



## Quarterly Letters

# Aligning Philosophy with Practice

**F**ew healthcare managers keep copies of works by Heidegger or Marx next to their *Harvard Business Reviews*, but in this instance putting the critical theory toolbox to work may help us get to the heart of a problem raised in the last issue of *HealthcarePapers* ([www.longwoods.com/hp/4-1Leaders/index.html](http://www.longwoods.com/hp/4-1Leaders/index.html)).

In an Aesop fable, Jupiter holds a beauty contest to crown the king of the birds. A cunning jackdaw collects the feathers of other birds, and wears them in the hopes of becoming the prima donna. At the ceremony, the other birds reclaim their feathers and the jackdaw beneath is revealed.

Like the jackdaw, we in healthcare collect the concepts of our industrial peers, but as David Brown from the Ontario Securities Commission points out, there is a great benefit to be had from a “more in-depth analysis of the unique features of the healthcare system” (Brown 85). Although we have appropriated ideas like total quality management, internal markets, the patient as consumer, hospital restructuring, and managed care, the triad of accessibility, quality and affordability remains elusive in most developed countries where at best any two of these have been achieved in part.

An implication of siphoning concepts from other disciplines is our having changed the nature of our discourse in several ways. Some have suggested that in healthcare our mantra is driven in large part by an evidentiary system rooted in biomedical evidence as opposed to a broader perspective. In an effort to critique healthcare dogma with that of another discipline, we embarked on an exercise to apply the “evidence” two of philosophy’s heavy hitters, Karl Marx and Martin Heidegger.

For one, in using business terms and business analyses we often treat the products of healthcare like commodities, and so commodify healthcare itself. In Marx, a product of labour has a use-value. When these products enter a system of exchange they take on a new value which is actually a reduction of their complex characteristics. So, for example, a chair one makes for oneself has a use-value, but when one wants to exchange it for a product of someone else’s labour it must be reduced conceptually so that one chair will equal  $x$  in proportion to someone else’s product. Commodification involves this reduction to dollar value.

In healthcare we increasingly focus on outcomes, unit costs and products as a means to achieve the best balance between accessibility, quality and affordability. Our new knowledge has

changed our practices, arguably leading to a broader commodification of our services. For example, we are now at risk of viewing the care of a patient on the level of single interventions (clinical procedures) and their immediate outcomes. Through conceptualizations like Case Mix Groups (CMGs) and Resource Intensity Weight (RIW), and even the trend of Evidence-Based Practice, we are increasingly reliant on a sort of reductionist strategy. We break down the complex phenomena of healthcare to ratios and numbers.

Each commodity we identify – whether a clinical procedure, a specialty service or a management report – has consumers ranging from patients, to physicians, to politicians. Consequently, the process of commodification changes what we emphasize, thereby changing the priority we give to products of healthcare. This process guides or shapes the way people think about healthcare and quality, and so changes its consumers as well.

We might be inducing our consumers to what Marx might have called “part-object fetishism”; in other words highlighting parts or aspects of the healthcare system rather than healthcare as a whole. Could evidence-based healthcare be a way of fetishizing, where wearing our clinician hats we focus on clinical outcomes; our epidemiologist hats; population health, and our political hats, cost control and accountability for taxpayers? Different consumers focus on the aspects of healthcare that have the greatest face-validity to them, thereby ignoring some complexities. In response to part-object fetishism many steps are now being taken to bring practitioners, managers and policy-makers together to understand the whole system again. In Canada we have gone far as to revisit the value-system on which our methods are based to reaffirm it with the recent publications of the Kirby and Romanow reports.

Continuing on the philosophical path begun above, there are also byproducts of “the fetishism of the commodities of healthcare” to be seen through the Heideggerian lens. In “The Question Concerning Technology” Heidegger hypothesizes that the way we conceptualize something actually affects the essence of the thing. When human action, including thought, reveals something a certain way it shapes the very nature of the thing epistemologically. He gives the example of the Rhine River: “the hydroelectric plant is not built into the Rhine River as was the old wooden bridge that joined bank with bank for hundreds of years ... what the river is now, namely a power supplier, derives from out of the essence of the power station (Heidegger 16).”

Some ways of revealing are oppressive (Heidegger 17), like in the aforementioned example where a river is only conceived of in terms of what it can produce for humanity; as a means to an end. Is this what is at risk when diagnostic testing becomes

more important than a patient's self-reported symptoms? Heidegger goes so far as to say that people are affected through "the current talk about human resources, about the supply of patients for a clinic" (Heidegger 18).

We might ask how the essence of a patient is altered for a surgical team when using minimally invasive techniques, where the patient is represented by what appears on the screen. The incorporation of certain technologies, then, also plays a role in these reductions; so might our lessened focus on self-reported symptoms. Where reductionist strategies rely on generalization, particulars may not even appear on our managerial radar and may be eliminated from clinical practice. Not encompassing its totality, the risk of cleaving important features from the essence of healthcare lingers.

Despite our information systems, measurement tools and evidence-based methodologies we are plagued by unpredictability and controversy. We have not achieved the forecasting power of a business manager or accountant in, say, a production plant. Other divergences like management of the bottom line correlating with higher-quality and larger hospitals yielding the expected economies of scale have not, to date, reaffirmed business models, and some evidence-based clinical interventions have not impacted mortality rates as hypothesized.

Somehow our focus on conceptual reduction, evidence and outcomes has not achieved the accessibility, quality and affordability we desire in a healthcare system. We need to better under-

stand the dynamic between this reduction and the essence of healthcare if we are to understand why. We must pay attention to our consumers, but also be conscious of the steering power of our conceptualizations. For this jackdaw to become ruler of its realm it will have to care for its own plumage, and this may require a comb with each tooth reflecting the aggregate evidence of often-conflicting disciplines. Our soliloquy's aim is not to diminish any source of evidence, or, in our preferred language, "information." Rather, we aim to acknowledge multiple resources and the conflicts inherent in and among them.

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