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PHILOSOPHICAL EXPLORATION

The Decent Care Movement: Subsidiarity, Pragmatic Solidarity, and Cross-Cultural Resonance

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Abstract Decent Care is the World Health Organization and The Ford Foundation's joint effort to articulate a healthcare paradigm that makes a patient's voice equal to the voice of the healthcare provider. In this article, the six tenants of Decent Care are outlined with particular emphasis on subsidiarity. Liberation theology's preferential option for the poor maxim is presented and compared with other major world religions to demonstrate the cross-cultural focus of "decency." The power of this paradigm is in its emphasis and proclamation of human flourishing in a healthcare setting, generally speaking, and more specifically, human flourishing in the presence of affliction from chronic disease or dying cross-culturally.

Keywords Decent Care · Pragmatic solidarity · Preferential option for the poor · Health care · Pluralism

By listening to and honoring the voices of the people, we can develop care processes and models that respond to individuals' needs, actualize rights to universal access and effective care, and strive toward the greater goal of 'identifying and responding to the needs of a community to enable human flourishing' (International Labor Organization [ILO], 2009).
~Ted Karpf, *et al., Light Still Shines in the Darkness: Decent Care for All*

Introduction

Throughout occidental history,[1] ideas surrounding both health and healthcare delivery have varied depending on the epoch and culture under consideration. More recently, academic disciplines, ranging from public health to anthropology, have attempted to understand the

[1] In this text, Western and non-Western—or, Occidental and Oriental—are not mentioned in the context of monolithic binaries. For more on Orientalizing ideas prominent in "the West," see Said 1978.

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conditions that give rise to different disease processes, as well as appropriate ways to facilitate the amelioration of the these diseases processes. Physician–anthropologist and co-founder of the nonprofit organization Partners in Health, Farmer (2001:8–12) has written extensively on the proclivities of both medicine and anthropology to neither fully account for the role of social institutions nor the historical trajectory in terms of politics and economics that become embodied as biological pathology. While it is beyond the scope of this paper to look at the historical trajectory that has led to a mechanical view of the body (Foucault 1973/1994), as well as the view, in the USA, of the patient as a customer, I will outline why the Decent Care approach to health care is the most appropriate model to facilitate both curing *and* healing. More specifically, I will look primarily at one of the six core values of Decent Care, namely subsidiarity, before addressing the cross-cultural resonance of Decent Care. I hope to demonstrate below that Decent Care, as well as the preferential option for the poor in the context of subsidiarity, is as integral to medicine as it is to Christianity and other world religions. Furthermore, individuals working in healthcare fields have an obligation—a moral duty—to be the advocates of the most vulnerable in society. Decent Care methodology provides the theoretical framework of accompaniment that promotes health and human rights. For without the voices of the people, care is not Decent.

Preliminary Remarks on Decent Care

Decent Care is the World Health Organization and The Ford Foundation's joint effort to articulate a healthcare paradigm that makes a patient's voice equal to the voice of the healthcare provider. It aims "to develop health systems around the primacy of persons in health care and to build a bridge between the principles of human rights and the practice of medicine" (Ferguson et al. 2009:1). In accompanying individuals and communities,[2] which involves "listening to and honoring the voices of the people, care processes, and models can be developed that are responsive to individuals' needs, actualize access to care, and strive toward the greater goal of 'identifying and responding to the needs of a community to enable human flourishing'"(*Ibid*.). Thus, the goal of Decent Care is to provide an all-encompassing model of health that addresses the needs of individuals and communities as they see their needs by utilizing modern tools to facilitate sorely needed local, national, and global transformations that allow an individual—and, *thus*, society—to flourish. In order to co-create an environment that provides the necessary conditions for human and societal flourishing, Decent Care's theoretical model is based on a triad of individual, social, and systemic values: agency and dignity, interdependence and solidarity, and subsidiarity and sustainability, respectively (Karpf et al. 2010).

