ENGAGEMENT IN CONTEMPORARY PRACTICE: A RELATIONAL ETHICS PERSPECTIVE

O COMPROMISSO NA PRÁTICA CONTEMPORÂNEA: UMA PERSPECTIVA DA ÉTICA RELACIONAL

EL COMPROMISO EN LA PRÁCTICA CONTEMPORANEA: UNA PERSPECTIVA DE LA ÉTICA RELACIONAL

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KEYWORDS: Nursing ethics. Professional practice. Patient rights.

ABSTRACT: The challenges and constraints of meaningful engagement with patients are discussed from a standpoint of relational ethics. If openness to others and to their situation is the beginning of ethics, as is argued by philosophers whose work informs relational ethics, then in health care we must address that openness (or its lack) as it is lived by individual health professionals within the immediacy and complexity of their practice. If, as has been also argued, disengagement is the source of maleficence within healthcare systems, addressing constraints to engagement becomes particularly urgent.

PALAVRAS-CHAVE: Ética de enfermagem. Prática profissional. Direitos do paciente.

RESUMO: Os desafios e restrições da interação significativa com os pacientes são discutidos do ponto de vista da ética relacional. Se a abertura para os outros e sua situação é o início da ética, como argumentado por filósofos cujo trabalho informa a ética relacional, então, no cuidado de saúde, nós devemos lidar com esta abertura (ou sua ausência) assim como vivida pelo indivíduo que é profissional da saúde, dentro das necessidades imediatas e da complexidade de sua prática. Se, como tem sido argumentada, a falta de compromisso é a origem da maleficência nos sistemas de saúde, enfrentar limites ao comprometimento das profissionais de saúde se torna particularmente urgente.

PALABRAS CLAVE: Ética de enfermería. Práctica profesional. Derechos del paciente.

RESUMEN: En el presente artículo, los desafíos y restricciones del significado de compromiso con los pacientes son discutidos del punto de vista de la ética relacional. Si la abertura a los otros y su situación es el inicio de la ética, tal como es argumentado por los filósofos vinculados con la ética relacional, entonces, nosotros en el cuidado de salud debemos dirigir esta abertura (o su falta) como siendo vivida por un profesional de la salud dentro de la importancia y de la complejidad de la práctica. Como ha sido argumentado, si la falta de compromiso es el origen de la maleficencia en el sistema de cuidado a la salud, es particularmente urgente establecer límites y comprometerse.

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THE RELATIONAL ETHICS PROJECT

In the early 1990s, an interdisciplinary research project, funded by the Social Sciences and Humanities Research Council of Canada began at the University of Alberta. The principal investigators of the project were Vangie Bergum (a professor of nursing) and John Dossetor (a professor of medicine). This research arose out of questioning of the concept of autonomy and its dominance within contemporary bioethics. Bioethics, this research group believed, needed to encompass community responsibility as well as individual freedom, hermeneutic knowledge as well as rationality, and relationship as well as definitive principles. The research group was composed of eighteen clinicians (of which I was one) from medicine, midwifery, nursing, psychology, physical therapy, social work, pastoral care, and scholars from anthropology, law, philosophy, psychology, theology. The objective was to create a new lens through which to approach ethics in practice.

To do so, we used interpretive inquiry to explore real healthcare scenarios. These real situations were brought "into the room" through such means as personal testimony, documentaries, or written narratives. Each scenario was opened by discussion of perceived ethical issues and responses, with explicit effort to attend to relational aspects. The discussions were audio-taped and transcribed as the research data. Thematic analysis was then undertaken.

The core elements of relational ethics were identified as engagement, mutual respect, embodied knowledge, uncertainty/vulnerability, and attention to an interdependent environment. We believe that these elements are informed by the concepts of interdependency, relational personhood, authentic dialogue, and the importance of community. Relational ethics, while it encompasses traditional approaches to health ethics that focus on moral reasoning (e.g., principlism), shifts attention to relationship as the source of ethical action

This paper is focused on the element of "engagement" in ethical healthcare practice. In our current research, we are learning from health professionals that the relationships created and shared between patients, families and caregivers seem to be increasingly in jeopardy. Healthcare systems are not only lacking in the support of patient-professional relations but, in many respects, are actually undermining them. This is a very serious matter if one believes that relational engagement is necessary to ethical care.[1-2] The connection created between patient and caregiver shapes the moral space inhabited by patients and caregivers. It is sharing this space (rather than the provision of a service from one to the other) that keeps both patient and professional safe in their mutual vulnerability.[1]

