergency Management (HEM) at the intersection of Prevention, Preparedness, Response, Recovery, and Resilience as an integrated framework to manage health emergencies effectively (World Health Organization, 2022, 2023, 2024). This framework emphasizes coordination, accountability, and system-wide functioning across the emergency cycle, yet largely conceptualizes performance through technical, operational, and governance lenses. How compassion is experienced, operationalized, or constrained within this multi-phase, multi-actor system has received limited empirical attention, particularly in low- and middle-income country contexts.

Sri Lanka in the recent past has been affected by disasters, disease outbreaks, conflict, and economic crises (Disaster Management Center, 2005; Parliament of the Democratic Socialist Republic of Sri Lanka, 2005; World Health Organization, 2021). The compassion in Sri Lanka's HEM has not yet been studied in detail. The overall objective of this study was to explore how compassion is experienced, enacted, constrained, or sustained within the HEM of Sri Lanka. Specifically, the study sought to (i) examine how compassion is understood and experienced by actors across different levels of the HEM system, (ii) identify how compassion is enacted or constrained across the phases of prevention, preparedness, response, recovery, and resilience, and (iii) explore organizational, structural, and contextual factors that influence the sustainability of compassion during health emergencies. By articulating these dimensions, the study aims to contribute empirical insights into compassion as a component of resilient health emergency management systems.

2. Methodology

This study adopted constructivist grounded theory (CGT) as the research approach, considering its potential to generate theory inductively from participants' lived experiences (Charmaz, 2006, 2014, 2017). Given the complexity and context-sensitivity of compassion within Sri Lanka's HEM system, grounded theory provided a flexible yet systematic approach to explore how compassion was experienced, enacted, constrained, and sustained across institutional and community levels. CGT closely associates with interpretivism and pragmatism in terms of its philosophical stance. The ontology of interpretivism posits that our knowledge of reality is socially constructed by human actors (Walsham, 1995). The pragmatic approach underlies three main principles: an emphasis on actionable knowledge, recognition of interconnectedness between experience, knowing and acting, and inquiry as an experimental process (Kelly & Cordeiro, 2020). The current research falls under interpretivism and pragmatism, as compassion in health emergencies is context-specific and subjective, depending on the human perspectives and experience. Further, CGT aligns with abductive reasoning, which is not limited to induction or deduction. The literature review for this study served as a deductive starting point, highlighting important research gaps that guided the data collection process. In contrast, data collection and analysis were carried out using an inductive approach, particularly employing the constant comparative method (Charmaz, 2006) .

2.1 Recruiting participants and theoretical sampling

A purposeful sampling strategy was employed to recruit participants directly engaged in HEM activities. Twenty-three key informant interviews (KIIs) were conducted with professionals working at national, district, and divisional levels. Participants included officials from the Ministry of Health, Disaster Management Centre, National Hospital, pre-hospital ambulance services, army, navy, air force, police, district health administrators, hospital clinicians, disaster management officials, and representatives of non-governmental humanitarian agencies involved in health response. Maximum variation sampling was used to capture diversity across disaster risk profiles and roles, while theoretical sampling was applied iteratively during analysis to deepen emerging categories. Several experts were involved in validating the emerging theory during the final stage of the process which marked the saturation, aligning with the theoretical sampling (Charmaz & Thornberg, 2021).

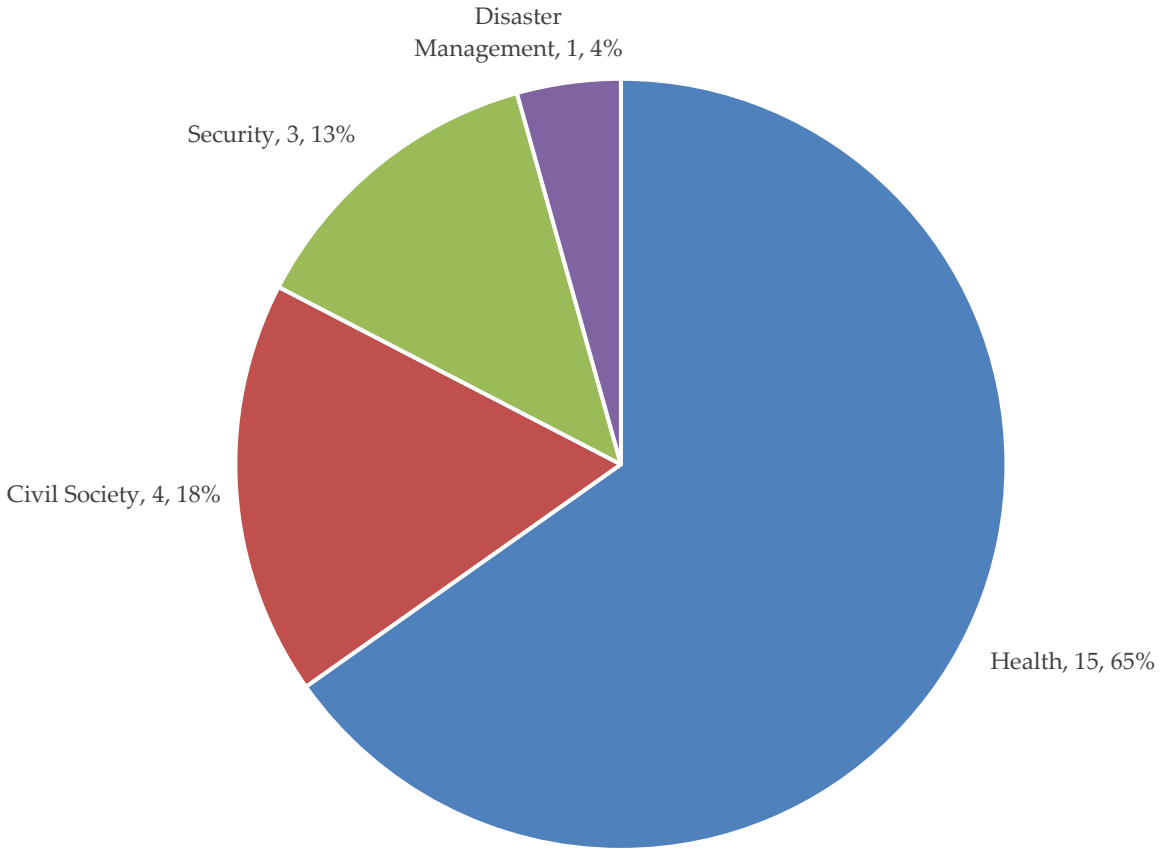
Participants of the study represented a wide range of roles across Sri Lanka's health emergency system, including health professionals, security forces, civil society actors, disaster managers, and community representatives (Table 1 below).

Table 1. Main professional identity of the respondents

Main Professional Identity	Number
Health Emergency Manager	4
Tri-forces and Police Health	3
Civil Society Organizations Representative	2
Medical Administrator	2
Pre-Hospital Care	2
Public Health Inspector	2
Public Health Midwife	2
Disability Activist	1
Disaster Manager	1
Emergency Physician	1
Epidemiologist	1
Independent Community Volunteer	1
Nursing Officer	1

Most respondents were from the health sector, with additional perspectives from civil society, security forces, and disaster management, ensuring a multi-sectoral understanding of compassion in emergencies (Figure 1).

Figure 1. Sector of the respondents



The respondents brought with them experience cross across different categories of emergencies (Table 2). The number of experiences of the respondents ranged from 3 years to 39 years.

Table 2. Health emergencies in Sri Lanka Faced by the respondents

Human-Induced Hazards	Natural Hazards	Infectious Hazards
War	Tsunami	COVID-19
War Related Internal Displacement	Floods	Dengue
Easter Sunday Attacks	Landslides	Leptospirosis
Mass Casualty Incidents		

While majority of the respondents were Buddhist, which was over-represented relative to other religions based on the national figures, there was some representation of all the major faiths/religions in Sri Lanka (Table 3).

