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Healthcare for All:

Sustainability and Equity

Pope Leo XIV

It is a pleasure for me to meet with you for the first time, together with your new President, Monsignor Renzo Pegoraro. I would like to thank you for your scientific research placed at the service of human life and for the work undertaken by the Pontifical Academy.

I greatly appreciate the theme you have selected for this year's meeting: *Healthcare for All. Sustainability and Equity*. This topic is very important, both for its relevance and for its symbolic meaning. Indeed, in a world scarred by conflicts, which consume enormous economic, technological and organizational resources in the production of arms and other types of military equipment, it has never been more important to dedicate time, people and expertise to safeguarding life and health. In regard to the latter, Pope Francis affirmed that it "is not a consumer good, but a universal right which means that access to healthcare services cannot be a privilege.[1] I therefore thank you for choosing this theme.

In this Issue

We begin with the Pope's recent address to the members of the Pontifical Academy for Life.

Steve Matthews then outlines a professional stance he labels 'compassionate understanding' - a professional commitment to preserve the inherent dignity (or worth) of people living with dementia.

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[1] Address to "Doctors with Africa – CUAMM," 7 May 2016 https://www.vatican.va/content/francesco/en/speeches/2016/may/documents/papa-francesco_20160507_medici-africa-cuamm.html

The first aspect that I wish to emphasize is the *connection between the health of all and that of each individual*. Covid-19, the pandemic, demonstrated this, even harshly at times. Indeed, it has become clear how much reciprocity and interdependence underpin our health and our very lives. Studying this interdependence requires dialogue between different fields of knowledge: medicine, politics, ethics, management and others. It is like a mosaic, whose success depends on both the choice of tiles and their combination. In fact, in matters regarding healthcare systems and public health, it is a question, on the one hand, of understanding the phenomena and, on the other, of identifying specific political, social and technological actions that affect family, work, the environment and society as a whole. Our responsibility lies, therefore, not only in taking measures to treat diseases and ensure equitable access to healthcare, but also in recognizing how health is influenced and promoted by a combination of factors, which need to be examined and confronted in their complexity.

In this regard, I would like to reiterate that we must focus not "on immediate profit, but on what will be best for everyone, knowing how to be patient, generous and supportive, creating bonds and building bridges, working in networks, optimizing resources, so that everyone can feel they are protagonists and beneficiaries of the common work". [2]

Here we come to the theme of *prevention*, which also involves a broad perspective, for the situations in which communities find themselves are the result of social and environmental policies, and have an impact on the health and life of the person. When we look at life expectancy and the quality of health in different countries and social groups, we discover enormous inequalities. These depend upon variables such as income level, the level of education attained and the neighbourhood in which one lives. Sadly, today we are also faced with wars that impact civilian structures, including hospitals, which constitute the most grave attacks that human hands can make against life and public health. It is often said that life and health are equally fundamental values for all, but this statement is hypocritical if, at the same time, we ignore the structural causes and policies that determine inequalities. In reality, despite declarations and statements to the contrary, all lives are not equally respected and health is neither protected nor promoted in the same way for everyone.

The concept of *One health* can help us as a basis for a global, multidisciplinary and integrated approach to health issues. It emphasizes the environmental dimension and the interdependence of the various forms of life and ecological factors that enable their balanced development. Therefore, it is important to grow in the awareness that human life is

[2] *Address to the participants in the Seminar "On Ethics and Business Administration in the Healthcare Sector"*, 17 November 2025

incomprehensible and unsustainable without other creatures. Indeed, to quote the Encyclical Laudato Si', "all of us are linked by unseen bonds and together form a kind of universal family, a sublime communion which fills us with a sacred, affectionate and humble respect.[89] This approach is very much in line with the global bioethics that your Academy has repeatedly taken an interest in and which you do well to continue to cultivate.

Understood in terms of public action, *One health* calls for the integration of health considerations into all policies (transportation, housing, agriculture, employment, education, and so on), since questions of health touch upon every aspect of life. Thus, we need to strengthen our understanding and promotion of the common good, so that it is not violated under the pressure of specific individual or national interests.

