Anusandhanvallari
Vol 2026, No.1
August 2026
ISSN 2229-3388

The Metricization of Compassion: A Philosophical Critique of Spiritual Care Metrics through the Lens of Karuṇā

[1]Kannan S, [2]Dr. Anand Sadasivan

[1]Research Scholar (Corresponding Author), Amrita School of Spiritual and Cultural Studies, Amrita Vishwa Vidyapeetham, Amritapuri, Kerala, India, Email:drkannansuresh@gmail.com

[2]Assistant Professor Amrita School of Spiritual and Cultural Studies, Amrita Vishwa Vidyapeetham, Amritapuri, Kerala, India

Abstract: Contemporary healthcare systems are increasingly shaped by practices of audit, accountability, and performance measurement associated with New Public Management reforms. While such developments have contributed to important forms of quality assurance and organizational oversight, they have also expanded into relational, emotional, and spiritual dimensions of care. As healthcare organizations increasingly seek to document and evaluate compassion, empathy, and spiritual support, important questions arise concerning the limits of measurement and the nature of compassionate practice. This paper examines whether the growing standardization and measurement of spiritual care may be understood as a form of epistemic and conceptual colonization. Drawing on Michel Foucault's concept of governmentality, Arlie Hochschild's theory of emotional labour, and contemporary discussions of epistemic injustice, the paper critically analyzes how organizational systems may reshape compassion into an object of assessment, documentation, and professional performance. As an alternative philosophical framework, the paper explores the concept of Karuṇā (compassion) within Buddhist thought and situates it alongside insights from the Kerala Model of Health, a widely discussed example of community-oriented public health development. Through this analysis, compassion is reconceptualized not as an individual competency or measurable intervention but as a relational and socially embedded practice that emerges within supportive institutional and communal conditions. The paper argues that an exclusive reliance on metrics risks narrowing the meaning of compassionate care and marginalizing forms of knowledge that resist standardization. It concludes that nursing philosophy and healthcare administration may benefit from greater attention to the structural, cultural, and relational conditions that enable compassionate practice, thereby broadening contemporary understandings of spiritual care beyond the logic of measurement alone.

Keywords: Karuṇā; Compassion; Spiritual Care; Nursing Philosophy; New Public Management; Audit Culture; Epistemic Injustice; Kerala Model

Introduction and the Crisis of Commodification

The contemporary healthcare landscape is increasingly shaped by tensions between the ethical foundations of nursing and the managerial logics that govern modern healthcare systems. Nursing has historically been understood not merely as a technical profession but as a moral and relational practice grounded in human caring, compassion, and responsiveness to suffering (Watson, 2023). However, scholars have argued that the rise of neoliberal governance has transformed healthcare institutions by introducing market-oriented values, efficiency imperatives, and performance-based accountability mechanisms into domains traditionally organized around public service and professional ethics (Brown, 2015; D. Harvey, 2005).

This transformation is closely associated with the global spread of New Public Management (NPM) reforms during the late twentieth century. NPM promotes the adoption of private-sector management techniques within public services, emphasizing measurable outcomes, performance indicators, competition, efficiency, and consumer choice (Hood, 1991; Pollitt & Bouckaert, 2017). Within healthcare, these reforms have reshaped

hospitals and health systems through the expansion of audit practices, managerial oversight, and standardized accountability frameworks (Power, 1997). As a result, healthcare professionals increasingly work within environments characterized by documentation requirements, performance targets, and organizational metrics that influence both clinical decision-making and everyday care practices (Newman & Lawler, 2009).

Critical nursing scholars have argued that these developments may alter how patients and nurses are positioned within healthcare systems. Under New Public Management reforms, patients and health service users have increasingly been reframed as consumers or customers of healthcare services, reflecting broader shifts toward consumer-oriented models of care and service delivery (Bolton, 2002). At the same time, nursing work is increasingly evaluated through measurable indicators of productivity, compliance, and quality assurance, raising concerns about the effects of managerialism on professional autonomy and relational care (Traynor, 2017). While such reforms are often justified in terms of efficiency and accountability, critics contend that they risk privileging what can be measured over aspects of care that are relational, emotional, and difficult to quantify (Paley, 2014). Similar concerns have been raised across public institutions more broadly, where critics argue that excessive reliance on performance indicators may distort professional judgment and displace substantive goals with metric-driven targets (Muller, 2018).