No discussion of subsidiarity in the context of Decent Care can make sense without a brief overview of the above-mentioned values. Harvard economist Amartya Sen (1985:203) outlines agency freedom as "what the person is free to do and achieve in pursuit of whatever goals or values he or she regards as important." Agency assumes free will and, equally as important, is existential in that it focuses on the individual's ability to make choices. The concept of dignity is intimately tied to agency when it honors "the unique individuality and worth of the "lifeworld" the individual has constructed—her

[2] The model of Decent Care is very reminiscent of Roberto Goizueta's (2008) Hispanic Liberation Theology in *Caminemos con Jesus*, which is most likely a testimony to the fact that Decent Care is based on a set of principles that are found in all cultures.

needs, desires, relationships, and values" (Ferguson 2013). Stated another way, dignity provides the environment for an individual to enact one's agency, especially in the context of the clinic. Implicit in the concept of dignity is two important notions that flow from and make dignity possible, namely interdependence and solidarity. Interdependence represents reciprocity, "actively participating in our own caring process and the caring processes of others," (*Ibid.*) while solidarity relates to "*seeing, hearing, and responding* to the stories and peoples most threatened by present structures" with the accompaniment—with dignity, and hand-in-hand—of "profound efforts to listen, perceive, understand, and respond" (Vigen 2006:204). Finally, sustainability is "the appropriate use of natural, societal, and individual resources" in a way that is guided by the aforementioned values of Decent Care (Hughes 2008:28–29). With these concepts cursorily defined, it is now possible to discuss subsidiarity and the preferential option for the poor in the context of health care.

Subsidiarity

The etymology of subsidiarity comes from the Latin "subsidium," which is loosely defined as help or support, specifically in the context of larger bodies ontologically "justified only in the relation to the *subsidium* they offer to the smaller and less powerful bodies" (Mathew 2009:246). Stated another way, larger governing bodies are to help individuals and small, less powerful bodies attain individual and collective goals, yet it must restrict its own interference only to necessary situations to provide the environment for small groups and individuals to act in accordance with their own judgment and in full freedom (*Ibid.*). Apart from its etymology, subsidiarity, in the context of Decent Care, conceptually depends on the above-defined values of agency and dignity, solidarity and interdependence, and sustainability.

As authors of the Hebrew Wisdom Tradition wrote in Ecclesiastes (1:9, NRSV) that "there is nothing new under the sun," Decent Care wisely relies on the Catholic notion of Just Work in its formulation of subsidiarity (Mathew 2009:243). In 1891, Pope Leo XIII stated in *Rerum Novarum* that "whenever the general interest or any particular class suffers, or is threatened with harm, which can in no other way may be met or prevented, the public authority must step into deal with it"; however, the limits of that intervention "must be determined by the nature of the occasion which calls for the law's interference—the principle being that the law must not undertake more, nor proceed further, than is required for the remedy of the evil or the removal of the mischief'" (Carozza 2003:41). Thus, the core idea of Just Work is that the larger governing body is to assist if and only if the general interest of a smaller group is inhibited in some way inhibited, and the nature of this assistance is that it may only assist to the extent that it *only* ameliorates processes that are affecting the aforementioned smaller group. It is in this context of the history of ideas that Carozza (2003:38) defines subsidiarity as "the principle that each social and political group should help smaller or more local ones accomplish their respective ends without, however, arrogating those tasks to itself." Given this foundation, Mathew (2009:248) explains the core principle of subsidiarity as fundamentally rooted in "the dignity of the person as the absolute."

