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Just compassion: implications for the ethics of the scarcity paradigm in clinical healthcare provision

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ABSTRACT

Primary care givers commonly interpret shortages of time with patients as placing them between a rock and a hard place in respect of their professional obligations to fairly distribute available healthcare resources (justice) and to offer a quality of attentive care appropriate to patients' states of personal vulnerability (compassion). The author argues that this a false and highly misleading conceptualisation of the basic structure of the ethical dilemma raised by the rationing of time in clinical settings. Drawing on an analysis of the Aristotelian virtue of *nemesis*, or "the sense of justice", it is argued that, far from being a moral orientation distinct from justice, compassion is a justice response insofar as it is conceptualised as a rational, appropriate response to others' adversity. The author then proceeds to point out that the perspective on justice and compassion as attributes of healthcare professionalism suggests a novel critical viewpoint on the ethics of managed forms of clinical rationing and the "scarcity paradigm" they engender: clinical conditions where primary care givers' time is intentionally rendered a commodity in chronically short supply run a deficit of justice, because they fail to make adequate accommodations for the provision of the quality of care human beings deserve in situations of illness and injury, and when they are dying.

The problem of deciding how to best care for patients where resources are finite, or "healthcare rationing", affects every level of care, from industry to policy and institutional structure to the bedside. At the national level, healthcare rationing is most immediately a justice issue. It focuses on the right to healthcare and the extent to which people have that right.¹⁻⁷ Of course, the issue of how to fairly distribute medicines, beds and equipment—the goods typically at stake in distributive justice problems at the national level—trades on a corresponding concern for beneficence as well, if often tacitly. The best medical system is the one that best approximates the ideal of beneficence: universal provision of the best available healthcare when it is required and most beneficial. From this perspective, healthcare rationing is fundamentally concerned with identifying and justifying the least bad (or most fair) departures from this ideal. By contrast to the national level, at the level of patient care it is common for primary care givers to perceive healthcare rationing problems as involving an explicit opposition between justice and caring. In clinical settings, where time is ever in short supply, primary care givers face competing demands between the professional obligation to treat patients equitably and to offer a quality of

attentive care that patients merit in light of their state of personal vulnerability. Because it is inadequate time that prevents nurses and physicians from offering an appropriate quality of attentive care, the availability and just distribution of time is, for many them, among the most salient ethical issues in professional practice.⁸⁻¹³

The perspective of practice and of the practitioner has always been integral to clinical ethics. But in recent years the advent of the so-called "outcomes-based" movement in education and professional training gives a different kind of impetus to the project of examining ethical problems in healthcare as problems of healthcare professionalism. A curricular and pedagogical approach that spurns inventories of knowledge items in favour of comprehensive lists of competencies that comprise skilled, effective and ethical professional practice, outcomes-based education indeed has considerable ramifications for professional ethics and its erstwhile preoccupation with the analysis and application of key concepts and principles of professional role-morality to novel problems.^{14 15} A real innovation in the outcomes-based approach is that it encourages the articulation of standards of professionalism in explicit reference to what are referred to variously as "attributes", "traits", "competencies", "virtues", "values", "attitudes", "qualities" and "commitments" of professionalism.¹⁶ Professional obligations as disparate as respecting and communicating effectively with stakeholders, clients and colleagues, promoting and modelling the public or personal good the profession supports, obedience to statutory and other regulatory frameworks, promoting and modelling the basic socio-personal good the profession supports (eg, health), and dedication to continuing professional self-improvement generally become stated in terms of personal ethical attributes the practitioner is expected to possess.^{11 17-22} Unsurprisingly, standards of healthcare professionalism universally list "caring" (also referred to as "compassion", "empathy" and "beneficence") and "justice" (also referred to as "fairness" and "equity") as core professional attributes—albeit the latter sometimes in the form of an admonition to adhere to the profession's code of ethics, which in turn makes explicit reference to just service provision.^{11 17-22}