Digital health technologies have become central to this transformation. Electronic health records (EHRs), clinical decision-support systems, and healthcare analytics platforms have expanded the capacity of organizations to document, standardize, and monitor clinical activity (Greenhalgh et al., 2010). These technologies are frequently promoted as tools for improving patient safety, reducing error, and enhancing continuity of care. Nevertheless, sociological studies of healthcare technology suggest that digital systems also function as mechanisms of governance by translating complex clinical work into standardized categories that can be audited, measured, and managed (Timmermans et al., 2003).

Within nursing practice, this emphasis on documentation and measurable outcomes has generated concerns regarding the status of relational care. Activities such as attentive listening, emotional presence, comforting touch, and accompaniment during suffering remain central to many nursing theories, yet they are often difficult to capture through performance metrics or standardized documentation systems (Watson, 2023). Consequently, some scholars argue that the increasing dominance of audit cultures may inadvertently marginalize dimensions of care that are essential to therapeutic relationships but resistant to quantification (Paley, 2014; Power, 1997).

The expansion of measurement into domains such as compassion, patient experience, and spiritual care has generated considerable debate within healthcare policy and nursing scholarship. Healthcare organizations increasingly rely on patient experience surveys, quality indicators, and standardized assessment tools to evaluate care experiences, improve accountability, and monitor organizational performance (Anhang Price et al., 2014; Robert & Cornwell, 2013). Examples of such standardized instruments include the FICA Spiritual History Tool (Faith, Importance/Influence, Community, Address), which uses open-ended questions to elicit patients' spiritual beliefs and needs in clinical settings, and the Spiritual Needs Questionnaire. While these tools aim to enhance continuity of care and interdisciplinary communication, empirical evaluations reveal mixed outcomes. Studies indicate feasibility in palliative contexts, with correlations to quality-of-life measures, yet they risk oversimplifying complex relational dynamics when integrated into audit systems (Borneman et al., 2010; Cosentino et al., 2020). While such initiatives aim to improve quality and accountability, critics question whether complex moral and spiritual dimensions of care can be adequately represented through standardized metrics alone (Bradshaw, 2016; Paley, 2014). In particular, nursing ethicists have argued that compassion is not merely a behavioural competency but a moral virtue embedded within relationships and contexts of care (Bradshaw, 2016; Watson, 2023).The consequences of these organizational changes extend beyond patient care to the wellbeing of healthcare workers themselves. Research has consistently linked heavy workloads, staffing shortages, bureaucratic pressures, and constrained professional autonomy with burnout, moral distress, and job

dissatisfaction among nurses (Aiken et al., 2002; Epstein & Hamric, 2009). Although healthcare organizations increasingly promote resilience and wellbeing initiatives, critics argue that interventions focused solely on individual coping may obscure the structural conditions that contribute to professional suffering (Rushton & Rushton, n.d.; Traynor, 2017). From this perspective, moral distress emerges not only from personal vulnerability but also from organizational environments that impede the delivery of ethically appropriate care.

Against this backdrop, there is growing interest in alternative frameworks that conceptualize care as a collective, relational, and socially embedded practice. The Kerala Model of Health has frequently been cited as an example of how sustained public investment, community participation, decentralized governance, and a commitment to social welfare can contribute to favorable health outcomes despite relatively modest economic resources (Adithyan et al., 2024; Drèze & Sen, 2002; Joseph et al., 2023). Within this context, the South Asian concept of Karuna, often translated as active compassion or compassionate action, offers a potentially valuable lens for rethinking spiritual care beyond managerial frameworks. Rather than viewing compassion as an individual performance indicator or measurable competency, Karuna emphasizes relational interconnectedness, collective responsibility, and responsiveness to suffering. This perspective invites a reconsideration of whether compassion can be fully understood through systems of measurement and audit, or whether it emerges primarily from the social, moral, and institutional conditions that enable genuine caring relationships to flourish.

Neoliberal Governmentality and the Mechanics of "Emotional Labor"

Although nursing scholars have critically examined compassion, emotional labour, audit culture, and the effects of managerialism on healthcare practice, relatively little attention has been given to how non-Western ethical traditions might challenge contemporary approaches to spiritual care measurement. In particular, the concept of Karuṇā has rarely been mobilized as a philosophical framework for evaluating the assumptions underlying spiritual care metrics. This paper addresses that gap by bringing Karuṇā into dialogue with critical theories of governmentality, emotional labour, and epistemic injustice.