Keeping in mind the dignity of the person as the absolute, Komonchak outlines the core principles of subsidiarity in the following manner: The person is the origin and purpose of society; self-realization is achieved via social relationships; social relationships and our local communities provide "the sets of conditions necessary for personal self-realization";

larger, higher communities have the same role but to smaller communities; larger, higher communities are to help "people help themselves"; subsidiarity regulates "competencies between individuals and communities and between the smaller and larger communities"; and finally, as a formal principle "it is grounded in the metaphysics of the person, it applies to the life of every society" (Mathew 2009:248–251). While this may seem unnecessarily complex, Komonchak is merely demonstrating that (1) both the agency and the dignity of the *person* are natural values at the core of subsidiarity and (2) the "function of subsidiarity is to safeguard the "autonomy and responsibility characteristic of the human individual vis-à-vis society." To do this, subsidiarity regulates structures and agencies that can either directly or indirectly be involved in "help that facilitates self-help" (Mathew 2009:251). An exemplary manifestation of the principle of subsidiarity in *everyday* life is Catholic social teaching of the "preferential option for the poor," which is also referred to as "pragmatic solidarity" in the context of health care.

Preferential Option for the Poor

Before we can address the preferential option for the poor and pragmatic solidarity, it is important to note both the theological anthropology and the ethics behind Catholic thought at the core of the aforementioned topics to be discussed. To begin, in the Judeo-Christian tradition, a "person is understood as the substantial individual reality and consequently what is important is not the becoming but the being. Before becoming comes being. It is due to being that the exigencies of becoming arise. Thus, the person is the subject of all rights." Given a theological anthropology that views the human as created in the image of God, the assumption is that humans have the ability to reason and, therefore, the freedom to make choices (free will). In this regard, "human rights become a gift and a task or a demand of God." A violation of these rights is a violation of *both* human dignity and the will of God because it prevents the individual from fully participating in "the absoluteness of God" (Mathew 2009:241–243).

Since human dignity and human rights are, as outlined above, rooted in "the participation in the absoluteness of God," Catholic ethics relies on deontological and virtue ethics (Hughes 2008:28). In *Restoring Hope*, Hughes (2008) states that deontological ethics following in the Kantian tradition view "each individual as an end and not simply as a means to an end." Deontological ethics from this perspective is contra the Marxian perspective, which views the individual as solely inhabiting a role within the division of labor. Marxist-based ethics, thus, *grants citizens*, rather than all humans, rights because they are active members of the state (Mathew 2009). Concerning virtue-based ethics, Hughes (2008:28) states that this perspective focuses on traits that make a good person (or, in the context of medicine, traits that make a good healthcare provider). As mentioned at the beginning of this paper, the goal of the values of Decent Care is to ensure human flourishing. Before I discuss one example of the implementation of Decent Care, it is important to briefly discuss human flourishing.

The concept of human flourishing is a development consonant with the Aristotelian notion of *eudaimonia*, or happiness and flourishing (Schleifer 2012). Rasmussen (1999) articulates the fundamental components of human flourishing as all of the following: an objective good; inclusive; individualized; agent-relative; self-directed; and achieved in a social context (Ferguson 2013). In short, human flourishing is a teleology that is individually and socioculturally contextualized within the framework of the core values of

Decent Care. Moreover, it is something to be strived "to, for, and with others" (Schrag 1999:78). As Ferguson (2013), a bioethicist at the American Medical Association, notes: "To flourish—*to live a meaningful life that is virtuous, healthy and productive, where we are able to actualize, and capable of actualizing*, *our unique talents and potentialities*—is something I do and pursue always as a self in community where I exist with others as they are also embarking on their praxes of flourishing." While the values of Decent Care and its goal of promoting human flourishing seem reasonable, Christians may need to see how they resonate with Christian values in addition to being based on the Judeo-Christian anthropology outlined above.