The common good — one of the fundamental principles of the Church's social teaching — risks remaining an abstract and irrelevant notion if we do not recognize that it is rooted in the fostering of close relationships between people and bonds between members of society. This is the ground upon which a democratic culture can grow, one that encourages participation and is capable of uniting efficiency, solidarity and justice. We need to rediscover the fundamental attitude of care as support and closeness to others, not only because someone is in need or is sick, but because they experience vulnerability, the vulnerability that is common to all human beings. Only in this way will we be able to develop more effective and sustainable healthcare systems, capable of satisfying every health need in a world of limited resources as well as restoring trust in medicine and healthcare professionals, notwithstanding any misinformation or scepticism regarding science.

Given the global importance of this question, I reiterate the need to find effective means of strengthening international and multilateral relationships, so that they "can regain the strength needed for undertaking its role of encounter and mediation. This is indeed necessary for preventing conflicts, and for ensuring that no one is tempted to prevail over others with the mindset of force, whether verbal, physical or military".[3] This vision also applies to the cooperation and coordination carried out by supranational organizations engaged in the protection and the promotion of health.

And so, my friends, I conclude by expressing my hope that your commitment will bear effective witness to mutual care, which expresses the way God treats us, because he cares for all his children. I cordially bless each one of you, your loved ones and the work you do.

[3] Address to Members of the Diplomatic Corps, 9 January 2026.

Compassionate Care

for People Living with Dementia

Steve Matthews

Abstract

Practitioners of person-centred care (PCC) for people living with dementia aim to preserve personhood through recognition, relational care, and support for agency and interests. Yet the translation of the principles of PCC into everyday practice often falters. This gap, between the ideals of PCC and their practical realisation, can be addressed through a professional stance of compassionate understanding. Such a stance integrates enlightened compassion with a structured moral psychology consisting of forbearance, moral perception, skilled virtue, and professional empowerment. Properly supported by adequate resources and collaborative organisational cultures, compassionate understanding enables carers to translate the principles of person-centred care into sustained and humane practice.

1 Introduction

Person-centred care (PCC) is widely regarded as the guiding ethical framework in dementia care. Its central commitment is to preserve the dignity of people living with dementia through principles of recognition and respect, and via supportive relationships. Despite broad acceptance, the practical realisation of PCC remains inconsistent. But failures here do not arise because its ideals themselves are flawed. Rather, the institutional and psychological conditions required to enact them are sometimes absent.

As the final report from the Royal Commission into Aged Care Quality and Safety 2021 noted, two institutional problems are especially common: resourcing and culture. The Commission identified systemic underfunding and workforce shortages as key drivers of poor-quality aged care. It found that many residents received substandard care because there were not enough staff to meet basic needs; it also highlighted workforce capability gaps, noting shortages of skilled nurses and allied health professionals, observing that many care workers were undervalued and insufficiently trained for complex care. In addition, many facilities were

described as outdated and not fit for purpose, particularly for people living with dementia, leading to the recommendation for new National Aged Care Design Standards.

Less attention has been paid to the *moral psychology* required to enact PCC in everyday care. On this point, the principles of person-centred dementia care are best realised through a professional stance I call *compassionate understanding*. This stance combines enlightened compassion with a disciplined practical understanding, and enables practitioners to translate ethical commitments into stable patterns of care.

My argument combines these elements: I argue that compassionate understanding can work best when resources are abundant, and when an organizational culture provides the right supports and training for it to flourish. In what follows, I first set out what is at stake in resourcing and culture, before describing PCC and the challenges of making it operational; I then discuss in detail the concept of compassionate understanding, and how it can be applied to bring the ideals of PCC into being.

2 Two Conditions

The successful practice of PCC depends on two conditions. First, dementia care must be adequately resourced. Second, major care decisions should be collaborative and interdisciplinary. These conditions form the institutional setting within which compassionate understanding can best operate.

Adequate resourcing allows facilities to create environments that reduce stress and support non-pharmacological interventions. Physical spaces should permit movement, social interaction, and access to natural light. Equally important are staffing levels that allow carers to develop stable relationships with residents. Continuity of relationships is central to relational dementia care and becomes difficult to sustain when staff turnover is high.

The second condition concerns collaborative decision-making. Ideally, significant care decisions involve clinicians, care staff, residents where possible, and family members. Interdisciplinary case conferences often provide the most effective forum for such discussions.

Consider an illustrative composite case. Mrs D, an 83-year-old retired librarian with Alzheimer’s disease, began insisting that someone was sleeping in her bed and stealing her belongings. Environmental adjustments provided only temporary relief. The facility therefore convened a case conference involving clinicians, care staff, and her family. Discussion focused on her personal history and longstanding preferences. Her daughter noted her mother’s lifelong love of quiet reading spaces. The team arranged for Mrs D to move to a calmer room overlooking trees and provided a small reading area. Within a short space of time her distress diminished and she resumed reading to fellow residents.