In this way, outcomes-based statements of standards of healthcare professionalism may offer practitioners and ethicists a new way of talking about such dilemmas as the one raised by the clinical rationing of time, but it does not make resolving them any easier. For medical ethicists, conflicts between the principles of justice and

beneficence are a productive source of philosophically engaging ethical problems. Healthcare ethics as a field of abstract, conceptual inquiry and topic of professional reflection, however, is one thing. The practicalities of healthcare delivery are quite another. And while from the clinician's point of view, the actual prioritisation of justice over caring in healthcare contexts may of course be odious, and legitimate grounds for "moral distress",^{23, 24} from the standpoint of practical, clinical choice the question of assigning deliberative weight to justice over compassion, at least under conditions of close clinical rationing of time, approaches a proverbial ethical no-brainer: in an understaffed critical care unit, taking the time necessary to provide a patient with compassionate medical care is not supererogation. It amounts to professional irresponsibility on the grounds that doing so may very well put the lives of the other patients on the unit at risk. This moral choice can be explained theoretically in terms of the ascendancy of the so-called "primacy-of-justice" thesis. A staple of philosophical accounts of justice from Plato to Kant and Rawls, the primacy-of-justice thesis turns up in common morality as the view that justice is of a different and higher order than other moral principles and virtues. Accordingly, ethical conflicts between considerations of justice and other moral values can be resolved, at least for pragmatic purposes, by prioritising justice.²⁵

Here I argue, in spite of the intuitive appeal of this conceptualisation, that it is wrong and highly misleading to regard the clinical rationing of time as presenting an ethical dilemma between the duty to provide just care and the duty to provide compassionate care. I begin by presenting an analysis of compassion and justice as personal ethical attributes. According to this analysis, justice and caring do not represent distinct moral orientations. Compassion is instead one of a set of four emotions that comprise a sense of justice, where a sense of justice is understood as the positive personal attribute characterised by reasonable, human response to others' fortunes and misfortunes. I go on to point out that the conceptualisation of compassion as a desert-based ethical perspective entails a revised interpretation of the ethics of clinical conditions where time is a scarce resource. Rather than generating a classical dilemma for healthcare professionals, such circumstances constitute a perplexing paradox: the demand to disregard standards of professionalism vis-à-vis compassion in order to meet standards of professionalism vis-à-vis justice is also and at once a demand to disregard standards of professionalism vis-à-vis justice. In the closing section, I suggest that the outcomes-based notion that professionalism is coterminous with the possession of a set of occupational-domain-specific personal ethical attributes such as "just" and "compassionate" does more than merely extend the vocabulary of clinical ethics. When the moral psychology of professionalism is taken seriously, it provides a fresh critical perspective from which to question the ethics of managed forms of clinical rationing referred to in the literature as the "scarcity paradigm" in healthcare. Clinical conditions in which primary care givers' time is a commodity intentionally made chronically in scarce supply run an acute deficit of justice, because patients in such contexts are denied access to the care that human beings deserve in their vulnerable situations of illness and injury, and in the process of dying.

A SENSE OF JUSTICE (NEMESIS)

As personal attributes, justice and compassion are among the most richly social. In the first place, they are excellences of response to human beings as moral entities. There are other

personal ethical attributes that are not "social" in this sense because they are excellences of response to non-human objects. Courage, for instance, is an excellence of response to dangerous situations just as moderation is an excellence of response to one's bodily appetites. Of course, honesty, generosity, friendliness, considerateness and other positive personal attributes are also frequently person-directed. Yet unlike the problem of being honest, generous, friendly and considerate, the problem of justice and, as I will argue, of compassion is uniquely tied up with determining how to respond appropriately to others in the face of what befalls them in life. A person disposed to respond appropriately to the fortunes of others can be said in the vernacular to *possess*—and one who is not so disposed to *lack*—a sense of justice.²⁵