Understanding how spiritual care metrics influence clinical practice requires attention not only to organizational policies but also to the subtle mechanisms through which healthcare professionals come to regulate themselves. A useful framework for examining this process is Michel Foucault's concept of governmentality, which describes how modern forms of power operate through the shaping of conduct rather than through direct coercion alone. In neoliberal contexts, institutions encourage individuals to internalize organizational goals and evaluate their own actions according to prescribed norms of performance, accountability, and productivity (Davidson et al., 2008; Dean, 2010). Within healthcare systems, these processes are reflected in the increasing emphasis on measurable outcomes, documentation practices, and self-monitoring behaviours among healthcare professionals (Traynor, 2017).

The expansion of electronic health records (EHRs) and digital documentation systems has intensified these dynamics. Drawing on Foucauldian theory, Dillard-Wright (2019) argues that the electronic health record may function as a contemporary form of panoptic surveillance, structuring what is visible, recordable, and accountable within nursing practice. Through documentation requirements, timestamped activities, and performance monitoring systems, digital infrastructures shape professional conduct by encouraging nurses to align their actions with organizational expectations. Rather than relying solely on external supervision, these systems promote forms of self-regulation in which practitioners continually evaluate their own performance against institutional standards (Dillard-Wright, 2019).

Several nursing scholars have expressed concern that contemporary performance measurement and documentation systems may privilege activities that are readily measurable while rendering less visible aspects of care more difficult to recognize, document, and value (Allen, 2014; Paley, 2014; Traynor, 2017). Relational practices such as attentive listening, emotional presence, and support for families experiencing distress often resist

quantification and may therefore receive less institutional recognition within audit-oriented environments(Paley, 2014; Traynor, 2017). This creates tensions between the documentation demands of contemporary healthcare organizations and nursing's traditional emphasis on therapeutic relationships.

These developments can also be examined through Byung-Chul Han's concept of psychopolitics. Han (2017) argues that contemporary forms of power increasingly operate through self-optimization rather than external discipline, encouraging individuals to view themselves as projects requiring continual improvement. Within healthcare organizations, expectations related to communication, patient satisfaction, emotional responsiveness, and professional performance may become internalized as personal obligations rather than experienced solely as external managerial requirements (Han, 2017). Consequently, nurses may feel pressure not only to complete clinical tasks efficiently but also to continuously manage and optimize their emotional engagement with patients.

This phenomenon bears important similarities to Arlie Hochschild's theory of emotional labour. (Hochschild, 2012) distinguishes between surface acting, in which workers display emotions they do not genuinely feel, and deep acting, in which they actively attempt to align their internal emotional states with organizational expectations. Research in nursing has shown that emotional labour is a routine feature of clinical practice, requiring practitioners to manage their feelings while maintaining professional relationships with patients and families (Theodosius, 2008). Although emotional labour can facilitate compassionate care, difficulties may arise when institutional expectations transform emotional expression into a performance requirement that must be consistently demonstrated, documented, or evaluated (P. Smith, 2012) .

From this perspective, concerns about spiritual care metrics extend beyond questions of workload or administrative burden. Critics argue that the increasing measurement of compassion, empathy, and spiritual support risks transforming deeply relational aspects of care into organizational performance indicators (Bradshaw, 2016; Paley, 2014). The challenge is not simply that these dimensions are difficult to measure, but that their meaning may be altered when they become objects of audit and evaluation.

A complementary philosophical perspective is provided by Martin Heidegger's analysis of technology. In "The Question Concerning Technology," (Heidegger, 1977) argues that modern technological rationality tends to reveal the world through what he terms "enframing" (Gestell), a mode of understanding that renders beings primarily in terms of utility, efficiency, and resource availability. Although Heidegger was not writing about healthcare specifically, several contemporary scholars have applied his ideas to examine how bureaucratic and technological systems can reshape professional practice. From this perspective, there is a risk that qualities such as empathy, compassion, and spiritual presence may increasingly be valued for their measurable organizational outcomes rather than for their intrinsic ethical significance (Paley, 2014; Traynor, 2017).

