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The art of medicine

Compassion in a time of COVID-19

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The verdict on the success of the global response to the COVID-19 pandemic remains to be written, but the consequences of the disease are indisputable and rapidly coming into focus. In many countries, efforts to contain COVID-19 have resulted in an economic recession, pushing millions out of their jobs, and creating previously unprecedented unemployment in many countries worldwide. In addition to the millions of people infected by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), hundreds of thousands have died—and will die—from COVID-19. An anticipated wave of mental and behavioural problems is beginning to be documented—compounded by social and economic stressors and uncertainties—that will likely present a population health burden for months and years to come.

COVID-19 has also triggered enormous displays of pro-social behaviour with neighbours coming to the aid of those isolated by the containment efforts and of support for front-line workers, including doctors, nurses, and other health-care personnel, whose responsibilities keep them at risk of infection. In the public conversation about this pandemic, an admirable empathy has been evident for those who have been affected and for those who have died from COVID-19. In some ways, the pandemic has brought populations together, generating an understanding that our health is interlinked and that we could all be at risk. That understanding made it possible, perhaps in an unprecedented way, to empathise with those with the disease and to wish them well out of a clear sense that they could also be us.

Infectious diseases have always been the paradigmatic example of diseases that show how our health is interlinked. We take vaccinations and make sure our children are vaccinated both to protect ourselves and as a social good. This impulse is laudable and, indeed, useful. It has helped, for example, ensure that during this pandemic an enormous number of people worldwide have followed guidance and orders to physically distance with relatively little demonstrable social disturbance. In fact, the opposite quickly became true: in many countries social norms shifted to encourage physical distancing, casting opprobrium on those who may have flaunted physical distancing norms and expectations. Public apologies by prominent figures who were found to be flaunting these guidelines became a feature of national media coverage.

And yet, it is worth reflecting on the extent to which our response to the COVID-19 pandemic has been informed by an understanding that we are all in this together, that the virus does not discriminate, and that as a result it benefits us all to comply with physical distancing guidelines to protect others and ourselves. Our empathy, our capacity to envision that we too could be affected, has been a powerful tool in the public health arsenal. But, in large part, it is hard not to notice that our empathy is informed here, as it often is, by an appreciation of our own personal risk. We feel regret and feel terrible about those who are suffering, in no small part because we can imagine that suffering being our own.

But is it true that this suffering is our own? Is it true that COVID-19 does not discriminate? Evidence is emerging that the effects of COVID-19, far from being indiscriminate, follow deeply entrenched patterns of health inequities, mirroring burdens of disease that are near universal. Those with resources, money, and power, often majority racial or ethnic groups, are better able to physically distance, work from home, and retain their employment. Those same groups then have lower risks of becoming infected or dying from COVID-19, probably reflecting a combination of factors, including better access to health care and a lower underlying burden of morbidity that predisposes to worse COVID-19 outcomes. It turns out that COVID-19 does discriminate, and that those who are already vulnerable—for example, the unstably housed, people on low income, those with poorer education, and individuals with less access to reliable nutritious food—are more likely to both become infected with the virus and die from COVID-19.

And this is where empathy fails. Empathy in the context of health is largely predicated on our appreciating the

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risks of a disease because we can imagine getting the disease ourselves. When we imagine we can also be infected, we are then willing to take the steps necessary to protect ourselves—and others—from the disease. And that force has been powerful and contributed to the dramatic change in how we live and in a shutdown of large parts of the world's economy, informed by fear of a novel disease and the need to protect ourselves and others around us.

But what if those efforts contribute to health divides? What if those efforts also result in economic consequences that are inevitably going to be borne principally by those who are vulnerable and marginalised to begin with? What if those efforts are therefore going to result in the long-term widening of health inequities, consigning many people to worse mental and physical health for years to come? How do we account for this eventuality and how do we factor this into our thinking?

This calls ultimately for compassion as the animating force behind our thinking about health, and our thinking about how we go about informing the decisions we make to contain a novel threat like COVID-19. Compassion extends beyond empathy. It does not motivate our action because we too may be harmed. Compassion motivates action because the phenomena we observe are unjust, not worthy of the world we would like to live in. Martin Luther King Jr spoke often of compassion, enjoining us to see that compassion ultimately motivates not to "[fling] a coin to a beggar" but to "see that the edifice which produces beggars needs restructuring". Compassion pushes us to understand how we have structured the world, and to ask how we can structure it better, not because we may suffer but because others are suffering and that is not how the world should be.

What would such a world look like? It would be one that is grounded in the principles of justice and the equitable distribution of resources. An approach to health that is rooted in compassion would help us see beyond ourselves, and place the good of others first. A world rooted in compassion would embrace health as a public good. This means treating health the way we do parks, education, the post office, fire stations, or our environment—in essence, as a crucial piece of the global commons supported by our collective investment for the benefit of all.

I recognise that this might seem theoretical, but such an approach would have concrete implications for our approach to health that can shape all our actions, be they in times of crisis, or in other times. In some respects, the current overwhelming investment in doctors and medicine has pushed a vision of health as a private commodity, something we can buy and sell, particularly in countries like the USA that do not have access to universal health care.

But what we can buy—health care—can only help us after we have become sick. And what we have been buying in the time of COVID-19 is largely an approach to bludgeon an epidemic into submission, informed by strict prioritisation of the biological imperatives of viral transmission. But our focus should always have been, and more importantly should now be, on building a world that is resilient to these challenges. Our focus should be on health as a state of not being sick to begin with, grounded in an approach that balances the health of all in all our actions. We must recognise that unless we invest in the preventive conditions of health—like safe housing, good schools, liveable wages, gender equity, clean air, drinkable water, and a more equal economy—any action we take during this and any future pandemic is likely to widen entrenched health gaps. And that situation should be unacceptable to all of us.

Would our approach to COVID-19 have been different were we accustomed to seeing health through the lens of compassion? I would argue yes. First, we would have long invested in the conditions that make people healthy, aiming to remove the underlying disproportionate burden of preventable illness that accrues to vulnerable populations worldwide. Second, our response to COVID-19 would be informed in equal parts by efforts to contain the spread and to mitigate how the consequences of our efforts to do so can bring about disproportionate harm to those who are removed from the decision making around this pandemic. Third, our response would recognise the global differences that characterise a world that puts the burden of disease squarely on countries with fewer resources, often driven to that condition by centuries of cross-national injustice, and would push us to redouble our efforts to do everything in our power to help those countries, perhaps before our own.

Surely this moment calls for careful reflection and a reinvestment in compassion as a foundational approach to health. Calling attention to compassion in this way is not sentimental. It is pointing out a tangible good, without which health for all is impossible. In a sense, COVID-19 has shown us that a healthy person and a healthy world are the same. And healthy people and a healthy world are both strengthened immeasurably by having compassion at the heart of health.

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