Table 2. Distribution of respondents by faith/religion

Faith/Religion/Belief	Number, Percentage	National %
Buddhist	19, 82.8%	69.8%
Hindu	1, 4.3%	12.6%
Christian/Catholic	2, 8.6%	10.7%
Islam	1,4.3%	5.6%

2.2 Data collection

Semi-structured interview guides were developed to elicit narratives on personal experiences, systemic enablers and inhibitors, and perceptions of compassion in emergencies. In line with the constructivist grounded theory approach, the semi-structured format allowed the guide to function as a flexible framework rather than a fixed questionnaire, enabling participants to emphasize issues they considered most salient while ensuring consistency across interviews. The development of the interview guides was informed by a review of relevant literature on compassion in health care, emergency medicine, disaster leadership, and health emergency management, as well as by the World Health Organization's Health Emergency Management framework across prevention, preparedness, response, recovery, and resilience. These sources were used to identify key thematic domains for inquiry. Probing questions were used to clarify responses and encourage depth and concrete examples.

A predefined or standardized definition of compassion was not imposed for the purposes of this study, consistent with the grounded theory–informed qualitative approach adopted. Instead, participants were invited to articulate their own understandings and lived meanings of compassion specifically in the context of health emergencies through open-ended prompts such as *"How do you understand the term compassion in health emergencies?"* and *"What do you feel or think of when you hear the term compassion in the context of a health emergency?"* Interviews were conducted in either English or Sinhala, depending on participant preference. In Sinhala-language interviews, compassion was explored using commonly understood direct equivalents such as *karuṇikabhāvaya* or *karuṇāwa*. Given this direct linguistic equivalence, analytical emphasis was placed on participants' expressed meanings and emotional responses rather than on literal translation across languages. Variations in how compassion was described were treated as

analytically meaningful, reflecting its relational, situational, and culturally mediated nature within Sri Lanka's health emergency management context.

Though a predefined definition of compassion was not used, the development of the interview guides was informed by the concepts such as the disaster management cycle and the World Health Organization's Health Emergency Management framework across prevention, preparedness, response, recovery, and resilience.

Interviews were conducted via Zoom in Sinhala or English, depending on participant preference; a small number were conducted via WhatsApp calls where participants requested. With consent, sessions were audio-recorded and supplemented by detailed field notes. All English-language interviews were transcribed verbatim using Otter AI, after which the transcripts were manually reviewed, corrected, and verified against the audio recordings by the research team prior to analysis. After each interview, the research team prepared reflexive memos documenting impressions, contextual details, and emerging concepts.

2.3 Data analysis

Interview transcripts were coded manually using comments and color highlighting in Google Docs, following initial coding and focused coding aligned with protocol of the CGT approach (Charmaz and Thornburg 2021)). A constant comparative approach was applied across codes, interviews, and participant groups to refine categories and identify relationships between conditions, actions, and consequences. Memo-writing was used throughout to support theoretical development and maintain reflexivity. Data collection and analysis proceeded concurrently, allowing insights from earlier interviews to shape subsequent sampling and questioning. Themes presented in the analysis were arranged based on the major categories that emerged during the coding process, especially with a strong reflection of focused coding.

2.4 Trustworthiness and reflexivity

The positionality of the research team—primarily national HEM professionals with expertise in policy and coordination rather than frontline response—was explicitly acknowledged. An intentional effort was mounted ensure that the perspectives of diverse partners involved in HEM were reflected throughout the study. Reflexivity was integrated through reflective journals and team debriefs to surface assumptions and minimize bias. Triangulation of data sources (KIIs), maximum variation sampling, and iterative comparison enhanced the credibility, dependability, and transferability of findings.

3. Results

The key themes identified in the study were recognition of compassion in health emergencies, origins and determinants of compassion, factors eroding the capacity for compassion, organizational enablers and inhibitors of compassion, contextual variability in compassionate practice, compassion as a flowing, reciprocal force in health emergencies, and compassion and its anti-thesis in humanitarian action.

3.1 Recognition of compassion in health emergencies

Despite the diversity of respondents, there was broad agreement that compassion was essential in health emergencies, where people seeking services were invariably subjected to suffering as a direct consequence of crisis. As one midwife reflected,

> *"Those who come to us for services are those in need of compassion. Those who can afford may even go to the private sector. We should think that the person who comes to receive services is myself."* – Midwife

Placing oneself in the shoes of those affected was described as a critical pathway for enacting compassion during emergencies.

> *"Compassion helps build trust between the emergency service provider and the affected persons"* – Health Emergency Manager

> *"As usual, we work for the public, so we must show compassion towards them. This not only gives us a boost but also brings us a sense of satisfaction."* – Epidemiologist

Several respondents observed that compassion was often expressed more openly and visibly during disasters compared to routine situations, as the extremity of suffering brought an urgency to compassionate responses. However, it was interesting to note that a representative of persons with disabilities argued that compassion becomes less expressed towards persons with disabilities in the aftermath of disasters, compared to normal times.

> *"During the COVID-19 pandemic, numerous guidelines were issued. However, these guidelines did not take into account the special needs of persons with disabilities. For example, a vision-impaired person requires physical guidance, even though the guidelines required maintaining one meter of social distancing. For persons with hearing impairments, others wearing masks was a huge barrier to communication, since they relied on lip reading and facial expressions. Most handwashing stations were foot-operated, but wheelchair users could not use them. Similarly, during evacuations such as tsunamis, or in displacement settings after floods and landslides, persons with disabilities have special needs that must be considered. Spending extra time to accommodate these needs is an expression of compassion."* – Representative of persons with disabilities

This reflection highlights how the expression and enactment of compassion itself change when viewed through the lens of special needs**.** Compassion is no longer limited to providing medical treatment or adhering strictly to rules; it extends to adapting systems and practices so that vulnerable groups can access care with dignity. In this sense, compassion is important not only as an individual attitude but also as a systemic responsibility to recognize difference and promote inclusion during health emergencies in Sri Lanka.

3.2 Origins and determinants of compassion

3.2.1 Cultural and religious foundations of compassion in Sri Lanka

Compassion was reflected as a phenomenon that is deeply woven into the cultural fabric of Sri Lanka, echoed by many respondents.

> *"In Sri Lanka, compassion is not new. It is part of our culture."* – Health Administrator

Those who take up health care or social services was pointed out as having compassion within them, as something inherent, as a super power, that was awakened.

Across communities influenced by Buddhism, Hinduism, Christianity, Catholicism, and Islam, there is a shared understanding that when a fellow human being is in need, one must step forward to help. This moral impulse is not seen as extraordinary but as part of everyday life. As one participant explained,

> *"Whenever there is someone in distress, at least one or two people will come forward, even if it is just to make a call to bring first responders."* – Health Emergency Manager

Examples from daily life illustrated this ingrained ethic. Road traffic accidents were cited as a common instance: rather than turning away, bystanders would typically gather around the victim, offering immediate assistance and ensuring help was on the way. Such behaviors, participants reflected, stemmed from long-standing associations with religious traditions and philosophies that have shaped the social consciousness of compassion across generations.

Although respondents acknowledged that expressions of compassion may have ebbs and flows, they stressed that the cultural grounding remained strong. In moments of crisis, compassion was expected—not as a policy or regulation but as a natural and collective human response. This cultural ethos provided a moral reservoir that supported both professional and community responses during emergencies, reinforcing that compassion in Sri Lanka is not an "imported" principle but one nurtured through lived traditions, faith, and daily practice.

For example, a public health staff drew on Buddhist teachings to contextualize his own practice.

