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Commentary

Why Good Quality Care Needs Philosophy More Than Compassion

Comment on "Why and How Is Compassion Necessary to Provide Good Quality Healthcare?"

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Abstract
Although Marianna Fotaki's Editorial is helpful and challenging by looking at both the professional and institutional requirements for reinstalling compassion in order to aim for good quality healthcare, the causes that hinder this development remain unexamined. In this commentary, 3 causes are discussed; the boundary between the moral and the political; Neoliberalism; and the underdevelopment of reflection on the nature of care. A plea is made for more philosophical reflection on the nature of care and its implications in healthcare education.
Keywords: Compassion, Care Ethics, Neoliberalism, Political

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Marianna Fotaki's analysis of the role of compassion in good quality healthcare is helpful and challenging.[1] It is helpful because she makes clear that promoting compassion on an individual level can never be a solution for a healthcare system that fails to be humane as regards the atmosphere it creates for individual caregivers and patients. Suggesting that the crisis in contemporary healthcare can be solved by blaming individual caregivers only increases the stress these people already are subjected to. Therefore, Fotaki proposes one needs to look at both: the professional and organisational side of the coin. Her analysis is challenging, because there are a number of causes that make it very hard to give compassion the place healthcare it should have.

In this commentary, I would like to reflect on Fotaki's contribution from a care ethical perspective. Fotaki rightly refers to care ethics in her Editorial as a movement with feminist roots. Since Carol Gilligan's seminal work in the beginning of the 1980s, however, care ethics has developed into an interdisciplinary field of enquiry in which insights have been articulated that help understanding the deeper causes of why we do not seem to manage developing a more humane healthcare. Drawing on these insights, I would like to raise three issues that may help understanding why changing our culture is so hard. The 3 issues are: the relation between the moral and the political; the role of Neoliberalism; and the absence of reflection on what care essentially is.

The Boundary Between the Moral and the Political

One of the central critical insights of care ethics coined by Joan Tronto is that the virtual boundary between the moral and the political in our culture has made it possible that unjust political systems may continue to exist next to highly moral individual practices.[2] This is precisely what happens when individual care givers are promoted to be more compassionate in order to held up a healthcare system that in return is not compassionate to their workers and patients. Tronto's insight that the moral is political and vice versa means that we cannot consider compassion to be a feature of isolated individuals. We should look more deeply into an analysis of why compassion is so hard to reinstall nowadays.

When we think of the story of the Good Samaritan – the western role model of compassion par excellence – and its widespread use still in contemporary culture, we are reminded of the fact that once compassion was one of the most important foundations of healthcare. Grit and Dolfsma,[3] eg, analysed the different rationalities underlying the developments in healthcare during the last century in the Netherlands and list 4 discourses with their own logics that shift from a central role of compassion to a central role of the market. According to their analysis, in the beginning of the 20th century healthcare was organised from institutions with a religious – mainly Christian – identity. Many of the religious people serving as healthcare givers in these institutions, lived and worked in a world in which compassion was both an individual virtue, reflected in the public policy of their healthcare institution and part of a meaning frame that was shared by both professionals and patients. This unity of discourse, expressed in a continuity between the individual and the institutional, the moral and the political, was changed when a new paradigm and discourse was developed in the 1950s. Due to the great developments of medical science a medical discourse began to dominate healthcare in which an idea of professionalism was developed, replacing the central

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value of compassion. In the 1970s, a political discourse was introduced into healthcare in which accessibility of healthcare and participation of all citizens began to dominate. In the 1980s, the Netherlands, as many other North Atlantic countries, were confronted with a new discourse: economy began to reign over healthcare, managers were introduced and the market was seen as the best way to reduce costs. The role of compassion shifted from a central organizing value to a commodity to enhance low quality care.[4]