Kristján Kristjánsson's recent analysis of justice as a personal trait provides valuable insight into the sense of justice and its meaning as a personal attribute. *Nemesis*, as he refers to it, adopting terminology from Aristotle, is precisely that ethical disposition to respond with appropriate pleasure and pain at what befalls others in life.²⁵ He argues that the sense of justice comprises four more-or-less familiar desert-based emotions: compassion (ie, pain at undeserved bad fortune); but also indignation (ie, pain at undeserved good fortune); satisfied indignation (ie, pleasure at deserved bad fortune); and, finally, an emotion for which he coins the term *gradulation* (ie, pleasure at deserved good fortune).²⁵ What distinguishes the emotions comprising *nemesis* is that they seem, again, to reflect balanced, rational and appropriate emotional responses to others' fortunes, a feature which may be best appreciated by considering them in contrast with their irrational, unbalanced counterparts—for example, *Schadenfreude*, or pleasure at another's undeserved bad fortune or what Kristjánsson calls "begrudging spite", a kind of envious pain at another's deserved good fortune.²⁵ *Nemesis*, then, takes in the signature emotions of a character endowed, as stated by Kristjánsson, with a "sense of justice as a personal, emotional virtue: a virtue that binds good, reasonable people together in a community of feeling and judgement and lays the ground for justice as a social institution" (Kristjánsson, 2006, p102).²⁵

In ordinary English, the adjective *just* is, indeed, more likely to be used to describe institutions and social relations than persons. Westerners have on the whole become unaccustomed to speaking and thinking about justice as a personal virtue. This habit of language and thought owes much to political liberalism and its significant influence on popular ethical and political discourse. Summarily, liberalism is preoccupied with identifying, justifying, advancing and protecting rights as social entitlements.^{26, 27} Rights are fundamentally conceived of as unconditional, universal entitlements.^{26, 27} Liberalism is naturally wary about considerations of desert as a basis for justice judgements, since it seems to allow that respect for human dignity may be conditional and particular, dependent on whether or not such forms of respect are deserved. But from the ancient scriptures to Confucius to Aristotle—and, indeed, in a whole swathe of contemporary desert-regarding theories of justice^{28–31}—justice as a virtue of institutions and social relations is seen as deriving from a prescriptive account of justice reasoning as a dimension of practical wisdom. That is to say, just social arrangements are held to be those that just political actors would endorse, establish and maintain in order to further the cause of justice in society because, possessing justice as a personal attribute, they care about justice.²⁵

Viewed from this perspective, to expect, in the manner of the outcomes-based standards of professionalism, justice from

healthcare workers in their professional conduct—or, for that matter, from any human being in any domain of activity—means to expect them to treat others in ways that are congruent with their own sense of justice. Of course, ethical “requests” of this sort are not exhortations to unquestioningly follow one’s subjective inclinations.³² To be sure, the exercise of practical wisdom implies getting moral problems right, but it also implies caring about getting moral problems right, a disposition of scepticism towards one’s own moral intuitions, and the mastery of reasoning skills that help one gauge the acceptability of ethical claims.^{33–34} If it is not too obvious to state, the very presence of ethics on healthcare curricula is a tacit acknowledgement that professional conduct cannot merely be coextensive with practitioners’ pro tanto intuitions about what constitutes professional conduct. A core preoccupation of professional ethics education, as remarked above, has been precisely to ensure that prospective members of the professional body possess basic skills of critical ethical reflection.³⁵

Now, the idea that compassion is a justice-structured emotion departs importantly from the leading conception of the relationship between justice and compassion as moral outlooks. As suggested above, the received view in practical ethics is that considerations of justice must sometimes intervene as a necessary corrective to otherwise laudable compassionate other-directed responding. It also tacitly assigns to compassion conditional moral value—conditional, that is, on whether it meets standards of justice.³⁵ The basic assumptions that structure this picture of the relationship between justice and compassion are not far to seek. On the one hand, compassion seems clearly to possess some singular moral value on the grounds that it expresses the attitude of solicitude towards others’ well-being and the protection and promotion of fundamental human needs,³⁵ needs that specifically characterise the moral domain as an area of social interest.^{36–38} Yet on the other hand, compassion, being an emotion, is an action incentive that is liable to diverge from standards of moral impartiality. It may, accordingly, cloud or distort better moral judgement if left unregulated by a justice motive. After all, an action’s moral status is determined in relation to whether the action meets certain criteria of a moral action; tensions and inconsistencies between a person’s sympathies (eg, my hungry daughter should get fed first) and what is just or fair (eg, my hungry daughter is fourth in a line of other people’s equally hungry daughters) are not only possible, but commonplace. Thus, while compassion may play an important role in motivating morally justified acts, it stands ever in need of regulative constraint by rationally justifiable principles of fairness—that is to say, by a concern for “justice”.^{39–42}