Taken together, these perspectives suggest that contemporary healthcare organizations face a difficult challenge. Efforts to improve accountability, transparency, and quality measurement may generate important benefits, yet they may also create pressures to standardize dimensions of care that are fundamentally relational, contextual, and resistant to quantification. The resulting tension lies at the heart of contemporary debates regarding spiritual care, professional autonomy, and the future of nursing practice.

The Philosophy of Karuna: De-Colonizing the Compassionate Act

Efforts to reimagine spiritual care in nursing may benefit from engagement with philosophical traditions beyond dominant Western healthcare frameworks. One such resource is the Buddhist concept of Karuṇā (compassion), which emerged within South Asian religious and philosophical traditions and has influenced broader Indian ethical discourse. While Karuṇā is most fully articulated within Buddhist thought, where it denotes active compassion directed toward the alleviation of suffering, its significance extends beyond any single tradition. It is important to note that this analysis draws primarily on Buddhist philosophical sources and does not assume equivalence between Buddhist, Hindu, or other South Asian understandings of compassion. Karuṇā is emphasized here

because it integrates compassion, action, interdependence, and ethical responsibility within a single conceptual framework (Analayo, 2015; P. Harvey, 2011). Unlike approaches that conceptualize compassion primarily as an individual psychological skill, emotional disposition, or professional competency, Karuṇā is understood as a transformative ethical orientation that directs attention toward the reduction of suffering and the cultivation of human flourishing (Analayo, 2015; P. Harvey, 2011; Lama, 2013).

Within Buddhist philosophy, Karuṇā is inseparable from the recognition of dukkha (suffering) and the interconnected nature of existence. Rather than treating suffering as a problem belonging to an isolated individual, Buddhist traditions emphasize that human beings exist within networks of mutual dependence and vulnerability (Analayo, 2015; P. Harvey, 2011). Compassion therefore arises not simply from emotional identification with another person's distress but from an ethical recognition of shared humanity and interdependence. Consequently, compassionate action is understood as a practical commitment to responding to suffering and addressing its causes wherever they are encountered. This understanding shifts compassion beyond the realm of personal sentiment and locates it within a broader moral practice oriented toward the wellbeing of others and the conditions that shape human flourishing.

This understanding differs in important respects from some contemporary healthcare approaches that conceptualize empathy primarily as a professional skill requiring emotional regulation and boundary management. Nursing scholars have frequently emphasized the importance of maintaining professional boundaries to protect both practitioners and patients, particularly in contexts of emotional strain and burnout (Theodosius, 2008). By contrast, Karuṇā is often described in Buddhist literature as an ethical disposition that arises from recognizing the fundamental interconnectedness of all beings rather than from maintaining distance between self and other (P. Harvey, 2011).

The concept of Karuṇā is particularly significant because it emphasizes action rather than sentiment alone. Classical Buddhist texts describe compassion as the wish to remove suffering and its causes, linking ethical awareness with practical engagement (Analayo, 2015). In the Visuddhimagga, compassion is characterized by concern for those experiencing suffering and is distinguished from forms of pity that remain passive or self-focused (Buddhaghosa & Ñāṇamoli, 1999). This distinction highlights an important philosophical insight: genuine compassion is not simply an internal emotional state but an active orientation toward alleviating suffering.

The selection of Karuṇā in this analysis does not imply that other non-Western or relational ethical traditions are less valuable. Comparable insights may be found in African philosophies of Ubuntu, Indigenous relational worldviews, feminist care ethics, and Levinasian accounts of ethical responsibility (Held, 2006; Lévinas, 1969; Metz, 2007). Karuṇā is emphasized here because of its particularly strong integration of compassion, action, interdependence, and the alleviation of suffering within a single conceptual framework (P. Harvey, 2011). Unlike models that may focus primarily on emotional identification or interpersonal obligation, Karuṇā explicitly links ethical awareness to practical efforts directed toward the transformation of conditions that generate suffering. This makes it especially relevant for examining healthcare systems where organizational structures shape the possibilities for compassionate practice.