> *"In the Buddha's life, there is a place where the Buddha went to a sick monk, suffering from a skin disease, and helped him, setting an example. During COVID, it was like that."* – Public Health Inspector

The story of Buddha caring for Rev. Thissa, who had a rotten body due to a skin disease is often depicted as a visual reminder of compassion in Sri Lanka (Figure 2) (Thero, 1993). Importantly, such ideas were not viewed as a uniquely Buddhist insight. Respondents highlighted parallels across faith traditions. One recalled the Christian ethos of Ora et Labora ("pray and work"), which integrates spiritual grounding with practical action (Nursia, 1981). Some other quotes from the Holy Bible that resonated with compassion were stated by the respondents as follows:

> *"When he saw the crowds, he had compassion on them, because they were harassed and helpless, like sheep without a shepherd"* – (Matthew 9:36) (The New International Version Bible, 2011)
>
> *"The LORD is good to all; he has compassion on all he has made"* – (Psalm 145:9) (The New International Version Bible, 2011)

Respondents also pointed out that Hindu philosophy emphasizes compassion through the principle of interconnectedness and the sanctity of all life. They referred to the concept of *"Vasudhaiva Kutumbakam"* from the *Maha Upanishad* and other texts—meaning *"the world is one family"*—which invites individuals to extend care and empathy beyond their immediate circles to embrace all living beings (Radhakrishnan, 1994). This worldview, they noted, cultivates a universal sense of responsibility, reminding people that suffering anywhere is a shared concern. In the context of health crises, respondents reflected that this ethic of oneness becomes especially vital, encouraging compassion not only toward patients and families but also across communities, institutions, and nations.

> "In Islam, compassion is central—our Holy Prophet Muhammad (may peace be upon him) showed us through his life how to care for people in need. Our religion teaches us to practice compassion in all situations, and this guides us as medical professionals as well." – Epidemiologist

Respondents also drew on some concrete examples of Islamic teachings to explain how compassion is embedded within their cultural and spiritual life. They referred to *Surah Al-Baqarah (2:263)*: *"Kind speech and forgiveness are better than charity followed by injury. And Allah is Free of need and Forbearing."* This verse was highlighted as a reminder that compassion is not only about material giving but also about the manner in which kindness is offered—with gentleness, respect, and forgiveness (The Qur'an, n.d.).

Figure 2. Replica of a popular Buddhist mural which narrates the story of Buddha's compassionate act of attending to a monk with a skin disease

Artwork Credit: R. Kouwshigen. This artwork was created for this paper and is used with the permission of the artist.

A Hadith was also cited to illustrate compassion in community life: *"You see the believers as regards their being merciful among themselves and showing love among themselves and being kind, resembling one body, so that, if any part of the body is not well then the whole body shares the sleeplessness and fever with it."* Respondents reflected that this teaching resonates strongly in health emergencies, where the suffering of one individual or group is felt by the entire community, creating a moral responsibility to respond with compassion (Al-Bukhari, n.d.). It is interesting to compare this with the concept of *"Vasudhaiva Kutumbakam"* from the Hindu tradition.

3.2.2 Systemic and organizational expressions of compassion

Inspiration for compassion in health emergencies was not confined to religion alone. Respondents from the security and tri-forces emphasized that their ethos of service is deeply rooted in compassion, expressed through the principle of *leaving no one behind*.

> *"We are trained to leave no one behind—whether in combat, disasters, or health emergencies. Our duty is to save others so they may live, even if it means risking our own lives."* – Military Official

This account illustrates how compassion can be institutionalized as an ethic of collective responsibility, transcending individual emotion to become a professional and organizational value. In this way, compassion was not only seen in the everyday care of patients but also in the willingness of responders to risk themselves for the safety and dignity of others. Such narratives reinforce that compassion in Sri Lanka's emergency management system is systemic, encompassing health staff, administrators, communities, and even military responders, each embodying the principle in contextually distinct yet complementary ways.

3.2.3 Compassion shaped by collective crises and historical experience

Respondents also pointed to Sri Lanka's history of disasters and crises as formative in shaping compassion as a lived practice. Beyond religious or cultural teachings, repeated exposure to collective suffering—whether through natural hazards or man-made crises—has embedded compassion into the national consciousness.

> *"We have had so many shocks in our history—the tsunami, the civil war, and other man-made disasters. During these moments, people were always there to provide compassion to a fellow human being. It has become part and parcel of being Sri Lankan."* – Health Emergency Manager

> *"During the 2004 tsunami, when there was a war, even conflicting parties helped each other. That was true compassion in action."* – Medical Administrator

> *"During the war, we transported patients, including pregnant mothers, through dangerous zones without international protection. These were voluntary efforts by doctors, drivers, and helpers. In three of such cases I personally handled the situation which resulted in saving lives. Compassion guided these actions."* – Medical Administrator

The above administrator recalled the wise advice of some senior officials: "Don't worry about codes or rules if your actions are for the people", reflecting on a compassionate administrative culture despite the conflict.

These experiences, respondents suggested, created a kind of social conditioning: an expectation that in the midst of crisis, people will reach out, extend care, and stand together. Even when resources were scarce or social tensions ran high, the reflex to help often surfaced—sometimes in small gestures like making a phone call to summon first responders, and other times in large-scale mobilizations of aid and volunteerism.

While participants acknowledged that compassion can wax and wane depending on circumstances, they emphasized that the country's history of recurrent shocks has made compassion an almost instinctive response. Thus, Sri Lanka's disaster and emergency experiences act as a crucible in which compassion is continuously tested, challenged, and renewed—strengthening its place not just as an individual virtue, but as a collective survival strategy and moral anchor for the nation.

3.2.4 Factors eroding the capacity for compassion

In contrast, stress, fatigue, and professional constraints were identified as eroding the capacity to act compassionately.

Respondents highlighted several broader systemic and contextual factors that shaped whether compassion could be practiced in health emergencies. One recurring theme was the shift in the education system over time, with an increasing emphasis on technical competencies at the expense of moral and ethical formation. While professional training equipped health workers with clinical skills, respondents felt that it did not adequately prepare them to engage with patients and communities in compassionate ways.

Another constraint repeatedly mentioned was the gap between patient demand and service availability. Overcrowded facilities, staff shortages, and limited resources placed heavy pressure on health workers, leaving them with little time or energy for compassionate interactions.

> *"We need to triage who needs compassion."* – Health Emergency Manager

Compassion, in such contexts, was not a universal ethos but something rationed under strain. Participants also reflected that compassion varied depending on the role and category of health staff. Doctors and nurses, often directly engaged with patients, were seen as more able to express compassion, whereas other cadres who were more removed from patient care sometimes found fewer opportunities or support to do so. This variation created uneven experiences of compassion within the system.

Finally, respondents raised concerns about the dominance of quantitative indicators in measuring health system performance. They observed that the drive to achieve targets could overshadow quality-of-care dimensions, including compassion.

> *"If we focus too much on indicators rather than quality, we will lose compassion in the struggle for achieving numbers."* – Health Emergency Manager

Taken together, these reflections reveal that compassion in Sri Lanka's health emergency system is not only about individual dispositions or organizational culture but is also influenced by systemic pressures, educational orientations, and policy priorities. When technical efficiency and numerical achievements are prioritized without equal attention to relational care, compassion risks being sidelined—further reinforcing the need to position it as a core value within health system resilience.

Respondents also reflected that the expression of compassion often varied according to the type of patient. Pregnant mothers and children, for instance, were described as more likely to receive compassionate care, particularly in disaster settings where health staff were "more vigilant" toward these groups. Yet, at the same time, some participants stressed that the system's mandate was to provide *medical care*, not necessarily *compassionate care*. One respondent gave the example of treating a sick child during a disaster: while clinical care might be provided promptly, the communication to the anxious guardian might lack compassion, exposing gaps in relational care even when medical needs were met.