The point cannot be overstated that at issue here is not which of the two conceptions of compassion just adumbrated is correct. When considered as a subjective emotional response, compassion can of course distort moral perception and moral judgement. In this respect, compassion is no different from any other emotion; hate, love, envy, greed, lust and hope can do so too.^{30–33} But compassion is also and just as certainly a specific personal, ethical attribute and one that, as this section has argued, seems satisfyingly conceptualised as a dimension of the broader trait of *nemesis*, a disposition to being appropriately affected by injustice in the world. As the discussion of the ethics of the scarcity paradigm in the next section will argue, running these two senses of *compassion* together is a swingeing conceptual error, and one that itself occludes a clear-sighted, honest appreciation of the fact that possessing compassion and

justice as traits of medical professionalism entails more than being dedicated to providing a quality of care commensurate with respect for patients’ dignity. Most significantly for the purposes of this paper, compassion and justice enjoin healthcare professionals to endorse, maintain and—when institutional arrangements impede the capacity to provide this level of care—advocate appropriate institutional change.

THE ETHICS OF THE SCARCITY PARADIGM IN HEALTHCARE

Clinical rationing raises specific, predictable problems, depending on whether it arises in a mass-casualty situation, in a developing-world context or in an urban hospital in an OECD (Organisation for Economic Co-operation and Development) country. According to some analyses, however, recent years have witnessed the emergence of a novel form of planned clinical rationing that is the product of a cost-cutting managerial movement within organisations entrusted with overseeing healthcare administration. This movement is widely associated with so-called “managed care”. Although invariably defended publicly on the grounds that they maximise efficiency in the use of limited financial resources, it is also common knowledge that policies aimed at such things as shortening hospital stays, reducing the number of active beds and increasing primary care givers’ productivity are highly conducive to maximising returns on private investment in healthcare management organisations.^{11–43–44} In this process of “rationing by dilution”, quantifiable measures of a healthcare system’s performance may improve, but at the level of patient care, it fosters a culture or “paradigm” of scarcity that comes to permeate hospital life.⁴⁵

The main commodity that is in short supply in the scarcity paradigm is primary care givers’ time.⁴⁶ Time pressure becomes such that patients can be offered little more than the treatment they require as a strict medical necessity. As a natural consequence, the emotional and intellectual work that primary care givers and nurses in particular can do in caring for patients is rendered impracticable and devalued.^{11–43} The institutional climate of the scarcity paradigm also sends a clear message to patients and their families: nurses’ time is precious, and attentive and compassionate care are unaffordable luxuries that cannot be expected during a hospital stay.⁴⁶ Many nurses, having become convinced that such levels of scarcity are a fact of professional life that cannot be changed, come to perceive the nurse’s work as that of providing the least bad care possible in circumstances of permanent shortage.^{11–41} Dissenters risk social ostracisation in the workplace and may be openly disparaged by coworkers as “whiners”, “bleeding hearts”, “slow workers” or “too talkative with patients”.¹¹ Unsurprisingly, perhaps, occupational research on the experience of primary care giving has observed links between the scarcity paradigm and “moral distress”, “burnout” and “compassion fatigue”.^{8–13–23–24–43–44} According to this research, nurses and physicians understand these related forms of work-related stress as resulting from their inability to provide the compassionate care that they have been trained provide, that they are otherwise willing and able to provide and that some regard as being central to their fiduciary responsibility as professionals.^{8–13–23–24–43–44}