Classical Ayurvedic literature provides an additional perspective that complements the understanding of Karuṇā as a relational and socially embedded practice. Across the major Ayurvedic compendia, caregiving is not conceived as the responsibility of the physician alone but as a collaborative undertaking involving attendants (paricārakas or paricārikās), family members, and the wider therapeutic environment. Charaka identifies four indispensable components (catuṣpāda) of successful treatment: the physician (bhiṣak), the medicine (dravya), the attendant (upasthātṛ/paricāraka), and the patient (rogī), emphasizing that effective healing depends upon the coordinated functioning of all four elements rather than the actions of any single individual (Sharma, 2007) (Murty, n.d.) (Ananta Venkataraman, n.d.)(Caraka Saṃhitā, Sūtrasthāna 9; Suśruta Saṃhitā, Sūtrasthāna 34–35;

Aṣṭāṅga Hṛdaya, Sūtrasthāna 1). The attendant is described not merely as an auxiliary worker but as an essential therapeutic agent possessing competence, attentiveness, cleanliness, compassion, and practical skill. Charaka further elaborates the qualities of the ideal attendant, stressing devotion to the patient, intelligence, dexterity, and the ability to understand and execute therapeutic instructions faithfully (Sharma, 2007) (Caraka Saṃhitā, Sūtrasthāna 15). The importance of caregiving relationships is particularly evident in descriptions of purification therapies (śodhana karmas), where trained attendants are required to assist patients before, during, and after procedures, ensuring safety, comfort, and continuous observation. Similarly, in the management of childbirth, Charaka's discussion of obstetric care describes the presence of skilled female attendants (paricārikās) who support labouring women through practical assistance, reassurance, observation, and timely intervention (Sharma, 2007) (Caraka Saṃhitā, Śārīrasthāna 8). These descriptions reveal a conception of care that extends beyond technical treatment to encompass sustained human presence and relational responsibility. The Ayurvedic emphasis on attendants as indispensable participants in healing suggests that compassionate care emerges through networks of support rather than through isolated acts of professional competence. In this respect, the classical role of the paricāraka resonates strongly with the concept of Karuṇā, reinforcing the view that care is fundamentally relational, communal, and dependent upon social arrangements that enable responsiveness to suffering. Rather than locating compassion solely within the moral character of individual practitioners, Ayurvedic traditions recognize that healing requires an ecology of care in which physicians, attendants, patients, families, and communities participate together in the alleviation of suffering.

Contemporary discussions of nursing frequently locate compassion within the psychological attributes, emotional labour, or professional competencies of individual practitioners. By contrast, the Ayurvedic conception of the paricāraka anticipates a more relational ontology of care in which healing emerges through coordinated human relationships, shared responsibilities, and supportive social structures. Such an understanding aligns closely with Karuṇā's emphasis on interdependence and offers an alternative philosophical vocabulary for thinking about compassion beyond the logic of individual performance and measurement.

From this perspective, critiques of contemporary healthcare measurement systems raise important questions regarding the relationship between compassion and quantification. While healthcare organizations increasingly rely on indicators, audits, and assessment tools to evaluate quality of care, some scholars argue that deeply relational aspects of nursing may resist complete standardization and measurement (Paley, 2014; Traynor, 2017). Rather than treating compassion as a discrete intervention that can be fully captured through metrics, Karuṇā suggests a broader understanding of care as an ongoing ethical practice embedded within relationships and communities.

These concerns also resonate with contemporary discussions of epistemic justice. Fricker (2011) argues that epistemic injustice occurs when dominant knowledge systems disadvantage alternative ways of understanding and interpreting experience. In particular, hermeneutical injustice arises when the conceptual resources of dominant groups shape how social experiences are recognized and communicated. Applied to healthcare, this framework raises important questions about whether standardized models of spiritual assessment adequately capture diverse cultural, religious, and philosophical understandings of suffering, healing, and compassion (Fricker, 2011).