Collaborative care planning has been shown to assist in managing behavioural symptoms such as agitation or aggression (Wong et al. 2024). Although such processes require time and coordination (with levels of resourcing as discussed above), they remain central to ethically grounded dementia care.

3 Making It Operational

Person-centred dementia care draws heavily on the work of Tom Kitwood (1997), who argued that dementia should be understood not only as a neurological condition but as one that is maintained through psycho-social causes. He re-conceptualised personhood; in his well-known formulation, it is "a standing or status that is bestowed on one human being by others in the context of relationship and social being". On this view, the maintenance of personhood depends heavily on the quality of interpersonal engagement surrounding the individual, especially in dementia care where cognitive capacities may decline. Caregivers are called to encounter the person with dementia not as an "It" – i.e., an object of management or clinical problem – but as a "Thou": a unique person whose presence calls for recognition and response. Such an orientation requires carers to look beyond the disease and sustain forms of interaction that acknowledge the individual's dignity and continuing moral significance.

From these ideas follows the thought that good care requires those virtues we associate with the moral qualities of relationships, e.g., recognition, respect, and trust. It also must avoid what Kitwood called the "malignant social psychologies", namely, those practices that undermine dignity through, e.g., infantilisation or stigma.

Subsequent work, particularly Dawn Brooker's VIPS framework, distilled Kitwood's philosophy into practical guidance emphasising value, individuality, perspective, and social environment. The shared aim from both these writers is to maintain personhood through supportive relationships, and that is because human persons are social and relational, not individual "islands".

This has an important implication, for PCC has sometimes been misunderstood when framed primarily in terms of a concept of personhood which emphasizes individual autonomy and consumer choice. This is problematic on three grounds. First, it presumes some stability of decisional capacity which can be at odds with the reality of fluctuating mental health and/or cognitive decline. Second, it can mask the under-resourcing of care services which severely limits available options. And third, it fails to capture what is ethically important in terms of the relational features of care. A *relational* care framework, by contrast, encourages carers to support continuity of selfhood through familiar roles, shared activities, and meaningful social engagement.

Yet knowledge of these ideas alone does not guarantee effective care. Staff frequently encounter situations in which the ideals of PCC conflict with institutional constraints or immediate safety concerns.

Three recurring challenges illustrate this tension. First, residents experiencing agitation or aggression often require responses that are personalised and non-pharmacological. In practice, however, limited staffing or rigid routines may encourage seemingly quicker “interventions” such as medication.

Second, so-called wandering behaviour raises tensions between safety and agency. Measures such as locked doors or alarms can conflict with relational approaches that emphasise dignity and freedom of movement.

Third, residents may express delusional beliefs, or make false accusations, creating situations that demand sensitive responses while raising ethical questions about truthfulness and reassurance.

In such circumstances carers often experience moral distress, and if this is not properly recognised and addressed such recurring distress may lead to moral injury. A moral injury occurs when a carer recognizes what a person-centred response would ideally involve, yet they feel constrained by institutional pressures that prevent them acting on what they see as morally required.

PCC, therefore, cannot function solely as a set of principles or techniques. To be sustainable, it requires a professional stance capable of navigating uncertainty, constraint, and emotional strain. And it requires an environment within which this may flourish. The stance proposed here, as flagged before, is compassionate understanding.

4 Compassionate Understanding and a Dilemma for Carers

At the ethical core of the helping professions should lie what I term *compassionate understanding*: a commitment to recognise serious suffering and to respond to it with intelligent impartiality. This stance integrates enlightened compassion within a structured professional psychology composed of four elements – forbearance, moral perception, skilled virtue, and empowerment – enabling clinicians to respond sensitively while maintaining professional clarity (Matthews 2026).

In this section I outline enlightened compassion in terms of a general professional stance – thus it has application in any of the client-facing helping professions – and then I will show how it may apply in dementia care.

Compassionate understanding combines emotional attunement with reflective judgement. It offers an alternative to empathy-centred approaches that might encourage clinicians to ‘feel

what patients feel'. While empathy may motivate concern, excessive emotional identification can impair judgement and contribute to burnout.

Compassionate understanding instead combines enlightened compassion with rational understanding. Let's unpack these ideas a little more.

