Moses on Hodges and Paech and Bennett, 'Without Compassion, There Is No Healthcare: Leading with Care in a Technological Age'

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Reviewed by Jacob D. Moses (University of Texas Medical Branch) Published on H-Sci-Med-Tech (December, 2022) Commissioned by Penelope K. Hardy (University of Wisconsin-La Crosse)


It has become so impossible today to imagine health care without technology that there is a strong case to be made that health care itself should be regarded as a sociotechnical system, replete with both the promises and perils that attend applications of knowledge to practical purposes. When viewed this way, it makes little sense to pit health care and technology in opposition. Nor is it sensible to hold faith for technological fixes purported to offer exogenous solutions to the formidable problems inherent in how systems of health have been built. Rather, the healthcare-as-technology tack invites reflection about how technology can best advance goals of health—and what those goals should be.

If this is the right conversation to be having, then the contributors to Without Compassion, There Is No Healthcare: Leading with Care in a Technological Age make an expansive case that one commitment guiding the design and use of technology in health care must be compassion. Alert to how easily debates about technology can diffract into polarized ends, the authors advance an accommodationist approach “in which gifted humans and the best technologies collaborate to create exceptional, compassionate care” (p. 29).

Hailing from different aspects of health care practice, education, research, and management in Ontario, Canada, the book’s authors hold up compassion as something to be persevered within—and to prevent the sapping of meaning from—health care. Brian Hodges, who along with Gail Paech and Jocelyn Bennett edited the book, asks in the preface: “Within an evolving technological landscape, how can healthcare remain grounded in, and driven by, its compassionate purpose?” (p. xii). While there is sustained engagement with this question throughout the volume, the chapters productively debate compassion’s meaning and applications.

The introduction offers a baseline definition that emphasizes that compassion is not only characterized by sensitivity to pain and suffering (which might be captured by “empathy”) but also requires the “deep desire to alleviate that suffering” (quoted on p. xiii).[1] Compassion, in this view, demands not only feeling but also being motivated to act. Rather than advancing a singular vision, the volume represents a call to consider compassion and its place in the design and running of...
complex health care systems. That this ambition faces formidable challenges in implementation or risks being co-opted should not deter readers and committed reformers. And I would suggest that the health humanities could only further inform analysis and action advancing this laudable project.

The starting points of the book are that technology and health care work are closely interlinked and that health systems face difficulties in delivering compassionate, patient-centered care. These should be straightforward premises for readers to accept, particularly when read in proximity to COVID-19. Consider how the pandemic has brought with it successive waves of threats to public health and acute occupational hazards to health care workers. After many tumultuous months of supply shortages, inequitable distribution, and confusion that cost the lives of health care workers, it became evident that some of these threats could be mitigated rather effectively through the application of technologies. The N95 respirator carried not only the technical ability to filter out minuscule virus particles, but also much symbolic and social meaning, representative of whose inhalation was worthy of being guarded. The capacity for personal protective equipment to prevent hospital-borne infections of COVID-19 was further emblematic of some of both the successes and structural vulnerabilities of health care systems in North America. To a great extent, these systems have privileged the use of technology and most often located responsibility for health with individuals. Even the name “personal protective equipment” locates responsibility on the individual and links safety with technology.

Yet other kinds of occupational hazards have presented great peril to health care workers, in ways that more fundamentally shake the foundation of health systems. Problems of burnout that preceded the pandemic by decades show how health care work is work, and a form of labor that is vulnerable to problems of disengagement. This volume is the outgrowth of the Phoenix Project, an initiative first launched a decade ago by the Toronto-based Associated Medical Services nonprofit. The name is suggestive of the mythical bird, rising from ashes, an apt image given the smoldering implied by the dominant burnout metaphor applied to the now widely recognized concerns of occupational exhaustion and disenchantment. According to prevalent understandings, burnout arises from caring “too much.” It could seem paradoxical that the answer is more compassion, but the authors seem to suggest that a bevy of difficulties could be addressed by more systematically prioritizing compassion. This is in part because the authors hold health care to be a compassionate enterprise, and they argue that changes that have removed compassion run counter to the proper goals of health care. As Hodges notes in his introduction, Cynthia Whitehead and colleagues found that the language of “compassion” has fallen out of medical training accreditation standards.[2] If a motivating concern of history of medicine, medical sociology, and bioethics in the twentieth century was the disappearance of the patient, a concern in the twenty-first century is the disappearance of the provider.[3] How will clinicians be displaced by machines, and what will be lost in this translation?