Several participants expressed concern that the health system as a whole had failed to institutionalize compassion as a priority. Compassion was rarely framed as a systemic value, and policies tended to emphasize efficiency and coverage over relational quality. The "no turn down" policy, while ensuring that no patient was denied treatment, was seen as paradoxically counterproductive. As one participant explained, the policy created an overwhelming burden on already strained services:

> *"We give treatment to everyone, but the extra burden is killing the quality aspects—including compassion."* – Health Emergency Manager

In this way, compassion was both situational and constrained: more evident in certain patient categories or emergencies, but easily eroded by structural policies and overwhelming demand. Respondents worried that if compassion continues to be overlooked in system design and policy frameworks, it risks being reduced to a personal choice rather than a collective responsibility of the health system.

At the same time, efforts were underway to instill compassion in new generations of health professionals:

> *"We are trying to inculcate compassion into new medical graduates through the good internship program,"* – Health Emergency Manager

> *"It is essential that young health emergency managers and administrators get experience in responding to disasters and emergencies, not only in the classroom, but this is also where we learned compassion, and many more…"* – Medical Administrator

3.2.5 Organizational enablers and inhibitors of compassion

Several organizational aspects related to compassion during health emergencies. Supportive leadership, adaptive use of rules, and initiatives aimed at improving accountability and service responsiveness were cited as enabling factors. A health emergency manager described the *Clean Sri Lanka* initiative, which not only addressed environmental conditions but also created a moral commitment to ethical service delivery, including a national helpline for public complaints. In contrast, poor role models, siloed organizations, rigid regulations, and lack of resources were described as organizational inhibitors (Clean Sri Lanka, 2025).

Leadership was highlighted as a key prerequisite for compassion at organizational level.

> *"If the head is shouting at the staff, and stressing them all, the staff also become stressed and lose their compassion. However, if the head of the institution is kind and compassionate, staff also naturally follow him or her."* – Emergency Physician

3.2.6 Contextual variability in compassionate practice

Context was repeatedly emphasized as shaping how compassion was understood and enacted.

> *"The way a nurse shows compassion in Anuradhapura[1] could be very different from how a nurse in Colombo[2] does. It depends on the context."* – Disaster Manager

In another example, an emergency physician reflected on the subtle variations in compassion shown when COVID-19 status intersected with other conditions:

> *"Suppose we have two patients with a heart attack. One is with Delta COVID-19 and the other is without. The compassion that the staff display can be less in the case of the heart attack who also has COVID-19."* – Emergency Physician

Acts that went beyond procedural obligations, reflecting empathy and relational care under highly constrained circumstances, were explained. Respondents described situations where rigid rules and logistical systems could have undermined humane responses, yet compassion guided creative solutions. A health official recalled:

> *"There was a bedridden elderly man who tested positive for COVID, but under the system he had to be sent to a male center while his daughter was admitted elsewhere. Since no one else could look after him, I coordinated with the health teams and arranged a special room so that his daughter could stay with him and care for him."* – Epidemiologist

[1] A Provincial Capital City of Sri Lanka.
[2] Capital City of Sri Lanka.

Another respondent recalled the case of a Sri Lankan cancer patient who had been receiving treatment abroad:

> *"We had one case during COVID-19 where a patient with terminal cancer in another country wanted to come back so that he could, in his own words, either receive treatment or die peacefully in his own country, rather than being quarantined in a foreign land. We had to navigate procedural barriers—immigration rules and other systemic challenges—but somehow we managed it with a compassionate angle."* – Health Emergency Manager

Respondents shared an example of compassion enacted under pressure. An account of treatment of injured individuals during the *Aragalaya* civil uprising, when political tensions were high, was narrated:

> *"When they were brought into the National Hospital for treatment, there were some who did not want them treated. We had to explain that irrespective of political affiliation, patients have to be treated based on their need. We were able to provide them treatment without discrimination."* – Emergency Physician

These stories illustrate how, even in the midst of a global pandemic marked by strict rules and logistical obstacles or a nation-wide economic crisis and public uprising, compassion could guide decision-making to ensure that people were not treated only as cases to be managed but as human beings deserving of dignity and care at the most vulnerable moments of life.

Yet respondents also reflected on moments when rigid rules and regulations, though framed as necessary public health measures, deeply undermined compassion and inflicted harm. One of the most painful examples cited was the mandatory cremation policy for those who died of COVID-19, which directly conflicted with the religious and cultural values of the Muslim community. A Muslim health professional spoke with visible emotion:

> *"I have no words to explain how I felt, as a Muslim health professional. There were several instances where I felt I should quit my job, as I and my family were not only concerned about losing life to COVID but also about being subjected to cremation, which is not in line with our faith. This decision, which was also against WHO guidelines, was a big blow to persons of Islamic faith."* – Epidemiologist

This narrative illustrates how rules, when applied without sensitivity to cultural and religious contexts, can damage trust, erode compassion, and leave health workers themselves feeling conflicted between their professional duty and their spiritual identity. While regulations are critical in emergencies, respondents emphasized that compassion requires flexibility—policies that safeguard public health while also respecting the dignity, traditions, and beliefs of affected communities. The responsibility of the individual in expressing compassion was highlighted.

> *"Every individual must change their own attitude—compassion has to come from within. We can guide health workers, but ultimately it is their own journey."* – Epidemiologist

It was also noted that systems, often seen as being against compassion, can at times incentivize compassionate behavior among service providers.

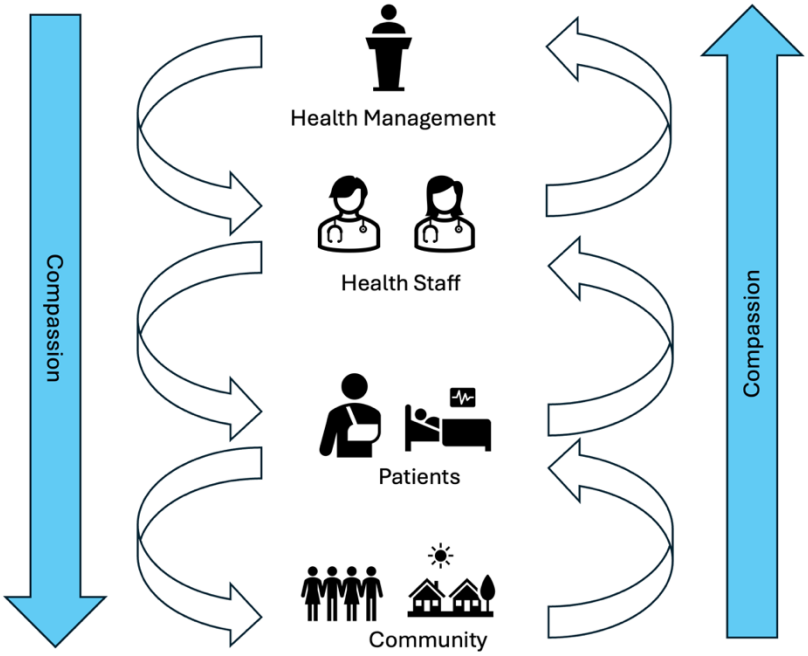
> *"I have observed that systems themselves can incentivize compassion. Within such systems, being compassionate becomes the norm. For example, if not showing compassion can be something that people can complain about, it creates a favorable environment for service providers to act compassionately."* – Police Official

This statement highlights that while it is important to create a greater supply of compassion, it is equally essential to create a demand for compassion as well.

3.3 Compassion as a flowing, reciprocal force in health emergencies

Across interviews, respondents consistently described compassion in health emergencies as relational and reciprocal, moving between leadership, health staff, patients, and communities, as shown in Figure 3.

Figure 3: Compassion as a multi-layered two-way process in health emergencies



Rather than being a one-directional act delivered by service providers alone, compassion was experienced as something that circulated through the system, shaping morale, trust, and collective resilience during crises.