In the opening section of this paper, I observed that conditions of time scarcity in clinical settings generate a *prima facie* ethical conflict between the professional obligation to fairly distribute healthcare resources (justice) and to provide a quality of attentive care appropriate to patients’ situations of vulnerability (compassion). What was presented in that section as the standard view of the conceptual relationship between justice and compassion furnishes at once an interpretation of

such conflicts and a ready solution to it. That is to say, in the face of shortages, while it is undoubtedly professionally commendable for healthcare workers to wish to provide compassionate care, professionalism demands that the compassion motive be regulated and suppressed in accordance with the more urgent requirements of justice. However, when viewed from the perspective of the alternative conceptualisation of compassion as a dimension of *nemesis* developed in the second section of this paper, the ethics of the clinical rationing of time takes on a different aspect. Instead of posing a conflict between the distinct and opposing moral orientations of justice and compassion, time scarcity is a thoroughgoing problem of justice. Sick, injured and dying human beings *deserve* compassionate treatment. Not caring compassionately for them is a failure of justice as a human excellence of other-directed response. This is the reason why caring compassionately for a sick, injured or dying person is part of what it means to treat that person justly.

This analysis, in other words, challenges the suggestion that the typical ethical problem generated by the close rationing of time in clinical settings can be resolved by the simple prioritisation of the professional obligation to justice over the professional obligation to compassion. The standards that healthcare professionals are called on to meet are standards of attitude and behaviour towards patients that are rational, appropriate and just in light of the patients' circumstances of personal adversity. Indeed, a cursory acquaintance with the recent outcomes-based statements of professionalism confirms that when "compassion" is presented as a core ethical attribute of healthcare professionalism, it is compassion in the sense used in this paper—ie, as a personal ethical attribute that contributes to a sense of justice—that is consistently invoked.^{11 17–22}

Of course, accepting that it is more accurate to regard the scarcity paradigm as raising a wholesale justice problem does not in any way imply denying that the clinical rationing may generate genuine ethical problems. Whenever time for primary caregiving is short, the imperative to provide attentive care will frequently have to cede to the imperative of maximising the availability of urgent or necessary medically treatment. What the present analysis does entail, however, is a radical re-interpretation of that problem. It is not whether to be "nice" or "fair". Instead, the fundamental and complex problem faced by the primary care giver is how to negotiate competing demands to further various fundamental human goods that time pressures have rendered incompatible: life, health, physical integrity, and also due and dignified treatment. Furthermore, the conceptualisation of compassion as part of balanced justice responding sheds theoretical light on the well-documented empirical link between the scarcity paradigm and the experience and rates of "moral distress" or "compassion fatigue" among providers of primary care.^{8–13 23 24 43 44} In short, time scarcity places primary care givers in a catch-22 situation. Rising to the level of professional standards concerning justice necessitates giving their patients inappropriately detached care. Yet failing to provide appropriately concerned care *also* amounts to a failure to rise to the level of professional standards concerning justice.

In conclusion, the erroneous interpretation of the scarcity paradigm as generating an ethical conflict between justice and compassion (rather than as an abnegation of both justice and compassion) obscures a simple truth. Managerial structures that give rise to the scarcity paradigm intentionally deny physically ailing human beings access to a reasonable minimum of compassionate care, and this for the purposes of maximising economic efficiency. To this extent, the primacy-of-justice

thesis in healthcare provision is a "convenient truth" from the point of view of managerial priorities. The analysis of justice and compassion as personal ethical attributes that is advanced in this paper casts the strict dichotomisation of justice and compassion in the context of the scarcity paradigm in a rather insidious light. At the level of patient care, it can be and is deployed in such a way that obvious affronts to patients' dignity appear to be ethically permissible in the name of fairness, whereas, in truth, such excesses of managed care bear the hallmark of institutional arrangements erected, endorsed and maintained by human beings who do not really care much about treating patients justly at all. As Florence Nightingale once observed, bad institutional arrangements often make it impossible to provide good healthcare. But the art of healthcare ought to include such arrangements as alone make good healthcare possible.⁴⁷

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