Decolonial scholars have similarly argued that modern institutions often privilege Western epistemologies while marginalizing alternative forms of knowledge and meaning-making (Santos, 2016; L. T. Smith, 2012). From this perspective, incorporating concepts such as Karuṇā into discussions of nursing and spiritual care is not simply an exercise in cultural inclusion but an effort to broaden the epistemological foundations through which care is understood. Within this analysis, colonization is not understood primarily as territorial domination but as the privileging of particular epistemological frameworks at the expense of alternative ways of knowing. The concern is that institutional systems may increasingly recognize only those dimensions of care that can be translated into

standardized categories, measurable indicators, and managerial forms of evidence. When this occurs, relational, spiritual, and culturally situated understandings of compassion risk becoming marginalized not because they lack value, but because they do not conform easily to dominant modes of evaluation. A decolonial approach therefore seeks to expand rather than replace existing frameworks by creating space for multiple understandings of care, suffering, and healing. Rather than positioning compassion as an individual competency or organizational performance indicator, Karuṇā invites consideration of compassion as a relational, ethical, and communal practice grounded in shared humanity and mutual responsibility.

The Kerala Model of Health: Compassion as an Emergent Structural Virtue

If compassion is understood as a relational and socially embedded practice rather than merely an individual psychological trait, then it becomes necessary to examine healthcare systems that have sought to create supportive social conditions for care. The state of Kerala in India offers a valuable case study through what is commonly referred to as the Kerala Model of Development and, more specifically, the Kerala Model of Health, which has been widely discussed for its emphasis on social welfare, public health investment, and community participation (Adithyan et al., 2024; Anju et al., 2023; Drèze & Sen, 2002; Thomas & Rajesh, 2011). It is important to clarify that the Kerala Model is not presented here as empirical proof of Karuṇā in practice, nor as evidence of a direct causal relationship between Buddhist ethical concepts and specific health outcomes. Rather, Kerala functions as a heuristic illustration of a broader theoretical claim: namely, that compassionate forms of care are facilitated by supportive social infrastructures, participatory governance, and collective commitments to wellbeing. The example is therefore used analytically rather than causally, helping to demonstrate how compassion may emerge from structural arrangements rather than from individual dispositions alone. Scholars have long noted that Kerala achieved relatively high levels of health and social development despite lower levels of economic wealth than many other regions with comparable outcomes (Drèze & Sen, 2002).

These achievements have frequently been linked to a combination of historical land reforms, investments in public education, expansion of primary healthcare services, and sustained political commitment to social welfare (Adithyan et al., 2024; Drèze & Sen, 2002; Franke & Chasin, 1992). Rather than viewing health solely as the outcome of individual healthcare consumption, the Kerala experience has often been interpreted as evidence that health outcomes are profoundly influenced by broader social, political, and community structures (Drèze & Sen, 2002).

From a theoretical perspective, the Kerala Model provides an important lens through which to reconsider compassion as a structural rather than exclusively individual phenomenon. While compassion is typically discussed as a personal virtue or professional competency, social theories of health suggest that caring practices are also shaped by the institutional environments in which healthcare workers and communities operate (Farmer, 2004). Farmer's (2004) concept of structural violence further illuminates this relationship. Structural violence refers to social arrangements that systematically constrain individuals' opportunities for health and wellbeing. From this perspective, compassionate care cannot be reduced to interpersonal benevolence alone; it also requires attention to the institutional and political conditions that produce suffering. Karuṇā therefore extends beyond emotional responsiveness toward a concern with transforming the social structures that perpetuate vulnerability and distress. In this sense, the ability to provide compassionate care may depend not only on individual intentions but also on the social conditions that enable meaningful human relationships to develop.

An important example of this approach emerged through Kerala's decentralization reforms during the 1990s. Following India's 73rd and 74th Constitutional Amendments, Kerala implemented the People's Campaign for Decentralised Planning, which transferred substantial decision-making authority and development resources to local self-government institutions (Isaac & Franke, 2002). Through this process, local communities gained greater influence over healthcare priorities, infrastructure development, and public service delivery. Scholars have argued

that this participatory approach strengthened local accountability and enhanced community engagement in health-related decision-making (Isaac & Franke, 2002).

The significance of these developments can be further understood through the lens of complexity science.(Plsek & Greenhalgh, 2001) argue that healthcare systems function as complex adaptive systems in which outcomes emerge from interactions among multiple actors and institutions rather than from isolated interventions. In complexity theory, emergence refers to properties that arise from interactions among multiple components of a system and cannot be reduced to the characteristics of any individual element alone (Plsek & Greenhalgh, 2001). Applied to compassion, this perspective suggests that caring practices may emerge from supportive organizational and social environments rather than being produced solely through individual training programs or performance metrics. Consequently, efforts to improve compassionate care may require attention to staffing, community support, organizational culture, and social policy alongside individual professional competencies.