A nurse philosopher finds that,[1] without engagement, patients are alone even if when surrounded by professionals. Professionals, without empathic connection with patients, cannot fulfill their fiduciary pledge to them.[3] This, in fact, is what engagement means: "engager" comes from the old French meaning "to pledge". Health professionals pledge to the public (e.g., as a part of professional regulatory legislation) that they will use their specialized knowledge in a trustworthy way.

The research from which the concerns expressed in this paper arise is situated in Canada. Canada is an affluent nation with a publicly funded healthcare system in which access is based on need, not ability to pay. In regards to our healthcare system, we are judged internationally to have much better conditions than many countries. If we are getting into difficulties, others are likely to be in difficulty, as well.

THE DOMINANCE OF SCIENCE AND TECHNOLOGY

Contemporary healthcare is dominated by a paradigm of scientific objectivity and biotechnological expertise. Emotions are suspect; distance is required for "clear" thinking. This assumption is held as true within much of bioethics, as well. There is an intellectual search for universal rules to govern decision-making across any situation. Yet, anxiety and uncertainty are fundamental to being ethical: one must question continually whether or not one's actions are ethically fitting.[4] There is need for attentiveness to the ethical domain of practice, an attentiveness that must be cultivated and maintained.[5] In environments deeply embedded in a mechanized view of the world, this can be difficult. Gabriel Marcel warned several decades ago against "hardening of the categories" by which the world is conceived and perceived. He described two kinds of thought: calculative and contemplative. A problem arises, Marcel believed, only when calculative thought pushes aside the contemplative.[6] This "pushing aside" is happening in health care.

As a recent example, a physician colleague recounted a situation that happened in the neonatal intensive care unit when he was making rounds. At the bedside of one infant who was on a respirator, he found that both a nurse and the mother were very uneasy about the baby's status. They felt something was wrong. The other nurses and the medical residents, however, pointed out that the monitors and blood work indicated everything was well. My colleague pulled back the covers and examined the baby. He found the baby's abdomen to be distended and determined that emergency surgery was required. One hour later she was in the operating room with a perforated small intestine. To look at the baby with his own eyes and not only with the lens proffered by technology is what the experienced physician knew to do that his young colleagues did not. This physician, like myself, is concerned that in our teaching, we ensure that our students learn to use technology well. This means that, while they must understand what it offers in terms of treatment and care, they never allow it to obscure their regard of the person in the bed.

We must also teach our students to see past the idea of "expertise". One of the real stories we discussed in relational ethics research in mental health care was that of a nursing student who was completing her senior nursing practicum on a psychiatric unit*. One evening, there was an incident with a 16-year-old girl who reacted to some frustrating circumstances by throwing things, punching walls and by banging her head against a window. She was put into her room by nursing staff and there, she began to scream. She screamed for about an hour at which time she was given sedation by injection. Male nurses helped restrain her for that injection. The student was impressed by the smoothness of the team response and wondered if she would be able to do as well in an emergency situation when she was a staff nurse. Will she know what to do? Will she be able to move efficiently and smoothly as a team member? Thinking about this, the student went into the unit office. There the clerk said to her, – "It must be terrible for a teenage girl to be restrained by men and to have her pants pulled down in front of them". – "Until then", the student said, "I hadn't even thought about that part of it". That she hadn't thought about it troubled her: – "What has happened to me?" She recognized that in the crucial moment she no longer saw the patient, but rather, was concerned about her own capacity to meet other, more technical role requirements. With her attention elsewhere, she essentially could not see the patient's experience.

As human persons we need to have an availability "to others".[7] If we are not careful, in our healthcare environments we may obscure that availability by a focus on techniques. When that happens, our patients may be, "de-faced".[8] Technology allows us to do incredible things but we are constantly challenged to use it as a tool that we control and to understand it as a means, not an end.

