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Commentary

Imagined in Policy, Inscribed on Bodies: Defending an Ethic of Compassion in a Political Context

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

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Abstract
In response to the *International Journal of Health Policy and Management (IJHPM)* editorial, this commentary adds to the debate about ethical dimensions of compassionate care in UK service provision. It acknowledges the importance of the original paper, and attempts to explore some of the issues that are raised in the context of nursing practice, research and education. It is argued that each of these fields of the profession are enacted in an escalating culture of corporatism, be that National Health Service (NHS) or university campus, and global neoliberalism. Post-structuralist ideas, notably those of Foucault, are borrowed to interrogate healthcare as discursive practice and disciplinary knowledge; where an understanding of the ways in which power and language operate is prominent. Historical and contemporary evidence of institutional and ideological degradation of sections of humanity, a 'history of the present,' serve as reminders of the import, and fragility, of ethical codes.
Keywords: Compassion, Ethics, Nursing, Health Politics, Neoliberalism, Austerity, Human Rights
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Introduction

This short commentary is an invited response to Marianna Fotaki's editorial *'Why and how is compassion necessary to provide good quality healthcare?'* published in the *International Journal of Health Policy and Management*.[1] It is a timely and valuable contribution to current debates about compassionate care in the context of specific failures in National Health Service (NHS) provision, and mediated reports of diminished public confidence in healthcare more generally. The title poses 2 key questions facing those individuals who, respectively, shape health policy, deliver caring services, or have responsibility for the preparation and training of future practitioners; and to each of these issues, 'compassion' and 'ethical awareness' are central constructs. Though, as it is noted, they are too often conflated and confused in both intellectual and 'common sense' accounts of the constituents of high-quality care; obfuscating individual attributes and organisational cultures.

In this reply, key themes from the paper are explored in relation to nursing academe, focusing on education and research which, it has long been argued, represent the foundations of progressive practice. Discussion is framed by an acknowledgement of the Foucauldian concept of 'discursive practice,' as a way of understanding the historic and cultural rules that produce different forms of knowledge, and permit certain statements to be made.[2] Translated into social research, this set of perspectives is represented by the contribution of discourse analysis as a form of inquiry that prioritises the 'discursive construction of reality.'[3] Here, attention is given to the performative, and collective, function of language in shaping the world around us, where what we 'know,' or accept as 'truth,' are inextricably linked to power and ideology.[4-6] These interrelated themes are elaborated below in terms of healthcare politics, research, practice, and education (wrapped up tidily in university 'corporate speak' as 'knowledge exchange').

Politics and Research

In the United Kingdom, healthcare is a political issue. The NHS is the last vestige of traditional socialist ideals of welfare founded on the principle of 'free to all, at the point of need.'[7] As an institution, its values are so deeply embedded in the public psyche that no 'serious' political party could campaign on an election manifesto that did not offer to protect the spirit of universality. Or, so it is routinely argued. Yet, results of the May 2015 election across England, Scotland, and Wales tell a different story, where any sense of collectivism was demolished by a surge of nationalism. The Scottish Nationalist Party (SNP) may have purveyed an 'anti-austerity' message to the voters and Westminster but, generally, identity prevailed over common interest. The reelection of a Government, freed of any coalition control, which systematically dismantled public services,[8] is a harbinger of the ideological landscape upon which future debate about healthcare ethics, and practice, will take place.

Activists, academics, and health economists note the

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detrimental effect, on health inequalities, of unchecked neoliberalism,[9,10] as a global movement that, in short, celebrates market forces as the basis of political liberty. A scholarly review of how global financial crisis impacts on physical and mental health[11] is summarised, more succinctly, as 'austerity kills.'[12] In the UK context, healthcare reforms – as a euphemism for privatisation – are coupled to further attacks on civil liberties with government proposals to abolish the *Human Rights Act* in favour of a *British Bill of Rights*; another example of de-universalisation as discursive practice in neoliberal times, where the ethical foundations of freedom and dignity are progressively chipped away.

Nurses, typically, work with vulnerable and marginalised groups, framed by a statutory duty of 'care' and 'candour,' to 'treat people with kindness, respect and compassion'[13]; a laudable, and paramount, set of principles that stand proudly against the pro-genocidal discourse of tabloid reporting around immigration, asylum seekers, and refugees.[14] The rise of the Nazi Party in pre-war Germany, though, is a dark reminder of how easily dominant nationalist ideologies can hijack intellectual and liberal aspirations, with import for how ethics are taught on nursing programmes today.[15] Like all healthcare professionals, nursing research is guided by ethical principles enshrined in the Declaration of Helsinki (2000) that echo the Nuremberg Code (1947); a response to 'human experimentation,' and state sanctioned murder, in the death camps of the Third Reich.