The editors write from backgrounds in health administration, psychiatry, and nursing. After an introductory framing from them, the book proceeds in two parts with seven chapters from twenty-nine authors.

The first set of three chapters offer definitions of compassion. Chapter 1 discusses interfaces between humans and machines, suggesting that the implementation of electronic health records has often introduced barriers between clinicians and patients. If compassion were taken on as a guiding principle, technological systems could be designed to promote rather than alienate relationships
between clinicians and patients. Chapter 2 considers patient engagement as a technology, compassion’s relationship with suffering, and how forms of recognition can forge pathways for social justice. Chapter 3 draws on a mix of theoretical approaches to argue that compassion should be distributed equitably, but also that what is compassion should not be taken to be static or stable but rather subjected to ongoing reflection. It brings one of the more critical perspectives to bear on the question of compassion, noting that efforts to advance health equity are often elided by a narrow focus on the singular patient encounter.

The second part of the book draws on reviews of the literature and reports on efforts to build compassion into health care. Chapter 4 suggests that health care providers have not sufficiently been conceived as deserving of compassion, which can help account for problems of burnout, and it reviews some interventions to build resiliency among health workers. Chapter 5 suggests that the “turbulence” of technology creates challenges for health professional education (p. 130). Chapter 6 advocates for leadership theories that reject hierarchical “command and control” in favor of styles of being and doing that privilege fostering relationships (p. 154). Chapter 7 closes out the substantive chapters by productively broadening the scope to consider how to build compassionate health systems and expand the discussion of technology as digital devices and machines to include institutions.

The book’s authors include clinicians (nursing, occupational therapy, psychotherapy, psychiatry, pediatrics, addiction medicine, internal medicine) and researchers (public health, health policy). But despite representing a range of perspectives, most chapters adopt a management vantage point. The resulting pictures often provide greater overviews than they do detailed portrayals of the affectively charged spaces of the clinic. The dominant countervailing force to this is the occasional brief vignette or potted case study. Readers coming from the humanistic social sciences will likely pine for the thicker descriptions produced from more sustained forms of humanistic analysis. Historians of affect and emotion will immediately think of how conceptions of compassion have changed over time, as has the infrastructure that fosters or frustrates its production in acts of healing.

One place where this would have likely enhanced the analysis demonstrates one shortcoming of the book. Although the authors debate the meaning of compassion and how to best promote it, there is little space given to debate the idea that “health care is uniquely anchored in human compassion” (p. 28). It is hard to imagine mounting a case against compassion, but it is precisely because compassion has a positive valence that readers should be alert to how emotions, even outwardly positive ones, can be double-edged. (Chapter 3, by Moral Paton, Thirusha Naidu, Lisa Richardson, Arno Kumagai, and Ayelet Kuper, is a notable exception in its discussion of the need for advancing compassion through equity.) As critical scholars in the history of global health have demonstrated, the political and scientific mobilization of emotions have forged alliances and sown divisions. Virulent forms of racism and nationalism have been pursued on the basis of an exclusionary love for only some. And there can be little doubt that within the annals of health and healing, compassion has been inequitably distributed. The charitable origins of hospitals were produced alongside notions about deservingness and those perceived as unworthy of compassion. Readers of this book should be cautious about romanticizing human connection as a broad category of unalloyed good.

As Keith Wailoo recently noted, the health humanities represent a vibrant space for bringing the work of ethicists and historians, patients and activists, literature scholars and artists into conversation with
Much work remains to contextualize the various meanings of and possibilities for the affectively rich topic of compassion. For those invested in this project and interested in the human dimensions of technology and health, *Without Compassion, There Is No Healthcare* provides a strong call for deepening these engagements.

Notes


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