In writing about technique, a family therapist uses the metaphor of the Samurai.[9] As he tells it, to become such a Japanese warrior, one had to study sword fighting diligently, learning every possible movement of the sword for several years. At the end of that time, one was not yet Samurai: first, the sword must be put down and travel and other study, like that of painting and poetry undertaken. After many months, when the sword was picked up once again, it was experienced as an extension of the warrior's arm; its use now, a natural act, not merely technique. The warrior had become Samurai. This metaphor has significant relevance to nursing practice.

Consider, for instance, the first time a student nurse performs a surgical dressing change. Most often, the student is so concerned with the maintenance of aseptic technique and with using the instruments properly, that s/he is unable to pay genuine attention to the patient. Once the technique of sterile dressing change is mastered, however, the student nurse is able to truly engage with the patient during the procedure. This mastering of technique is significant learning in becoming a nurse.

There was more to the senior student's story. The next day, the team debriefed the incident of forced medication and assessed whether or not they had followed protocol – used least restraint and so on. The student tried to raise the issue about what the experience must have been like for the patient. She wanted the team to admit how terrible it was – even though necessary to keep the patient safe from self-harm – to hold down a young girl and force medication upon her. But no one wanted

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* *This situation has been related in detail in Austin W, Bergum V, Nuttgens, S. Addressing oppression in psychiatric care: a relational ethics perspective. Ethical Human Psychology and Psychiatry. 2004; 6 (1): 147-157.*

to go there; no one wanted to talk about what it "felt" like to be coercive in providing safe care. In "Caregiver distress: if it is so ethical, why does it feel so bad?"[10:347] The authors suggest that caregivers are expected to keep their distress "in the closet" even though ethical decisions concerning patient care affect them on an emotional, as well as an intellectual, level. Even in psychiatry, distance and objectivity may be valued over embodied engagement.

Meštrović, a sociologist, argues that due to recent technological, social and global changes, western societies have become "postemotional": a state marked by a general cynicism and disconnect from community.[11] The experience of emotion has been disconnected from a desire to act. As the postemotional society emerges, the phenomenon manifests in smaller social institutions, such as the healthcare system, which mimics larger cultural changes. Applying Meštrović's social analysis to contemporary nursing practice,[11] Herdman notes the difficulty of retaining individualized care within a healthcare system that has undergone massive commodification and market rationalization,[12] also called "McDonaldization".[13]

THE MCDONALDIZATION OF HEALTH CARE

The company "McDonald's" is used to represent the push toward extreme efficiency, calculability (quantitative aspects), predictability and control. We see this push in health care as the system is increasingly dominated by market rationalization. Engagement is literally becoming a matter of customer service.[14] This transformation results in changes to how work is done (e.g., cost effective routinization, quantitative measurement, evidence-based practice, and prescribed modes of engagement). It alienates genuine emotions from practice.[12] Emotions are McDonalized, too: "bite-size, pre-packaged, rationally manufactured emotions – a happy meal of the emotions",[11: xi] "implicit in the postemotional outlook is disengagement or lack of empathy".[12:97]

One of the greatest changes we have experienced since a business ethic has begun to dominate our healthcare systems is in the resource of time, particularly the time to engage with patients. We certainly see this in our local continuing (long term) care facilities. In a study of ways to support relationships between families and staff in such facilities, we are learning from participants that the time to give individualized, holistic care to patients is disappearing. There are less staff for the same number (or more) patients and less qualified staff than there once was. These changes are taking their toll. Frontline staff describes rushing from one patient to another, knowing that even spending a few minutes extra with one of them is problematic.

In another of our studies, on the moral distress of mental health practitioners, efforts to give nursing care were described by a participant as *[...] a marathon. It's like running a marathon, you have very little time to ever stop and breathe. There's not enough time for each person usually. There's never any time to stop either and just talk to the people and treat them like people instead of... [tasks].*

In this study a young aide spoke about working in psychogeriatric units and the need to change 20 people in the course of an hour. Because time is in short supply, there is no flexibility to the way the staff approaches their care-giving. The patients are not treated as individuals. The aide said: *[...] these patients have to have their pajamas on right now (no matter how early in the evening it is) and then we are going to do all the patients in that NEXT room and then move on to the next. I try to remember that some day I might not have control of my bladder or my bowels and I may need someone to help me get changed and I would appreciate respect in that situation.*

This young aide, with only a brief orientation program to prepare her, feels empathy for the persons in her care; she resists responding to them as problems to solve, messes to clean. She possesses a willingness to engage in a meaningful way with those in her care. She sees it as a necessity.