At the leadership level, compassion was often expressed through structural and policy decisions intended to protect both staff and patients. A senior medical administrator reflected on leadership choices during the COVID-19 response:

> *"At the Infectious Disease Hospital (IDH), as the leadership, we were always compassionately concerned about managing the patient load at levels that could not overwhelm the capacity of our staff. Even this policy was questioned by the administrators from other hospitals."* – Medical Administrator

Here, compassion was enacted not through interpersonal gestures but through organizational judgment that balanced service delivery with staff well-being. Leadership attitudes were described as shaping the ethical climate of institutions, influencing how compassion was subsequently expressed by staff:

> *"Our caring and compassionate attitude towards the staff trickled down not only to the patients, but also to the community."* – Medical Administrator

Respondents emphasized that compassion did not flow in a single direction. Acts of compassionate leadership and service were often recognized and reciprocated by communities, reinforcing motivation and trust among health workers. One administrator recalled a personal experience during isolation:

> *"I was exposed to one of my hospital leadership team members who became positive for COVID-19, and I had to isolate myself from my family at the hospital quarters… I later found*

> *out from my wife that many people from the community had sent all necessary items to my home. I felt that the compassion we extended as the leadership team to the staff, patients, and community was reciprocated."* – Medical Administrator

Reciprocal compassion was also evident in extreme crisis situations. Following the Easter Sunday attacks[3], first responders working under intense physical and emotional strain described being supported by spontaneous community action (BBC News, 2019). While forensic professionals worked continuously to complete post-mortem examinations so that bodies could be returned to families, volunteers organized refreshments and emotional support for responders and mourners alike. These accounts illustrated how compassion flowed from professionals to communities through service**,** and back to professionals through solidarity and care**.**

Cultural traditions and public narratives further strengthened these reciprocal dynamics. Respondents described how compassion was amplified through shared symbols and meanings during the COVID-19 pandemic:

> *"The mass media helped create a compassionate image of our hospital within the wider community, rebranding it as the 'Mother Hospital' during the COVID-19 pandemic… Traditionally, it is believed in Sri Lanka that Mother Paththini compassionately prevents and controls infectious diseases among her 'children.'"* – Medical Administrator

Compassion at the intersection of hospital and temple, creating a public image of Mother Hospital is illustrated in Figure 4.

Figure 4. Blurring the line between hospital and temple through compassion original photo credit: National Institute of Infectious Diseases and Thisara Chaminda

Original Photo Credit: National Institute of Infectious Diseases and Thisara Chaminda (used with permission)

[3] The Easter Sunday attacks in Sri Lanka refer to a series of coordinated suicide bombings carried out on 21 April 2019, targeting three churches and three hotels in Colombo, Negombo, and Batticaloa during Easter celebrations. The attacks resulted in the deaths of more than 260 people and injured over 500.

By linking institutional care with deeply rooted cultural beliefs, compassion became a shared social resource, binding hospitals and communities together and reinforcing trust during uncertainty.

Taken together, these accounts demonstrate that compassion in health emergencies is systemic, multidirectional, and deeply contextual. It originates in leadership decisions, is enacted through staff practices, reaches patients and communities, and returns through recognition, cooperation, and support. These reciprocal patterns sustained morale, strengthened trust, and contributed to collective resilience during periods of acute crisis.

3.4 Compassion and its anti-thesis in humanitarian action

While compassion was widely regarded as a valuable and even aspirational quality within health systems and emergency response, participants also revealed a clear counter-narrative. This anti-thesis emerged particularly among those who viewed humanitarian principles and professional standards as competing with, or even more essential than, compassion in practice.

It was emphasized that for healthcare providers, compassion is often expressed through service delivery itself rather than through interpersonal gestures:

> *"Healthcare providers prioritize service, and for them, providing the service is the kindness. You can't expect a healthcare provider to behave like a priest! Someone receiving care may feel that the provider is unkind, but in reality, the provider is being kind to the entire affected population."* – Disaster Manager

Here, compassion is redefined away from personal warmth or emotional expression and reframed as an efficient, impartial commitment to serve the greatest number. In this view, prioritizing service equates to kindness, even if it does not appear compassionate at the individual level.

This tension was further reinforced by the belief that compassion need not be explicitly named within humanitarian practice, since it is already subsumed under broader humanitarian values:

> *"Compassion doesn't need to be in policies because it's already embedded in humanitarian principles like dignity, neutrality, and equity. These values guide humanitarian and health emergency work, and if we adhere to them, we don't need to separately worry about compassion."* – Disaster Manager

Such perspectives cast compassion as redundant in the face of established humanitarian frameworks. For some respondents, compassion risks being seen as a "soft" concept compared to the structural and enforceable nature of principles such as dignity, neutrality, or the right to health.

At the same time, humanitarian program managers described a more nuanced positioning of compassion in relation to rights-based approaches:

> *"Compassion and right to health, both of these things can play in health emergencies. In a stable situation, there is an expectation that the service providers would deliver services with compassion. However, in emergencies, this could be restricted."* – Civil Society Organization Representative

> *"In NGOs, in humanitarian programs, we do not name it as compassion, but most of the time, compassion is there within the programs. However, compassion is linked to right to health and dignity."* – Civil Society Organization Representative

These accounts reveal that while compassion and rights-based principles are not inherently in conflict, their prominence and expression can shift depending on the context. Emergencies, with their emphasis on speed, impartiality, and resource allocation, may restrict overt displays of compassion, whereas stable contexts allow more space for it.

Several respondents explicitly contrasted the subjective and individualized nature of compassion with the structural certainty of rights-based approaches:

> *"As I feel, right to health and compassion are not conflicting. At times, they both can work together. At times, each of them can exist in isolation."* – Civil Society Organization Representative

> *"Compassion is something subjective. However, right to health is within a structure…."* – Civil Society Organization Representative

This distinction positions compassion as fluid, personal, and variable, while rights to health are fixed, institutionalized, and non-negotiable.

Concerns were also raised about potential conflicts between compassion and professional standards in humanitarian work. One participant explained:

> *"When we are working in humanitarian settings, compassion may come out in our actions. But we are upholding professional standards only. Compassion may be beneficial for non-professionals, but for professionals, professional standards are essential."* – Civil Society Organization Representative

Here, compassion is portrayed as an optional or supplementary layer, particularly for non-professionals, while professionals are expected to adhere strictly to codes of conduct and humanitarian principles.

Finally, participants pointed out that compassion can occasionally create ethical dilemmas in humanitarian response. For example:

> *"Compassion can sometimes have conflicts in humanitarian response as well. For example, being compassionate to children can lead to conflicts with issues such as child protection, if the humanitarian workers try to express compassion by touch. Another example is in providing humanitarian assistance, such as food or nutritional support. Compassion can blur the boundaries between purely rights-based assistance. However, if they uphold humanitarian principles, such challenges of compassion may not arise."* – Civil Society Organization Representative

This perspective underscores the potential risks of unregulated compassion, particularly where it may blur professional boundaries or undermine impartiality.

3.5 Summary of findings

Taken together, the findings demonstrate that compassion in Sri Lanka's health emergency management is multi-level, context-dependent, and systemically mediated**.** Respondents consistently recognized compassion as essential during health emergencies, particularly where suffering is acute, visible, and morally urgent. Compassion was expressed not only through interpersonal acts of care, but also through organizational flexibility, adaptive decision-making, and collective efforts to prioritize vulnerable populations and "leave no one behind." These expressions were evident across community action, frontline health care, leadership decisions, and even security-sector responses, indicating that compassion operates across sectors rather than being confined to clinical encounters alone.