It was during the second half of the twentieth century that Catholic priests (see, e.g., Boff 1979; Gutiérrez 1983) became more vocal—or, perhaps, the Church finally started listening to its priests during this era—about *social* rather than *individual* ethics. As mentioned above, a violation of human rights is a violation of the will of God. Farmer (2005:138) mentions that the emphasis in liberation theology of the preferential option for the poor is a "constant interrogation: *how is this relevant to the suffering of the poor and to the relief of that suffering*? Thus, unlike most forms of social analysis, liberation theology seeks to yoke all of its reflection to the service of the poor." Hughes (2008:31) notes in *Restoring Hope* that the preferential option for the poor is for "those who are marginalized from society for any reason *have a special claim* under the call to pursue the common good, because they have been excluded to some degree from exercising their rights." Peruvian priest, Father Gutiérrez (1983:44), states in his *The Power of the Poor in History* that the poor person, broadly defined, is "the neighbor par excellence" in the Christian Scriptures. The poor person is not "an inescapable fact of destiny"; rather, the poor are "a byproduct of the system in which *we* live and for which *we are responsible*." As players in a system that persecutes the poor, it is the job of Christians—and, as I briefly argues below, healthcare providers—to accompany the poor and engage in pragmatic solidarity.

Pragmatic Solidarity

Pragmatic solidarity is based on Decent Care and the option for the poor. Unlike solidarity, which is "the desire to make common cause with those in need," pragmatic solidarity takes one step past abstract piety when it offers "the goods and services that diminish hardship instead of just thoughts and prayers" (Farmer 2001:146). To ascertain how to offer *subsidium* to smaller groups, pragmatic solidarity uses the methodology of the preferential option for the poor, namely to "observe, judge, act."[3] To observe is to use social analyses to describe the conditions of the marginalized. During this process, conscientization occurs (Freire 2000), which is a form of conscience raising, or "coming to understand how social structures cause injustice." When we have observed the conditions of the marginalized, we are moved to judge the situation. At this point, it can be as simple as noting that "something is terribly wrong." It also requires of the observer the rejection of "comforting relativism," which almost always conflates structural violence and cultural difference in order to allow an individual to not feel obligated to act. Finally, to act is more than reporting on the aforementioned reflections; rather, it is a call to *change the world with the world*. In the context of health, "medicine becomes pragmatic solidarity when it is delivered with dignity to the destitute sick."

[3] The following description and citations on Observe, Judge, Act are taken from Farmer 2005:138–144.

Echoes of preferential-option-for-the-poor medicine circulated well before Farmer's writings. The German physician Rudolph Virchow is most commonly known as the father of modern pathology, but his contributions as both an anthropologist and one of the founders of social medicine are often overlooked. In 1848, in his weekly medical newspaper entitled *Die Medizinische Reform*, Virchow wrote the following:

> Medicine is a social science, and politics is nothing else but medicine on a large scale. Medicine, as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution: the politician, the practical anthropologist, must find the means for their actual solution.

and

> The physicians are the natural attorneys of the poor, and social problems fall to a large extent within their jurisdiction (translated in Ackerknecht 1953).

Likewise, French philosopher Foucault (1973/1994:33) notes in his *The Birth of the Clinic: An Archaeology of Medical Perception* that "the first task of the doctor is therefore political: the struggle against disease must begin with a war against bad government. Man will be totally and definitively cured only if he is first liberated." Both Virchow's and Foucault's writings now seem prophetic given the relatively recent focus by Farmer and others concerning preferential-option-for-the-poor medicine. Virchow's and Foucault's statements are a stern reminder that the practice of medicine is much more than treating and managing various diseases; rather, it is the amelioration of social problems that plague disempowered populations. For Christians, Jesus's statement in his parable in the Gospel of Matthew (25:40, NKJV) must be heeded: "The King will reply, 'Truly I tell you, whatever you did for one of the least of these brothers and sisters of mine, you did for me.'" Furthermore, the physician Luke in the Gospel of Luke 9:6 recounts the following of the disciples' activity: "So they set out and went from village to village, preaching the gospel and healing people everywhere." There are numerous other examples throughout the Christian Scriptures of the preferential option for the poor and subsidiarity as elemental to the Jesus Cult. The Epistle of James places immense emphasis on the preferential option for the poor compared to any other text within the Christian Scriptures. Like Jesus, James seems to indicate that those believers who say, "Go, I wish you well," but then do not provide a "demonstrative act such as giving a gift or alms" are not part of the Jesus cult (Richardson 2001). In fact, the letter of James and, more specifically, the pericope of 2.14–17, serve as a basis for which modern Christians can prophetically preach against the structural forces that continue to plague the poor (Albl 2002:130).