Perhaps the most widely recognized example of this principle is Kerala's community-based palliative care movement. Frequently cited as an internationally significant innovation in public health, the Kerala palliative care model relies on collaboration among healthcare professionals, volunteers, families, local governments, and community organizations (Kumar, 2007). Rather than concentrating care exclusively within hospital settings, services are often delivered through home-based and community-centered approaches that emphasize social participation and collective responsibility for individuals experiencing serious illness.

Within this model, support extends beyond clinical interventions to include social, emotional, practical, and existential dimensions of care. Community volunteers may assist families, provide companionship, coordinate resources, and help reduce social isolation, while nurses and healthcare professionals contribute clinical expertise and ongoing support (Kumar, 2007; Sallnow et al., 2022). These practices illustrate how compassion can be understood not only as an attribute of individual caregivers but also as a characteristic of social systems that mobilize collective resources in response to human suffering.

Viewed through this lens, the Kerala experience offers an important challenge to approaches that locate responsibility for compassionate care solely within individual healthcare workers. Rather than framing compassion as a personal resource that must be continuously measured, evaluated, or optimized, the Kerala Model suggests that caring relationships may be strengthened when communities, institutions, and public policies collectively create conditions that support human dignity, social solidarity, and meaningful engagement with suffering.

While the Kerala Model demonstrates the value of public investment, decentralization, and community participation in fostering conditions conducive to compassionate care, it is not without limitations. Challenges include persisting inequities in access for underserved populations, rising burdens of chronic diseases and mental health issues, and difficulties in sustaining outcomes amid changing demographics and resource constraints. These realities highlight that no system is universally replicable and reinforce the need for context-specific adaptations rather than idealized emulation (D et al., 2025).

Implications for Global Nursing Philosophy and Practice

The critique of spiritual care metrics developed throughout this paper raises broader questions regarding the future direction of nursing philosophy and healthcare governance. If compassion and spiritual care are understood as relational, contextual, and culturally situated practices, then contemporary nursing must critically examine the assumptions underlying systems that seek to measure, standardize, and audit these dimensions of care. Rather than treating such systems as neutral administrative tools, critical scholars encourage examination of the values and power relations embedded within contemporary practices of measurement and accountability (Power, 1997; Traynor, 2017).

It is important, however, to acknowledge that the development of spiritual care metrics has not emerged solely from managerial imperatives. Advocates of standardized assessment tools argue that documentation of spiritual needs can enhance continuity of care, improve interdisciplinary communication, and ensure that existential concerns are not neglected within increasingly complex healthcare systems (Best et al., 2020; Puchalski et al., 2014). Similarly, patient experience measures may provide valuable insights into dimensions of care that have historically remained invisible to administrators and policymakers (Anhang Price et al., 2014). The critique advanced in this paper is therefore not directed at accountability per se, nor at all forms of assessment. Rather, it questions the assumption that the moral and relational depth of compassion can be exhaustively represented through standardized indicators. The concern is that when measurement becomes the dominant mode of recognition, dimensions of care that exceed quantification risk being redefined according to managerial logics rather than clinical or ethical significance.

From this perspective, the challenge facing nursing is not simply how to measure compassion more effectively, but whether certain dimensions of care can be adequately captured through quantitative metrics at all. Audit systems, patient satisfaction measures, and standardized assessment tools may provide valuable information regarding aspects of healthcare quality; however, scholars have questioned whether deeply personal experiences such as suffering, spiritual meaning, presence, and compassion can be fully represented through such instruments (Bradshaw, 2016; Paley, 2014). This concern becomes particularly significant in multicultural healthcare environments where diverse understandings of healing and spirituality coexist.

The concept of epistemic injustice provides a useful framework for examining these concerns. (Fricker, 2011) argues that dominant knowledge systems may inadvertently marginalize alternative ways of understanding experience. Applied to spiritual care, this perspective invites reflection on whose understandings of suffering, healing, and compassion are represented within standardized assessment frameworks and whose perspectives may remain insufficiently recognized. Decolonial scholars similarly argue for greater openness to diverse epistemological traditions when addressing complex human experiences such as illness, vulnerability, and care (Santos, 2016; L. T. Smith, 2012).