At the same time, the findings reveal important tensions and inconsistencies. Compassion was described as highly visible and valued during emergencies, yet far less institutionalized during routine periods. Outside crisis contexts, bureaucratic norms, performance pressures, and rule-bound systems were often seen to normalize the absence of compassion. This resulted in a fragile pattern in which compassion surged during emergencies but risked rapid erosion once the immediate crisis subsided. Similarly, compassion was not experienced uniformly across all groups, with persons with disabilities and certain patient categories facing reduced expressions of compassion when rigid guidelines or system constraints took precedence.

Another key tension emerged between individual-level compassion and population-level compassion**,** particularly in humanitarian contexts. While some respondents equated compassion with interpersonal warmth and emotional presence, others framed compassion as ethical service delivery guided by humanitarian principles such as equity, neutrality, and impartiality. These perspectives were not mutually exclusive, but reflected differences in scale, role, and context. In large-scale emergencies, compassion was often operationalized through structured systems designed to protect populations, even when this limited individualized expressions of care.

The study also challenges the assumption that compassion is inherently at odds with humanitarian principles or professional standards. While some respondents perceived compassion as subjective or "soft" compared to rights-based and principled approaches, the broader findings suggest that compassion and humanitarian principles are interdependent rather than competing**.** Humanitarian principles provided essential structure, accountability, and population-level safeguards, while compassion animated these principles, shaping how they were interpreted and enacted in practice.

Importantly, respondents also cautioned against unregulated compassion that could blur professional boundaries or compromise impartiality, underscoring the need for balance. Compassion that is detached from systems and standards risks inconsistency and ethical dilemmas, while systems devoid of compassion risk becoming technocratic and morally thin. These findings point to the need for an integrative understanding of compassion that accommodates both ethical governance and relational care.

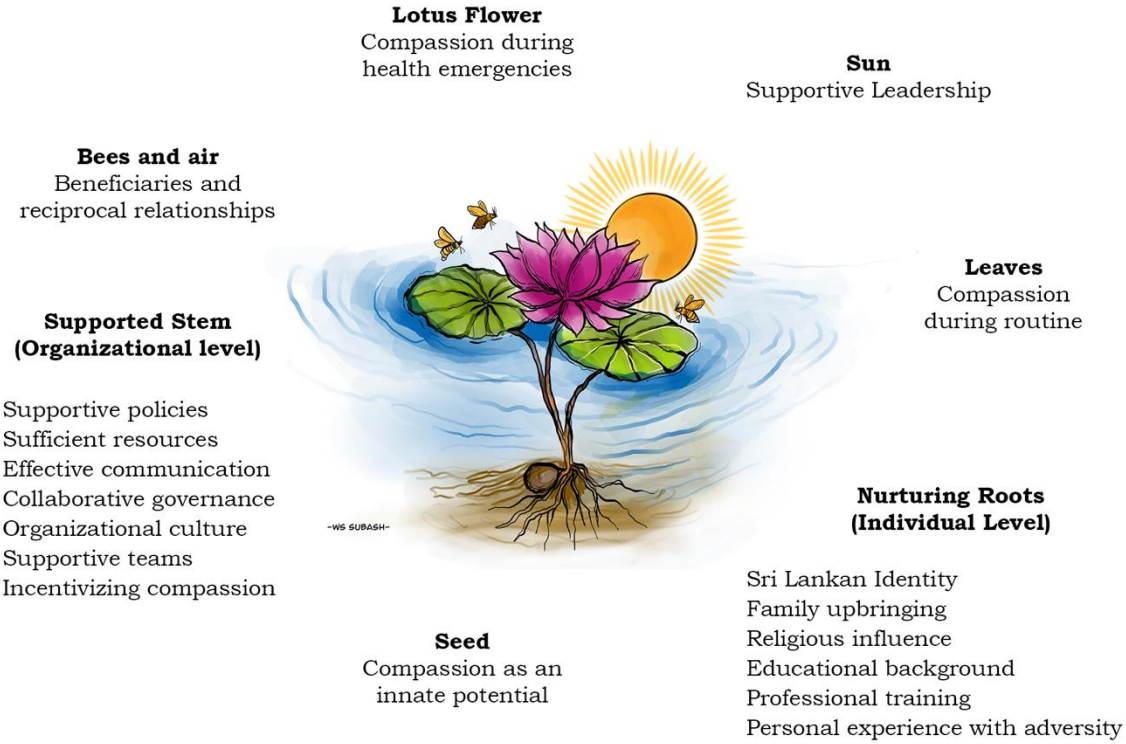
It is against this backdrop of convergence and tension that the Lotus of Compassion in Health Emergencies Model is proposed, which illustrates how compassion in health emergencies is seeded, nurtured, expressed, and sustained (Figure 5, below).

Like a lotus, compassion grows and blossoms through the interaction of multiple levels of influence—from individual roots to organizational structures, cultural nourishment, and reciprocal community relationships.

At the seed level, compassion exists as an innate potential within every health worker, responder, or volunteer. This potential takes root in the individual level, where formative influences such as Sri Lankan identity, family upbringing, religious and cultural values, education, professional training, and personal experiences with adversity provide the soil in which compassion is grounded.

The stem represents organizational and systemic structures that carry compassion upward. Just as the lotus depends on water to sustain its growth, organizational support—including sufficient resources, adaptive policies, effective communication, supportive teams, and cultures that incentivize compassion—determines whether compassion is nourished or stifled. The leaves symbolize everyday expressions of compassion in routine services. These are smaller, continuous acts such as kindness, patience, respectful communication, and care that sustain the system daily.

Figure 5. Lotus of compassion in health emergencies model



Artwork Credit: WS Subash. This figure was conceptualized by the authors and created by WS Subash for this paper. Permission for its use, reproduction, and publication has been granted by the artist.

The flower represents compassion in full bloom during crises and emergencies. In these moments, compassion becomes highly visible, expressed in extraordinary acts of empathy, fairness, and sacrifice that go beyond routine service delivery. The sun embodies leadership, which provides the direction, vision, and energy required for compassion to flourish.

Finally, bees and air represent beneficiaries and reciprocal relationships. Communities, patients, and families draw nectar—the care and services provided—but in turn, they also "pollinate" the system through gratitude, cooperation, and recognition. This exchange sustains morale among providers and reflects the supply–demand dynamic of compassion: compassion is not only supplied by systems and individuals, but also demanded and reinforced by the expectations and responses of communities.

The findings also suggest that humanitarian principles and professional standards are not in tension with compassion, but rather operate alongside and through it. While the Lotus model foregrounds compassion as an orienting and integrating force, humanitarian principles, ethical frameworks, and professional standards can be understood as complementary elements within the same ecosystem of emergency response. Extending the metaphor, these principles may be seen as other "flowers" in the garden, distinct in form and function yet contributing to the same shared environment, cross-fertilising practice and reinforcing collective accountability in service of affected populations during health emergencies.

Taken together, the Lotus of Compassion in Health Emergencies Model, derived through the grounded theory approach, highlights that compassion is multi-level and systemic. It thrives when rooted in cultural and personal foundations, supported by organizational structures, guided by leadership, and reciprocated by communities. When these conditions align,

compassion blossoms even in the most adverse emergencies; when they fracture, compassion withers, leaving humanitarian principles to function as procedural safeguards.

In the Sri Lankan context, the lotus metaphor captures these dynamics: seeds of innate potential, roots of individual formation, organizational stems supported by water, leaves of everyday practice, flowers of crisis compassion, leadership as sunlight, and communities as bees sustaining reciprocity. Compassion, therefore, must be recognized not as a "soft" optional value, but as a systemic quality essential to resilience, trust, and effective emergency response.