Preliminary Remarks on Cross-Cultural Resonance

Up to this point, however, I have focused primarily on how the Christian religion contains aspects of Decent Care in its core texts and history. What makes Decent Care so universally applicable, however, is its resonance with the fundamental tenets of religions and philosophies across the globe. What follows is a brief articulation of some of the salient intersections of different religious notions of decency. "The call for decency is an imperative that most of the world's belief systems share, providing a unifying frame for many diverse views" (Ferguson 2008:xxiv).

While countless philosophical and spiritual perspectives have the golden rule, in its various iterations, at the root of their respective understanding of decency, Ferguson

(2008:xxvi) understands that there will be "variations in how each one employs decency to grapple with the challenge[s]" of health care. For the articulators of Decent Care, it is not about fitting all ideas of decency into an easy to mold, cookie cutter philosophical system that is easy to implement (or, perhaps, export) across the globe; rather, the Decent Care movement "seeks to provide a shared space for diverse perspectives to work within… a common ground to work from and a common goal toward which to work" (*Ibid*.). If care is to be decent in the USA, then a brief overview of different cultures, from the World Health Organization's *Restoring Hope*, the foundational text for Decent Care, is necessary given the diversity of ethnicities and races that comprise the patient population.

A Brief Survey of World Traditions from *Restoring Hope*

In his chapter on "The Biblical Mandate to Care and Cure," Chief Rabbi Rosen (2008:39), writing form the Jewish perspective, states that "the point has been made that the religio-ethical precepts of Judaism are a matter of duties rather than human rights," yet the notion "of obligation in the Pentateuch… presumes the rights of those who are the object of these obligations."[4] Rosen (2008:39) observes from the Mishnah's *Bava Kama* 2:6 that "one has not only the right to life, but also the right to health and protection, the right to dignity, and the right to make a living and provide for basic needs and of oneself and one's dependents [sic]." Although Rosen (2008:42) outlines a few critical aspects of Judaism that resonate with the six tenets of Decent Care, he notes that "the message here of course is not in the fact that the sick man [does] not die, but primarily that appropriate care is as important as actual healing—and, perhaps even more important, as it addresses psychological and spiritual needs of the patient that lie beyond physical needs." The goal of health care, thus, is not just about cure, but it is also about care. Finally, speaking of the ability to emulate *imitatio Dei*, the divine attributes, Rosen (2008:43) notes that Maimonides "teaches that promoting and seeking to ensure health care for all—thereby affirming the divine image in everyone—itself expresses the highest human obligation to behave and create a society in a manner that reflects the most sublime divine qualities of compassion and respect." Rabbi Rosen's observations of dignity and the duty to serve those who are sick resonate with Dr. Sayed Elzenari's comments on the Islamic perspective of health and sickness.

Writing from the Islamic perspective, physician Elzenari's (2008:47) article, "An Islamic View of Health and Sickness: How Our Core Values Promote Decent Care," notes that "the Islamic notion of health…is not limited to the physical body, but extends much further to embrace social, psychological, and spiritual aspects of human life." It is important to note here, however, the religious root of decency and health for Muslims: "the belief in Allah is thus a fundamental component of Islamic health care for the individual, family, provider, and community," and it needs to be taken seriously for treatment efficacy. Moreover, the following point is of utmost importance because it describes the approach to disease from a metaphysical perspective: "Allah will reward both the ill person who displays patience and pleasure and the person who shows compassion for the sick. Though death is inescapable, it is not final, merely a new ration in another life that is much longer than this one" (Elzenari 2008:48–49). Modern biomedicine has built into the