These theoretical considerations have practical implications for nursing leadership and healthcare policy. Contemporary healthcare organizations increasingly invest in resilience training, wellbeing initiatives, and individual support programs intended to help healthcare workers manage occupational stress. While such interventions may provide meaningful benefits, critics have cautioned that an exclusive focus on individual resilience risks overlooking organizational and structural contributors to burnout, moral distress, and workforce dissatisfaction (Rushton & Rushton, n.d.; Traynor, 2017). Consequently, efforts to support compassionate care may require attention not only to individual coping capacities but also to staffing levels, workload demands, organizational culture, and opportunities for professional autonomy.

The Kerala Model and its associated traditions of community participation offer one possible example of how structural conditions may influence caring practices. Although no healthcare system is without limitations, Kerala's experience suggests that investments in public health, education, local governance, and community engagement can create environments that support both population health and social solidarity (Drèze & Sen, 2002; Kumar, 2007). The significance of this example lies less in providing a universal blueprint than in demonstrating that compassionate care may be shaped by collective social arrangements as much as by individual professional competencies.

From this perspective, Karuṇā may be understood not simply as a personal virtue but as a relational and social ethic that emerges within supportive communities and institutions. Rather than viewing compassion as a discrete intervention or measurable performance indicator, Karuṇā emphasizes interconnectedness, shared responsibility, and responsiveness to suffering (Analayo, 2015; P. Harvey, 2011). This understanding challenges purely

individualistic approaches to care and invites greater attention to the social conditions that enable compassionate relationships to flourish.

To avoid establishing a false dichotomy between necessary administrative accountability and authentic relational care, modern nursing might benefit from solution-oriented models that actively cultivate psychological balance. Rather than placing the insurmountable burden of dismantling structural violence entirely on the individual nurse, targeted therapeutic frameworks can be employed to help practitioners balance the cognitive demands of clinical metrics with the emotional depth of *Karuṇā*. Approaches that emphasize the cultivation of opposite qualities to balance the mind—such as balancing clinical detachment with profound empathic engagement—offer a way to maintain spiritual care competence while significantly reducing moral distress (Manookian et al., 2023). Such de-medicalized paradigms offer scalable, practical alternatives to purely systemic overhauls, allowing the nurse's own mind to serve as a primary laboratory for resilience and active compassion.

Several limitations of the present analysis should be acknowledged. First, this paper is primarily philosophical and theoretical in orientation and does not seek to provide empirical evaluation of specific spiritual care instruments or organizational practices. Second, healthcare systems are heterogeneous, and experiences of measurement, documentation, and accountability vary considerably across institutional contexts. Third, Karuṇā is only one among many ethical traditions that may contribute valuable perspectives on compassion and care. Future research could examine how different cultural and philosophical frameworks understand the relationship between compassion, organizational structures, and spiritual care practices, as well as investigate empirically how healthcare workers experience contemporary systems of assessment and documentation.

The central philosophical question raised by this analysis is not whether compassion matters in healthcare, but whether compassion remains the same phenomenon once it becomes an object of measurement. Ultimately, the future of spiritual care may depend upon nursing's ability to balance legitimate demands for accountability with recognition of the limits of measurement. While evaluation and quality improvement remain important components of healthcare practice, some dimensions of human experience may resist complete standardization without losing aspects of their meaning. Engaging with traditions such as Karuṇā, alongside contemporary critiques of audit culture and epistemic injustice, offers an opportunity to broaden the philosophical foundations of nursing and to reimagine compassion not merely as an individual competency but as a collective commitment to human dignity, relational care, and the alleviation of suffering.

Practically, nursing administration should prioritize structural investments—such as improved staffing ratios, enhanced community partnerships, and participatory governance models—over standalone resilience programs. Leaders can integrate philosophical insights like Karuṇā by supporting team-based reflective practices, reducing excessive documentation burdens, and evaluating care quality through mixed-methods approaches that honor relational narratives alongside quantitative indicators. Such shifts can help preserve the moral depth of compassion while meeting legitimate accountability demands.

Acknowledgment:

The authors would like to express their sincere gratitude to Sri Mata Amritanandamayi Devi, Chancellor of Amrita Vishwa Vidyapeetham, for her blessings, inspiration, and enduring support toward our research endeavors.

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