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The primacy of care

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Despite the emphasis on institutional efficiency and profit-making in neo-liberal economies, care should remain the central value for patients, families, healthcare professionals and community healthcare workers. (In fact, upon closer scrutiny, it is empirically at the centre.) What happens when the medical profession and healthcare systems insist on this re-evaluation? It will take a moral movement in global health, and likely in society more generally, for care to be accepted as the governing value in policies, plans and practices. Such a movement should also address the peril of artificial intelligence (AI) becoming the governing framework for care delivery, thereby threatening the loss of the human.

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What is the core value of medicine and healthcare? Ethicists have gone well beyond their earlier insistence on a rather limited set of abstract principles and are now moving toward more experiential and real-world contextual understandings. Solly Benatar's insistence on the inseparable tie between political economy and health is a key example. From my experience, the core value of medical ethics should be care itself. By not insisting that this is the most central value in medicine and healthcare, the medical profession has ceded to economists and health policy experts the transvaluation of care into institutional efficiency and financial gain, shaping what we do as professionals and what patients and families expect to receive from clinics and hospitals.

We measure institutional efficiency and profit, not quality care. To measure quality care, we would need to assess time spent communicating, the quality of caregiving relationships, clinical judgement, the value of technology in improving illness and treatment experiences, and other caregiving variables that matter most to clinicians, patients, families and communities. The late, great medical humanitarian Dr Paul Farmer, MD PhD, described 'accompaniment' as the most central of all clinical values. He insisted that the caregiver commit time and energy to being present with patients as they experience illness and treatment. Being there with those who suffer, bringing technical competence together with moral purpose, building emotional solidarity, refusing to accept socialisation for scarcity or bureaucratic indifference, and staying the course – accompaniment, for Dr Farmer, was his term for the commitment of health professionals and family members to the central value of care.[1] For Dr Farmer, this singular focus transformed a human relationship into a 'sacred' (I believe he personally knew no more fundamental term) obligation.

From an anthropological perspective on cross-cultural and historical evidence in medicine and healthcare systems, there is no more central value in the human response to suffering. In the Confucian tradition, for example, which underpins traditional Chinese medicine, virtue ethics rather than abstract principles are at stake. The practitioner must cultivate their humanity and that of their patients. Compared with biomedicine, traditional Chinese medicine is slower, involving more time with patients, more explanation, greater rapport and support and more hands-on care. It is therefore no great surprise that in China today, where even post-Covid there is lingering distrust of biomedicine (referred to in China as 'Western medicine'), traditional Chinese medicine stands out for its absence of serious conflict between doctors and patients or families, and for its lack of 'burnout' among practitioners.

Today, medicine and healthcare systems are increasingly caught up in a world-historical contestation between governance by artificial intelligence (AI) and governance by human care. The contemporary Leviathan of technology companies is working feverishly to substitute bots for caregivers. They argue that bots lead to greater efficiency and increased profits in healthcare systems.

Human care, on the other hand, when it is prized and practised at the most meaningful level, may not be as efficient or as profitable. In a sad, broken world filled with pain and suffering, its value lies not only in curing disease, when it can, but also in healing chronic conditions by providing attention to those who are forgotten, supporting those who are desperately waiting and uplifting those who would otherwise give up. Family care, when intact, amplifies professional care and is often the only care available. This makes policy to strengthen such care crucial. Dr Farmer's genius was to show how community care could be mobilised to support, extend and, when necessary, substitute for professional care. Such intimate care is a haven in a world that can, at times, seem heartless and cruel. That is why it's opposite – family absence or resistance – seems so fundamentally wrong, yet still human.

The dominant model of care, at least in the United States, is mistaken. It envisions an isolated individual at the centre of care: an active, autonomous patient, but also an active, autonomous doctor. However, all of us are relational beings, inhabiting vital networks of family, friends, co-workers, fellow community members and online neighbourhoods. Care is almost always intimately interpersonal, social and reciprocal, even when it is intensely subjective. And for practitioners, it is today most often institutionalised; as such, it limits the agency of the professional caregiver.

In my book, *The Soul of Care*,[2] I ask what our local worlds would be like if there were more adequate support for family care via long-term care insurance, direct compensation for family or network carers, greater provision of cognitive resources and

psychotherapeutic support, better-trained and more available home health aides, and practical policies that encourage and make feasible ageing at home. What would it be like if physicians, nurses, physician assistants and nursing assistants, and community care workers were incentivised to provide high-quality care, especially in global health settings? If they were assessed not only by standards of institutional efficiency and profit, or by protocols for particular treatments, but first and foremost by the quality of care delivered? If public health agencies and workers rejected socialisation for scarcity, and instead acted on the assumption that adequate resources to support quality care were almost always mobilisable? It would be a very different world.

To advocate for such a transformational reality, professionals, patients, families and communities need to insist that if care is the core value in healthcare systems, it must also be one of the core values in society more generally. Financial and political institutions must make the necessary resources available to ensure that this goal is more than aspirational and becomes an achievable outcome. For this to happen, a global moral movement for high-quality care would be required. Solly Benatar's contributions as physician, professor, department chair and leading figure in global bioethics can be seen as laying the groundwork for such a revolutionary movement. Dr Paul Farmer's words set out the value framework for this global moral movement:

> 'For me, an area of moral clarity is: you're in front of someone who's suffering and you have the tools at your disposal to alleviate that suffering or even eradicate it, and you act.'[3]

Dr Farmer also stated: 'The idea that some lives matter less is the root of all that is wrong with the world.'[3] As the 21st century advances, such a moral movement must include a serious reconsideration of how quality clinical care can be sustained in an era in which AI and robotics increasingly dominate our lived worlds. Although bots may effectively extend and augment the work of caregivers, they cannot and must not replace them. Preventing the loss of the human in healthcare needs to be considered absolutely essential. This conflict is shaping up to be the central challenge of our times. We must recognise it as such and do all we can, both locally and globally, to succeed in defending the human future of healthcare.

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