[4] For more on societal obligations in the Pentateuch from the perspective of covenant economics, see Richard A. Horsley, *Jesus and the Powers: Conflict, Covenant, And The Hope Of The Poor* (Fortress Press 2010).

operating premise that either (1) questions of the afterlife are not important or (2) that there is no such thing as an afterlife. Yet, a patient's health decisions will be based on the notion that the individual is a sojourner passing through a foreign land on the way *home*.[5]

While a patient's health decisions will be based on religious prescriptions, Islam is flexible with healing procedures and methodology that collide with religious proscriptions. Dr. Elzenari (2008:51) notes the story of Abdul Rahman Ben Oof from the Qu'ran. Ben Oof had a skin disease and the Prophet Muhammad allowed him to "wear silk clothing because it had been prescribed for him as treatment… despite the prohibition against Muslim men wearing silk at that time." The flexibility of Islam to adapt, in certain cases, to the situation of the patient seems to have its root in the concept *tibbi al-nabawiyy*, or prophetic medicine in the Hadith, which articulates "the Prophet Muhammad's explicit support of active medical treatment and care in times of sickness, as well as the promotion of general health and well-being; and His statements *concerning* specific diseases and health issues and the methods, *both* (emphasis mine) medical and spiritual, for treating them" (Esack 2008:63–64). Needless to say, spiritual treatment is also necessary given the positive and negative functions, according to Islamic texts, concerning the etiology of disease, such as: "(1) punishment from God; (2) a means of cleansing the individual from sin; and (3) a means of preparing the sick for blessings from God" (Esack 2008:67). Regardless of the palatability of these beliefs, a Decent Care approach takes into consideration the language in which health is articulated when attempting to provide a treatment regimen in the clinical encounter.

The Hindu concept of Dharma, in scope quite different from the three monotheistic religions of the world, is a great reminder of "our universal interconnectedness, and of processes such as rebirth that can translate our individual dharma into societal dharma" (Agnivesh 2008:71). Two key aspects that Agnivesh (2008:73–74) focuses on in Hinduism that directly correlate with Decent Care are compassion and love. "Gandhi's favorite *bhajan*, composed by Narasimh Mehta, says, 'A Vaishnav [devotee] is one who knows the pain of others and does good for others, especially for those who are in mister'." In other words, one must know the other and his or her suffering before doing good. Likewise, love follows compassion: "When we love our fellow beings, care for them flows automatically; it is not charity, but an expression of our own selves" (*Ibid.*).

Empathy is perhaps most powerful in its articulation in the concept of rebirth—"a principle found in all Asian religions":

> Destined to return to this world again and again, it is our duty to care for its well-being…what we perceive as different could very well describe our own selves in previous or future births…another's present suffering could be our own in a future or previous life, while our cosmic connection to one another means that another's suffering is actually our own (Agnivesh 2008:75–76).

Rebirth presents a way of understanding and/or imagining the suffering of the other as one's own suffering—past, present, or future. This principle seems connected to the concept of Vasudev Kutumbhakam, or "The universe is one family," found in the Vedas: "when we view the entire world as our family, we offer the same loving care to anyone that we would to a member of our own family…. if an individual is not well, society is not well" (*Ibid*). Such notions in Hinduism reflect the profound ontological connectedness and interdependence of the universe. While practitioners in biomedicine and

[5] "For Muslims, human life and living is part of a journey towards God. Neither our real beginning nor our real end lies in this world" (Esack 2008, pg. 63).

other Eurocentric-influenced healthcare fields might scoff at these principles, it is important to remember that the patient's religious, philosophical, and political views are just as important as the physicians—if not more so—when it comes to choosing appropriate, Decent Care.