Neoliberalism

In order to understand why it is so hard to change this situation, we have to dig somewhat deeper into the cultural climate change that set off in the 1980s and has had an enormous effect on every segment of society: Neoliberalism. As Wendy Brown has shown, Neoliberalism extends market values to social politics and all institutions that uphold our society, including healthcare.[5] The effect of this on our society can hardly be underestimated. Because it is so pervasive and omnipresent, it even influences the way we look at ourselves and the world around us. All aspects of economic life are subjected to an economic rationale, including the way individual subjects see themselves and organize their lives. In order to have a viable existence, citizens are forced to adopt entrepreneurial habits and be prepared to always be high performing. This creates calculating individuals, subjected to economic rationalism. The instrumental logic of Neoliberalism also transforms the way we look at care.[6] As, according to the laws of the market, all human capital must bear fruit, care is considered as an activity by which human beings deploy their human capital. Taking care of oneself is seen as an individual responsibility, whereas taking care of someone else is regarded as an economic transaction.

In a logic like this, human beings are not seen as the vulnerable corporeal beings they basically are. Neoliberalism holds a reductionist view of mankind as composed of rational self-supporting creatures that all strive for wealth and freedom. Compassion can only have a place in this logic if it is cut to an instrumental size. The roots of compassion as a premoral unpredictable and disruptive experience that opens up and connects human beings is to be avoided for its uncontrollable and irrational nature.[7] In the logic of Neoliberalism compassion appears as a commodity, a trick to manipulate vulnerable patients at a deeper level in order to gain profit from them.

Understanding Care

One should not be romantic about restoring compassion in healthcare. Neither does nostalgia bring us any further. Compassion cannot play the fundamental role it has played for centuries without the meaning frame that had accompanied it in those days, and the institutional and political structures that went with it. What can be done within our Neoliberal society, however, is change the way we look at things by working on the concepts we use to organize our society. No society can do without healthcare. The more care is generally understood and agreed upon as a multidimensional human practice that is intrinsically contributing to a more humane world, the less we need a concept as compassion to provide good quality healthcare. How can this be realised?

One of the most inspiring stories in 20th century healthcare is the way Dame Cicely Saunders contributed to transforming the way we care for the dying. Being denied and marginalised in a society traumatised by the second world war and hypnotized by the promises of modern technology, care for dying people was often limited to physical support, if at all.[8] By introducing the concept of 'total pain,' and founding an institution – St Christopher's hospice in London – that played a leading role in developing a new approach to terminal care, she helped developing a new way of understanding what care for the dying should be like. Worldwide palliative care is now seen as care for the whole person and his or her family, intrinsically multidimensional, including physical, psycho-social and spiritual support, and thus essentially non reductionist.

Although, of course, culture can never be changed by one single person, and the complexity of these changes involve a long and slow cultural process of patients and relatives learning to reorient their hopes and perspectives on living and dying, Saunders helped influencing policy making up to the level of the World Health Organization (WHO), and changed the face of care for the dying. The lesson we can learn from Saunders, is that healthcare can be changed, but only then when our thinking about healthcare is changed as well. Saunders installed new practices of care – accompanied with research and education – that articulated a new way of looking at reality. And by changing the way we look at the dying person, it became impossible to accept any form of reductionism any longer. Palliative care is not only a specific practice of caring for people in a specific state, but also an approach, a philosophy, including an anthropology that sees patients as relational beings embedded in a family context and asking for support in all dimensions of human life.

Just as Neoliberalism has entered our inner lives and deeply influences our perception of reality, other ways of looking at the people and world around us may touch and motivate us to shape different practices. That asks for reflective spaces in healthcare in which daily reality is analysed and reflected upon in order to understand why healthcare itself can be so unhealthy. Most healthcare professionals are trained to care for people for many years without ever reflecting upon the question what caring is and how it relates to a humane society. They are trained to perform actions without thinking about the systems their actions are embedded in, and the degree to which these actions contribute to a society that threatens the dignity of many of its weakest members.

Good philosophical reflection on caring makes clear that this practice, in whatever context or form it is performed, is aimed at building a humane world in which people can live together in sustainable relational webs. That compassion does play a role in such a practice goes without saying. But it is neither the foundation of this practice nor the decisive element which makes the difference between good and bad quality care. The real foundation of caring is our readiness and willingness to deal with our vulnerable and mortal human condition in a humane way. The philosophy that helps spelling this out should be part of any healthcare curriculum.

Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author's contribution

CL is the single author of the manuscript.

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