Families of patients in the continuing care study told us that it is the "small things" that count. The small things – for instance, their mother' hair is nicely brushed; she is up in a chair, wearing her favorite sweater – are indicators to the family of the quality of care. The staff knows this and they, too, value such individualized care. They told us, however, that some days they cannot manage it: there is barely enough staff to feed patients properly. The staff feels badly about those days.

The bureaucratic view of efficient management has other close up implications. In our moral distress project, psychologists told us of pleading to keep a particular patient on their clinic case load – they wanted the person to know that s/he could come back whenever necessary. For management, however, patient numbers have to stay within a particular range and so, despite the fact that this will be best for the patient (and ultimately for the system, too, as it will help keep the patient well), the file must be closed to keep the numbers looking good.

A Canadian physician describes in an article, "some days I just want out"[15:1361] the way his clinic has changed. His clinic used to have four physicians, a few nurses and some receptionists: *we were friend and neighbours.* Now there are nine physicians and an upward staff of 20 staff: *we are colleagues. We talk occasionally in the hallways for a few minutes. We are much too busy, too focused, to have time for each other, let alone ourselves.* Maybe, he says, medicine must be practised like this now, as a job not a way of life. But some days it feels so bad that he just wants out.[15]

In some hospitals there are compilations of length-of-stay statistics circulated, listed by physician with the "worst offenders" on top. A Canadian psychiatrist, describes waiting "in vain for rankings to be created and circulated of humanistic parameters such as compassion, empathy and supportiveness toward patients, or even simpler measures such as providing good treatment or treating other staff well".[16:1390]

A nurse colleague, has studied the moral education of health professionals. One of her participants, a second year medical student, described how he was learning to become detached and to cultivate a "remote" demeanour. He said his lessons in this began in first year when he was teased by emergency room staff for trying to answer the request of a patient on a stretcher for a drink of water. Now, he says, students walk past patients as fast as possible, averting their eyes. He emphasized that he did not do this initially, that this avoidance of engagement was learned behaviour.

Recently at a narrative medicine seminar at my university, the theme of which was the importance of learning the patient's story, another second year medical student stood to speak. He told us about the 22 patients that he had met with his clinical supervisor that morning. He held up the tabular form for patient information and asked how he could learn a patient's story in six or seven minutes and record it on such a table.

If we don't have the opportunity to truly listen to our patients, will we be able to hear the voices of those who speak in whispers? "If one burrows down through the theoretical and philosophical perspective of ethics",[17:310] ethics is about human suffering and the capacity to address it through the empathetic virtue of compassion. They emphasize that persons marginalized in our society (e.g., the elderly, the disabled, the poor) may feel safe to tell the stories of their suffering only in whispers. Health care, they argue, must be a place where even these soft voices can be heard.

A Canadian sociologist calls for a renewal of generosity within health care (He is inspired by Levinas' description of the degeneration of generosity)[18] He refers in this work to the personal story of a woman's experience of diagnosis with breast cancer. This woman,[19] describes her experience as similar to entering a tunnel in which her physician was a disembodied voice, never entering the tunnel where she was. The tunnel is also evocative of institutional medicine – a space that embodies nightmares.[18] The challenge of the 21st century is not new treatments for illness or disability (we are successfully doing that). It is to "increase generosity with which we offer the medical skill that has been attained".[20:1] He suggest we use the paradigm of hosts and guests rather than providers and consumers. A hospitable welcome is what he wants to exist in health care: "the grace to welcome those who suffer".[19:1] Ironically, the original meaning of hospital is a place for guests.

THE CHALLENGES OF ENGAGEMENT

It must be acknowledged that being genuinely present, attuned and engaged with those in our care will always involve great challenges. Such challenges are inherent in the nature of caring work. For example, a nurse researcher studied paediatric intensive care nurses (PICU) and described major influences on their practice.[20] One influence was the bodily caring of suffering children: nurses told her that at times they will care for a live child who becomes a dead child and organ donor during one shift. When this occurs, the nurse literally makes a final note in the child's chart and starts one for the organ donor. Although the organ donation protocol is a tidy, scientific ordering of events, caring for the body of the child is not so simple for the nurse.