As with Hinduism, Panichpant-Michelsen (2008) describes Buddhist teaching as thematic of boundless compassion, which is provided through the Four Noble Truths. Panichpant-Michelsen (2008:80) states, "Buddhist practice is 'designed to end suffering, transform karma, and halt all future rebirths'." The end of suffering and half of all future rebirths are dependent on the role of both choice and practice in Buddhist teaching: "precept practice, mediation practice, and skillful choice lead to the Buddhist patient and care provider suffering less as a result of acquiring a greater sense of confidence and well-being. Suffering is therefore dependent on one's choices and definitely 'optional'" (Panichpant-Michelsen 2008:81). Concerning karma, Panichpant-Michelsen (2008:82–83) cites The Reverend Jerome Ducor as saying that "if our present situation is a consequence of previous karma, our future equally depends on the karma that we are presently building," which he views as a perspective of hope as opposed to one of fatalism. Buddhism, through its various texts and traditions, "points to the value of interdependence, interconnectedness, and 'inter being'." These themes, as outlined above, resonate profoundly with similar concepts, though articulated differently, in the aforementioned religions.

In light of how different religious traditions share certain similar concepts, particularly those emphasized by Decent Care, Gary Gunderson, and Teresa Cutts (2008:90) note that faith communities often "contend that their model of care is holistic and ultimately decent," but the focus in these communities is, as is the case with biomedicine, on pathology. "Theology's version of pathology" is "brokenness/woundedness" as it pertains to spiritual poverty (Gunderson and Cutts 2008:91). Thus, care of the body is often neglected, or relegated to physicians, due to the primary focus on spiritual or emotional care. Gunderson and Cutts (2008:91) state that "both traditional and faith models of care fall short of providing truly holistic Decent Care… due largely to a shared obsession with death, and they focus either on diagnosing fatal diseases and preventing death, or on understanding the dying process and look forward to life after death." In order to promote decency in health care utilizing the key themes of Decent Care, Gunderson and Cutts (2008:91–92) outline "the leading causes of life" under the rubric of a "life-focused epidemiology," which focuses on "expected vitality so that it can be systematically strengthened and promoted." This is in contradistinction to a seeming obsession with pathology as noted above. A life-focused epidemiology assumes "that life is intrinsic to every community," which applies and transfers the Hippocratic dictum *primum non nocere* from its focus only on the individual to also include the community: "to avoid harming the life of a community, it must first be understood as being alive" Gunderson and Cutts 2008:92). To understand the life of the community, it is necessary to work with the aforementioned values of the communities as they view their care through a teleological, perhaps even eschatological, reference frame that influences healthcare decisions.

Conclusion

In this paper, I have attempted to outline some key concepts of Decent Care, including agency and dignity, interdependence and solidarity, and sustainability and subsidiarity. These concepts are rooted in the fundamental premise that agency is not given but honored.

Most importantly, scholars and individuals from different world religions developed these concepts. Noting the diversity of beliefs to center on similar themes, the New Mexico-based physician-philosopher Dosey (2008:121–123) remarks, "compassion and empathy are two of the themes that reoccur in all major religions." Empathy and compassion are, likewise, incredibly vital for physicians, as well as incredibly vital as a foundation for policies regulating the current healthcare system. Anthropologists Crain and Tashima (2008: 129, 133) remind the reader of *Restoring Hope* that empathy and compassion in the healthcare system will become manifest when the current provider-centered system is changed to a system that is centered on affected people.

What unites Virchow, Foucault, liberation theologians and the Church, various religious and philosophical traditions, and physicians with a passion to help the marginalized is compassion that results in pragmatic solidarity. Regardless of one's philosophical or religious proclivity, compassion combined with solidarity at the institutional and societal level results in subsidiarity that is patient-centered. Subsidiarity that is centered on affected people both honors agency and provides an environment for dignity to be realized. Religious adherents and physicians should be the most outspoken advocates for the disempowered, especially with respect to healthcare issues. The tenants of the Decent Care movement will hopefully gain more traction as nonprofits and governments develop an accompaniment model for global health. As a paradigm developed by numerous individuals from a myriad of religious and philosophical traditions, it has much to provide in the context of health and human rights for the foreseeable future as different cultures and models for health equality continue to collide.

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