The history of the Holocaust illustrates the extent to which doctors and nurses were willing to actively collude in bureaucratised killing of adults and children, in their care, with mental illness or a learning disability[16-18]; actions defended as 'medical therapy,' with individual ethics abandoned for the greater good of the 'fatherland.' The chief lesson to be learned is not rooted in the character traits of fascist street thugs or tyrannical sadists. Rather, it centres on the appropriation of psychiatric *knowledge* expressed in the spurious *science* of eugenics, within an ideological discourse that legitimated 'mercy killing,' without mercy[19]; deviance inscribed on the body of the 'other.' Such a 'history of the present'[20] raises profound and troubling questions for contemporary practitioners in the context of an increasingly visible, pan European, right-wing political presence.[21,22]

Practice and Education

Given the past failure of ethics, discussed above, the nursing profession needs to define itself as a 'moral community,' coalesced around the ethics of witness and virtue.[15] Two major UK inquiry reports, into high-secure care, published in the 1990s[23,24] produced finding that characterised the worst excesses of the old asylum system, and led to major structural and legislative changes. They described an insular and oppressive world, with an institutional culture described as racist, sexist, and densely macho. More recent research findings suggest that little has changed since that time, despite massive capital investment and culture-change programmes.[25,26] This raises questions for how ethical protection, and compassionate care, can be safeguarded for those groups who are vulnerable, excluded and marked by the stigma of a spoiled identity. Unlike current examples of a collapsed 'duty to care,'[27] related to general service provision for the seriously ill and elderly, prisoners and mentally disordered offenders do not make for the same sympathetic media coverage.

The idea of an 'ethics of testimony' as being important for nursing philosophy and science is also central to the work of Georges[28] who sees self-reflection as one way of challenging Eurocentric reductionism, and reconceptualising the concept of 'suffering.' It is suggested that increased attention to structural inequalities like sexism and racism should replace dominant cultural narratives which equate problems with 'pathology,' and solutions in terms of 'therapy.' Similarly, Ben-Sefer[29] argues that it is knowledge of 'suffering' rather than 'history' that needs incorporating into the design of nursing curricula as a way of combating intolerance and hate crime. The involvement of 'prisoner nurses' detained in concentration camps, it is posited, reframes ethical theorising about 'choice,' and situates personal decision-making in the context of politics and power relations.[30] It is suggested that masculinist discourses of 'disconnection' constructed a bio-political space in which moral categories collapsed, and corporeal violence was inscribed on the flesh of the inmate. The disciplinary knowledge of psychiatry, and discursive practice of mental health nurses, is riven with ethical dilemmas from involuntary detention under mental health legislation to 'treatment' methods[31]; described as a 'web of power' where tablets and talk can be equally invasive.[32] Critical scholars suggest that: "Psychiatry is not a mere medical science: it is an intensely political system of interrelated practices, discourses, and institutions."[33] In such settings, the enactment of concepts like 'advocacy' and 'therapeutic engagement' are permeated by what is referred to as the 'capillary power' of the carceral system, or micro-physics of disciplinary regimes.[34] For mental health nurses in general, and forensic staff in particular, any ethical framework is compromised, or constrained, by a dual allegiance to the person (care) and the state (control).

More generally, national and international evidence suggests that organisational cultures exert an impact on care and compassion in relation to, both, qualified members of staff and nurses in training.[35,36] Typically, this is described as damaging and detrimental to the philosophy of the profession, and quality markers of health policy; a 'hidden curriculum' where 'learning on the job' in clinical settings incrementally erodes levels of empathy.[37] Central to Fotaki's paper,[1] is a real concern about how compassion is cultivated, and embedded, in practice, and her discussion offers a valuable summary of philosophical and pragmatic issues in relation to a recent case study of care failures.[27] Against this background, the author of the present paper, with a colleague, was commissioned by NHS North West to undertake a 'values and behaviours' evidence review.[38] The findings, and themes, were congruent with the work of Fotaki.

Concluding Remarks

Professor Fotaki has furnished an excellent editorial relating to a very real concern in UK healthcare, which deserves a wide readership for all those concerned with ensuring that compassion and care remain at the heart of service provision.[1] It artfully integrates ethical debate with real world strategies, but it is for the individual reader to interpret these in the context of their own role and responsibilities. This is what has been attempted in this response. None of the content

has been challenged, or alternative views expressed. As an academic nurse, with a long career in high-secure care, it was an interesting opportunity to rethink these issues in the context of an organisational culture that personally shaped an ongoing intellectual critique of ethics and politics in forensic psychiatry. I would like to thank the editorial team at *IJHPM* for inviting me to write this paper, and hope that it complements the original.

Ethical issues
Not applicable.

Competing interests
Author declares that he has no competing interests.

Author's contribution
DM is the single author of the manuscript.

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