4. Discussion

This study makes three key contributions to the understanding of compassion in health emergency management. First, it empirically demonstrates that compassion in health emergencies is not limited to individual attitudes or bedside interactions, but operates across multiple system levels, including leadership, organizational structures, frontline practice, and community reciprocity. Second, it reveals a dynamic tension between individual-level compassion and population-level, principle-driven humanitarian action, showing that these are not opposing forces but contextually negotiated expressions of care shaped by scale, role, and crisis conditions. Third, it identifies compassion as a fragile but renewable system quality, one that surges during emergencies yet risks erosion during routine periods unless actively cultivated through supportive organizational structures, leadership, and cultural grounding. Together, these insights provide the empirical foundation for the Lotus of Compassion in Health Emergencies Model proposed above.

A vibrant discussion on what compassion meant to the respondents, and how they described it, is presented in the study. They often described compassion using related terms such as kindness, "leaving no one behind," or helping others in need. These expressions were not treated as synonymous with compassion but as conceptually adjacent ways through which compassion was articulated in practice. Analytical attention was therefore given to whether these accounts reflected elements of awareness of suffering, emotional attunement, and intentional responsiveness, distinguishing compassion from actions undertaken solely out of duty, convention, or procedural obligation. Variations in how compassion was described were treated as analytically meaningful, reflecting its relational, situational, and culturally mediated nature within Sri Lanka's health emergency management context, and informing interpretation of the findings as capturing both shared patterns and contextual diversity in how compassion is understood and enacted.

The findings resonate with prior work in PHC, which has consistently identified compassion as a driver of quality care, trust, and equity, while also noting barriers such as burnout, hierarchical cultures, and resource constraints (Addiss et al., 2022; World Health Organization, 2025). Similar to scoping reviews on compassion fatigue, this study found that individual stress and professional constraints can diminish compassionate capacity (Garnett et al., 2023; Jeanmonod et al., 2024). The emphasis on organizational enablers—supportive leadership, adaptive rules, and staff well-being—mirrors international evidence that compassion can be fostered through institutional culture and policy. Likewise, the recognition of compassion's reciprocal nature, circulating between providers and communities, aligns with the literature on catastrophe compassion and disaster sociology, which documents mutual aid and altruistic solidarity following crises ("In a Catastrophe, Compassion Rises," 2024). These findings resonate well with the narratives of compassionate flow at systems level by Kirby, Sherwell, & Hseih (2026).

At the same time, the grounded theory developed here extends current knowledge in several key ways. Whereas much of the international literature frames compassion primarily at the level of individual providers (nurses, physicians, allied health professionals), this study situates compassion across the entire HEM system, including administrators, policy leaders, and community actors (Garnett et al., 2023; Jeanmonod et al., 2024; Marks et al., 2025). While global reviews highlight compassion fatigue and burnout, this study emphasizes the positive systemic flows of compassion, showing how leadership attitudes cascade downward and community gratitude reinforces provider morale, producing a cycle of resilience. Moreover, while prior work often treats compassion as a psychosocial trait or organizational intervention, the present study embeds compassion within Sri Lanka's cultural-philosophical traditions—the Brahma Viharas and Sangraha Vasthu. This cultural grounding reframes humanitarian principles not as abstract "tick boxes" but as moral practices sustained by long-standing ethical traditions.

Importantly, the study challenges the common misconception that compassion stands in opposition to humanitarian principles. While some global discourses position humanitarian principles such as humanity, neutrality, impartiality, and independence as "rational" or professionally objective standards, compassion is often framed as "emotional," subjective, or potentially disruptive. Several respondents reflected this perceived tension, particularly in emergency settings where adherence to protocols, efficiency, and population-level equity were prioritized. In this framing, compassion was sometimes viewed as redundant or even risky when weighed against the structural certainty of humanitarian principles and professional codes.

However, participant narratives and the emergent grounded theory suggest that compassion and humanitarian principles are not in conflict, but operate at different levels and scales of ethical action. In the Sri Lankan context, compassion was understood as a moral orientation that animates and gives meaning to humanitarian principles rather than undermining them. When compassion is grounded in cultural ethics and supported by organizational structures, it enables humanitarian principles to move beyond procedural compliance and become lived practices. At the same time, respondents recognized that humanitarian principles themselves can be understood as institutionalized expressions of compassion at a population level, particularly through their emphasis on equity, impartiality, and the alleviation of collective suffering. Respondents described compassion as shaping how principles are interpreted, prioritized, and enacted, particularly in morally complex situations where rigid application of rules alone may fall short.

Within the Lotus of Compassion in Health Emergency Management Model, which conceptualizes compassion as an organic system with roots (individual formation), stems (organizational structures), petals (visible expression), and reciprocal flows (beneficiary-provider dynamics), humanitarian principles are embedded within the supportive stem, providing structure, accountability, and population-level safeguards, while compassion flows through the petals as relational responsiveness and ethical presence. In this integration, humanity is deepened through loving-kindness, impartiality resonates with generosity and kind speech, neutrality is sustained through equanimity, and independence is expressed through integrity and purposeful action. Compassion thus strengthens rather than weakens humanitarian principles, ensuring they are enacted with depth, authenticity, and resilience across health emergency contexts.

Participants consistently described disasters and outbreaks as conditions that compel systems, institutions, and actors to respond compassionately through adaptive decision-making, procedural flexibility, prioritization of vulnerable populations, and deliberate efforts to "leave no one behind." Such responses were understood as system-level expressions of compassion,

reflected in practices such as relaxing rigid rules, reallocating resources, and tolerating inefficiencies in favor of equity and dignity.

At the same time, participants articulated a critical tension that deepens understanding of systemic compassion. Several respondents expressed concern that compassion had not been institutionalized as a core priority within the health system. Instead, policies and organizational norms were perceived to emphasize efficiency, performance, and coverage over relational quality and moral responsiveness. While the health system demonstrated an ability to rapidly shift into a more compassionate mode during emergencies, compassion was described as far less embedded during routine or "normal" times. Outside crisis contexts, bureaucratic procedures, hierarchical arrangements, and rule-bound practices often rendered the absence of compassion socially acceptable or systemically normalized.

As a result, compassion during emergencies was experienced less as a sustained institutional value and more as a situational imperative triggered by visible suffering and heightened moral urgency. In this sense, compassion was described as both situational and constrained, more evident in certain emergencies or patient categories, yet easily eroded by structural pressures, policy design, and overwhelming demand. Respondents expressed concern that when compassion is not embedded in system design and policy frameworks, it risks being reduced to a personal or discretionary choice rather than recognized as a collective responsibility of the health system.

Rather than representing a contradiction, these findings point to a dynamic and fragile form of systemic compassion. The health system appears capable of compassion surges during crises; however, in the absence of consistent cultivation during routine periods, such compassion risks dissipating as institutions revert to pre-emergency norms. Participants cautioned that when compassion is weak or absent in everyday health system functioning, transitions out of emergency modes may result in a rapid "weaning off" of compassionate practices once the immediate crisis subsides.

This pattern underscores the importance of viewing compassion as a continuum rather than a binary state. Drawing on the lotus metaphor, compassion in normal times can be understood as the sustaining leaves that nourish the system, while compassion during emergencies represents the fully blooming lotus that emerges under demanding conditions. Without compassion being embedded in everyday governance, training, and organizational culture, emergency-driven compassion may be intense but short-lived. In this way, the Lotus of Compassion in Health Emergency Management Model extends beyond the epidemiology of compassion, which identifies contextual and relational risk factors but does not fully theorize their integration, by offering a holistic model of how compassion is cultivated, activated, and sustained across interdependent system levels in health emergencies.

Health emergency management frameworks, including those articulated by the World Health Organization, conceptualize emergencies across interconnected phases of prevention, preparedness, response, recovery, and resilience**.** When situated within this cycle, the findings of this study indicate that expressions of compassion were most strongly articulated during the response phase, when suffering is immediate, visible, and morally urgent. Participants' accounts of volunteering in the face of danger, assisting conflicting parties, and prioritizing vulnerable populations illustrate how disaster response can catalyze compassion at both community and health system levels. At the community level, compassion was expressed through spontaneous volunteering, mutual aid, and risk-taking to protect others. Within the health system, compassion flowed reciprocally across levels, from managers enabling flexibility, to frontline health workers adapting care practices, to communities supporting responders.