Sometimes it feels too difficult to do.

As nurses, we stand close to birth, death and the human condition. It can be too close at times. When it becomes too much, a nurse is said to be experiencing "burnout", "compassion fatigue," or "vicarious traumatisation". It is argued by some that it is empathic engagement that puts the nurse at great risk for such conditions. In our relational ethics research, however, we are questioning whether it may be the opposite; the cause may be a lack of opportunity to engage with patients and to do so with support.

In a pilot study of nurses' compassion fatigue, we are finding that the nurses are eloquent about a fatigue that seems a type of hopelessness. There is a deep sadness about the suffering that they see and despair about life's apparent meaninglessness. They feel their efforts to nurse well may be futile. These nurses describe being unable to find any genuine support to improve their practice situation and to find a safe place to be open about their distress. We believe that their descriptions of what is lacking in their environments offer us clues to ways we might prevent what is being called compassion fatigue.

My area of clinical practice is forensic psychiatric nursing. With an interdisciplinary team, I am studying ethical relationships in these settings. Forensic professionals have the dual responsibility of both custody and caring. "It is a characteristic of human life that we normally encounter one another with natural trust",[21:8] and that it is only special circumstances that cause us to distrust a stranger in advance. A forensic setting is a place of special circumstance. Caution and questioning of patients' motives and actions must be components of forensic practice and patients may view their caregivers as enforcers of their confinement. Some patients have committed serious crimes: arson, murder, rape, child abuse. One of our participants in this study, a psychologist, described looking at the hands of his client who had strangled a woman. He remembers thinking, not that he was in the presence of evil, but how very ordinary these hands, which had committed a terrible act, seemed. How does one engage with a person who has murdered another? In order to engage meaningfully in forensic settings, it may be the knowledge of a patient's crime that must be addressed rather than the distraction of technological equipment.

Engagement with patients can be a source of real danger and risk. In 2003, there was an outbreak of Severe Acute Respiratory Syndrome (SARS) in Canada. Health professionals died in giving care to those infected with the disease. It is a professional responsibility to accept such a risk, but professionals must be able to trust government and administration to support and to protect them as much as possible. Nurses, during the 2003 SARS outbreak, began to lose trust in those in charge and later hundreds of nurses demonstrated to demand better protection for health care workers.

Another contagious disease, HIV/AIDS challenges our ability to genuinely engage with patients. I am a co-investigator in a study exploring the experience of accessing health services by persons living with HIV illness. As one participant says - *I'm a quick get the gloves kind of patient.* Our participants shared stories of both genuine engagements with professionals and examples of lack of connection. To learn that one is HIV positive is frightening. A participant described how frightened she was, saying - *HIV always stands in front of me like a barrier.* But she told us, her physician gave her the necessary courage to live with HIV. Her physician was able to reach across the barrier of contagion and support her. What persons want from their caregivers was very clear. In the words of one, they want REAL practitioners: – *My GP just monitors it [HIV illness] and then that's that. Gets his $150 every time I come and visit him, gives me nothing, so now I want* ***a real doctor****. I want one that's going to be at least empathetic. I don't need his sympathy.*

They wanted to be cared for by practitioners who make them "feel human" and not "just a number". The real practitioner *first of all loves his job. He really cares about his patients and it's not superficial because you see it in his eyes.* A participant described her doctor (who is "real"): *He has my interests at heart. I know that because he shows it to me. Like, he stays and asks me what is on my mind. I could tell him anything, or ask anything, whatever I want to ask. That's really good, you know.*

The word "real" refers to a thing that is actual or true, genuine, not imaginary.[22] Real practitioners engage those in their care in a genuine way, seeing the person before them as more than a number, a disease, a matter of paperwork or a customer: – *He actually looks at me and he acts like he cares.*

As nurses, we are expected to reach out to our patients in their suffering and to alleviate it as much as we are able – even when this may mean, at most, simply being with them in their suffering. If openness to others and to their situation is the beginning of ethics, as is argued by philosophers whose work informs relational ethics, then we must address any and all barriers to that openness as it is lived (or not lived) within the immediacy and complexity of practice. If, as has been also argued, disengagement and detachment are the source of maleficence within healthcare systems,[23] addressing such barriers is particularly urgent.

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