Enlightened Compassion

Enlightened compassion involves recognising the seriousness of another's suffering and then responding without judging whether that suffering is deserved. Such judgement is all too possible when people, including healthcare workers, show less concern for others they deem to have been imprudent or reckless. Consider those who, e.g., over-indulge, or fail to curtail a lifestyle that they know will have an adverse or harmful effect. (Of course, a compassionate response here may be accompanied with advice about how to avoid these effects.)

Compassion also requires an impartial orientation that does not privilege particular individuals or groups. Thus, understood as a cultivated professional virtue, it should not depend on perceived similarity between the sufferer and the one who responds. Some philosophical accounts suggest that compassion arises when we recognise that we ourselves might suffer the same misfortune. Yet this makes compassion contingent on identification and shared vulnerability, narrowing its scope to those whom we perceive as "like us." Enlightened compassion, by contrast, responds directly to suffering itself. It is therefore not guided by race, class, gender, social identity, or other forms of in-group recognition. In clinical settings especially, compassion should arise from a disciplined moral attention to suffering wherever it appears, rather than from fear, prudential self-interest, or imaginative self-projection. The compassionate response is directed outward: its focus is the patient's suffering and the question of how it might be relieved.

Compassion, then, eschews harsh judgement, and it does not require directly sharing another person's feelings; rather, it involves a reason-guided commitment to alleviate suffering in whatever form it is presented.

Understanding

The understanding component of the stance consists of four interrelated capacities.

Forbearance refers to the ability to remain patient and non-judgemental when confronted with agitation, hostility, or despair. Such composure allows carers to interpret behaviour in light of fear, confusion, or cognitive loss rather than personal hostility.

Moral perception describes a form of ethically informed situational awareness through which practitioners recognise morally salient features of a situation. Experience and training gradually refine this capacity.

Skilled virtue reflects the way compassionate responses become habitual through practice. Experienced practitioners learn to perceive the moral contours of a situation and respond appropriately with minimal deliberation.

Empowerment arises when compassionate practice reinforces professional agency and meaning in work, supporting resilience and long-term commitment to care roles.

Together these capacities address a central dilemma in the helping professions. Regular exposure to suffering can lead either to emotional over-identification or to excessive detachment. Compassionate understanding aims to sustain a balanced stance that preserves moral sensitivity while protecting professional endurance.

5 Compassionate Understanding Applied

The practical importance of compassionate understanding becomes clear when examining failures of person-centred dementia care. The case of RT, presented to the Royal Commission into Aged Care Quality and Safety, illustrates how the absence of supportive institutional conditions and moral orientation can undermine care.

RT, born in 1946, was diagnosed with Alzheimer's disease after retirement. As his condition deteriorated, he entered a secure dementia unit where staff initially monitored his agitation and wandering behaviour. Over time, however, staff began managing these behaviours through repeated physical restraints and later antipsychotic medication. Although internal policy required restraint to be used only as a last resort, specialist behavioural support was not sought. RT's wife eventually removed him from the facility. By that time his physical and cognitive condition had deteriorated significantly, although some recovery occurred after his departure. Subsequent investigation revealed broader institutional problems, including understaffing, limited dementia-specific training, and a workplace culture that normalised emotional detachment. Residents were frequently labelled aggressive without adequate clinical review, and regulatory oversight failed to detect these practices.

This case illustrates how compassionate understanding could alter responses to distress. Rather than categorising RT as a difficult resident, carers trained in this stance would begin by interpreting the behavioural and psychological symptoms underlying his agitation. Such interpretation supports relational responses grounded in patience, respect, and careful assessment rather than restraint or sedation.

The case also underscores the importance of institutional support. Compassionate understanding can flourish when organisations provide adequate staffing, training, and encouragement of non-pharmacological care. Under such conditions the stance can function as a bridge between the ideals of person-centred care and everyday practice, strengthening both humane care and professional resilience.

Conclusion

Compassionate understanding translates the ethical principles of person-centred dementia care into the moral psychology of everyday practice. By integrating enlightened compassion with forbearance, moral perception, skilled virtue, and professional empowerment, carers can remain emotionally attentive while maintaining the professional detachment required for endurance and sound judgement.

Yet this stance cannot flourish in isolation. It depends on adequate resources, collaborative organisational cultures, and leadership that values reflective care. When these conditions are present, compassionate understanding helps bridge the gap between ethical ideals and lived practice, sustaining both resident dignity and professional integrity in dementia care.

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