By contrast, participants offered limited reflections on compassion in prevention, preparedness, recovery, or longer-term resilience-building, suggesting that compassion is less consciously recognized or operationalized in these phases. This absence should not be interpreted as a lack of relevance, but rather as an indication that compassion remains under-theorized and under-institutionalized outside acute response contexts. The predominance of response-phase narratives highlights how compassion is often activated by crisis, while its potential role in shaping anticipatory planning, inclusive preparedness, recovery processes, and resilient health systems remains less visible in practice.

This phase imbalance reinforces the importance of integrating compassion more explicitly into health emergency management frameworks beyond response. Doing so may help prevent compassion from remaining episodic and reactive and instead position it as a sustaining force that informs prevention strategies, preparedness planning, recovery efforts, and long-term resilience-building. In this sense, disasters and emergency responses not only reveal compassion but may also offer critical opportunities to cultivate and institutionalize it within both society and the health system, bridging humanitarian impulses with structured emergency governance.

While this study is grounded in the Sri Lankan health emergency management context, several insights are transferable across settings. The identification of compassion as a multi-level, systemic quality operating across leadership, organizational structures, frontline practice, and community reciprocity is likely applicable to diverse health emergency systems, particularly in low- and middle-income countries and crisis-prone settings. Similarly, the dynamic tension between individual-level compassion and population-level, principle-driven humanitarian action, and the finding that compassion tends to surge during response phases but erodes in routine periods, reflect structural patterns observed globally and resonate with international literature on humanitarian governance, burnout, and organizational culture. The conceptual integration of compassion with humanitarian principles through supportive organizational structures also offers a transferable analytical lens for examining ethical practice in emergencies beyond Sri Lanka.

At the same time, certain elements are context-specific. The cultural, religious, and philosophical grounding of compassion through traditions such as the Brahma Viharas, Sangraha Vasthu, and shared moral narratives shaped by Sri Lanka's history of conflict and recurrent disasters represents a locally embedded ethical ecology that may not directly translate elsewhere. Likewise, symbolic expressions such as the "Mother Hospital" narrative and culturally mediated forms of community reciprocity reflect specific social imaginaries. These context-specific elements do not limit the model's relevance but rather illustrate how universal system dynamics of compassion are locally expressed, suggesting that adaptation, rather than replication, is required when applying the Lotus of Compassion in Health Emergency Management Model in other sociocultural settings.

5. Limitations

Several limitations should be acknowledged. First, beneficiary perspectives were minimally represented in the interviews. While the study captured provider and managerial voices, the demand side of compassion—how patients and communities perceive and reciprocate it—largely remains to be explored. Second, although the researchers attempted to examine compassion during both normal service delivery and emergencies, the study was biased toward emergencies, which represent only a fraction of the health system's continuum of care. Third, the study did not attempt to evaluate the compassion of any particular staff category or within a given disaster

event. Instead, it study aimed to generate an overall contextual understanding across the system. These limitations could be overcome through more focused research in the future.

6. Conclusion

This study demonstrated that compassion in Sri Lanka's HEM system is not merely an individual trait but a contextual, relational, and systemic force. It was experienced and expressed across multiple levels—rooted in personal upbringing and histories, nurtured or constrained by organizational structures, reinforced through systemic flows between leaders, staff, patients, and communities, and anchored in the country's cultural-philosophical traditions.

The Lotus of Compassion of Compassion in Health Emergencies Model provided a way to capture this complexity: compassion begins as a seed within each health worker, grows roots through formative influences, is carried upward through organizational structures acting as the stem, and is expressed in everyday acts and in full bloom during crises. Crucially, compassion was shown to circulate reciprocally, as gratitude and cooperation from communities sustained the morale and resilience of providers.

While compassion was consistently valued as essential in health emergencies, it remained fragile—vulnerable to burnout, rigid rules, poor leadership, and resource shortages. Conversely, compassionate leadership, adaptive systems, and grounding in cultural values allowed it to flourish even under extreme conditions.

By situating compassion across the entire HEM system, this grounded theory extends beyond international literature that focuses primarily on individuals or compassion fatigue. It reframes compassion as a systemic quality that strengthens resilience and reinforces humanitarian principles. Far from being their antithesis, compassion deepens and sustains humanitarian values, transforming them from abstract standards into lived practices that sustain trust and solidarity in times of crisis.

7. Recommendations

Based on the findings, the following practical recommendations are proposed for strengthening compassion in Sri Lanka's HEM system:

- *Institutionalize compassion at the organizational level as a supportive stem.* Health emergency management frameworks should explicitly recognize compassion as an enabling organizational function, supported through flexible policies, adaptive decision-making, and leadership practices that balance efficiency with dignity and equity during emergencies.
- *Strengthen reciprocal compassion between health systems and communities.* Health emergency strategies should acknowledge and sustain the two-way flow of compassion observed in emergencies, by creating mechanisms that recognize community solidarity, volunteerism, and trust as assets that support responder morale and system resilience.
- *Embed compassion beyond emergencies to prevent post-crisis erosion.* Findings indicate that compassion often surges during crises but rapidly weakens in routine settings. Policies, training, and accountability mechanisms should therefore address compassion in everyday health system functioning, not only during emergencies, to sustain humane responses over time.
- U*se the Lotus of Compassion in Health Emergencies as a research and analytic model.* Rather than prescribing interventions, the Lotus model can guide future research, evaluation, and

policy analysis by examining how compassion is cultivated, constrained, and sustained across individual, organizational, and community levels.

Authors

Novil Wijesekara
Office of Deputy Director General, Public Health Services I, Ministry of Health, Sri Lanka; Department of Global Health, University of Washington, United States of America
http://orcid.org/0000-0002-0391-6220
novil.wijesekara@gmail.com

K. Rashmini Wasana Priyashantha
Department of Architecture, University of Moratuwa, Sri Lanka
http://orcid.org/0009-0007-6258-6886

Lahiru Kodituwakku
Global Disaster Resilience Centre, University of Huddersfield, United Kingdom
http://orcid.org/0000-0002-9243-2067

Thushara Kamalrathne
Department of Sociology, University of Peradeniya, Sri Lanka
http://orcid.org/0000-0003-4681-2568

Asanka Wedamulla
Disaster Preparedness and Response Division, Ministry of Health, Sri Lanka
http://orcid.org/0009-0000-2749-0845

Samiddhi Samarakoon
Disaster Preparedness and Response Division, Ministry of Health, Sri Lanka; Office of Deputy Director General, Medical Services II, Ministry of Health, Sri Lanka
http://orcid.org/0000-0003-2965-0405

Author contribution statement

NW is responsible for the study conception and research design, data collection, and data analysis, and led the writing of the manuscript. RW assisted with transcription of qualitative interviews, contributed to data analysis, and coordinated the development of graphics. LK supported the conceptualization of the research and data collection. TK supported improvements to the manuscript, particularly with regard to qualitative methods. AW assisted with the data collection process. SS provided institutional support and assisted with data collection.

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Conflict of interest statement

The authors report no conflicts of interest.

AI statement

During the preparation of this work the author used Grammarly and ChatGPT to improve language and readability with caution. After using this tool, the authors reviewed and edited the content as needed and

take full responsibility for the content of the publication. English interviews were auto transcribed using Otter AI. The transcripts were manually checked and corrected by the research team before analysis.

Data availability statement

The interview transcripts generated and analyzed during the current study are available from the corresponding author upon reasonable request and with appropriate justification.

Ethics statement

IRB approval for this study has been obtained from the Ethical Review Committee of the National Hospital of Sri Lanka.

Consent to participate

Informed consent was obtained from the respondents who participated in the study.

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