

The Ethics of Everyday Practice

Healthcare Environments as Moral Communities

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Traditional approaches to bioethics, that privilege impartiality and objectivity and that focus primarily on moral reasoning, are relatively silent on the moral habitability of healthcare environments. Nurses and others in “the trenches” of healthcare are increasingly voicing the need to address everyday ethical issues, interdisciplinary tensions, and systemic concerns, in addition to the ethics of high-profile medical cases. Attention to the institutional processes that shape and constrain ethical dialogue and practice is required. In this article, the call is made for a shift in thinking about ethics in healthcare. **Key words:** *bioethics, clinical ethics, healthcare environments, moral community, moral habitability*

ETHICS as it is applied to healthcare practice has evolved over the centuries. For much of that time, “medical ethics” was the domain of physicians, shaped by the phrases of the Hippocratic Oath and by exemplars like William Osler. It was not until after World War II that a major change occurred, sparked by concerns that medicine was being dehumanized. There was then a turn toward humanities and theology for direction.^{1,2} Post-war advances in science and biotechnology began to further alter medical practice, and medical ethics metamorphosed to become “bioethics” in the early 1970s, with the law and moral philosophy playing stronger roles. This time of transition should have been an excellent opportunity to embrace the perspectives and concerns of other health disciplines but, for the most part, this did not occur.³ The biomedical model prevailed within bioethics and, despite some profound challenges (eg, ethics of care, feminist ethics), does so to this day. This hegemonic framework continues to

shape the elements of ethical practice, including such basic understandings as what does or does not constitute an ethical issue.⁴ It will be argued here that to have an ethic for healthcare that is reflective of the interdisciplinary circumstances of healthcare, one that is relevant and responsive to the moral habitability of the environment, bioethics must evolve from its present state.

THE NEED FOR EVOLUTION IN BIOETHICS

Dissatisfaction with a bioethics that seems distanced from the ordinary, everyday ethical issues facing healthcare practitioners and policy makers is being increasingly voiced. Some of this dissatisfaction may arise from the too tidy, theoretical analyses of moral philosophy. Hatab, for instance, argues for a “moral philosophy that is an *engaged, interpretive, contextual, addressive discourse for the sake of disclosing ethical bearings in life*,” one that would “build from actual questions, doubts, disagreements, responses, and negotiations.”^{5(p4)} Moral philosophers, according to Beauchamp, have yet to connect their theories to the actual problems of practice, leading him to predict that philosophy and bioethics might go their separate ways.⁶ Nurse ethicists, Peter and Liaschenko, charge

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bioethics, itself, with failing to account for the actual experiences of practitioners in real time and space.⁷ They find "bioethical theory to be essentially irrelevant" to their efforts as ethicists.^{7(p259)} Chambliss, a sociologist who studied the social organization of ethics in hospitals, describes bioethics as expanding from medical ethics and, on the whole, bypassing nursing.³ While great attention is paid to high-profile medical cases, bioethics seems to be disinterested in the close-up ethical challenges of healthcare environments.⁸ For nurses and others who inhabit "the trenches" of healthcare, the *ordinariness* of everyday ethical issues can mean that their moral significance goes unrecognized. They are viewed rather as clinical/logistical problems to be solved.⁹

Rubin and Zoloth argue that clinical ethics needs to evolve so that it is responsive to the larger context of healthcare practice and that "doing" clinical ethics means making ethics an integral part of an organization with issues raised day-to-day, not just during crises.¹⁰ Taylor, a nurse ethicist, questions what various healthcare professionals see as appropriate for ethical study.⁴ She recalls a physician ethicist colleague querying the validity of an ethics consultation request "because no treatment decision seemed to be in dispute."^{4(p68)} This "quandary-style" ethics approach, argues Taylor, overlooks other kinds of ethical concerns, many of which involve interdisciplinary team tensions and broad systemic issues.

Nurses and physicians (from the same workplace) when asked to describe care situations in which they felt it was difficult to know the right thing to do selected different episodes and elements.¹¹ The nurses, although asked about situations of uncertainty, narrated situations where they knew how to act, but were restrained from doing so. The physicians told of situations where they felt uncertain regarding decisions. The nurses' stories had a personal tone (it was *their* story) and frequently featured physicians as a source of ethical conflict. Physicians did not personalize their experience and seldom men-

tioned nurses. The professions criticized one another as lacking understanding.

In Chambliss' sociological study of how nurses define and respond to ethical problems, it was found that ethics issues were sometimes thinly disguised turf wars. "Nurses, being employees, deal not so much with tragic choices as with practical, often political, issues of cajoling, tricking, or badgering a recalcitrant system into doing what ought to be done."^{3(p7)} Nurses tend not to address moral problems as disengaged thinkers considering binary solutions. Understanding ethics as less "the display of one's moral rectitude in times of crises" and more as "the day-by-day expression of one's commitment to other persons and the ways in which human beings relate to one another in their daily interactions"^{12(p846)} fits better with nursing practice. Varcoe and colleagues studied nurses' perspectives on ethics through focus groups across clinical settings (urban and rural).⁸ Nurses described a shifting context affected by the privileging of biomedicine, by technology and an emphasis on cure, by corporatization, and by a prevailing attitude of scarcity in relation to resources. Relations with physicians were described as conflict-laden and nurses' agency as shaped by demands to ration time and care.

Research indicates that moral agency as enacted by nurses is dialogical, relational, and influenced by gender and context.¹³ Many nurses are looking for a distinct nursing ethics because existing theories do not speak to their needs.⁸ At the same time, a number of physicians have been looking for richer approaches to ethics than have been furnished by conventional ethical theories.^{1,14,15} These searches are indicative of the need for the expansion of bioethical theory in ways that address the current moral challenges and experiences of healthcare professionals.

THE MORAL GEOGRAPHY OF HEALTHCARE ENVIRONMENTS

Some practitioners have turned to feminist ethics as its attention to context, in

particular the power inequalities of practices, expands the scope of bioethics in relevant ways.¹⁶ Patterns of discrimination, exploitation, and dominance are made visible and their moral dimension recognized. The quality of relationships and the power in those relationships become worthy of notice^{17,18} and the sociopolitical aspects of healthcare environments become significant. Although they despair of mainstream bioethics, Peter and Liaschenko⁷ find the feminist ethics framework of Walker¹⁹ to be relevant and helpful. Walker defines morality as “a socially-embedded medium of mutual understanding and negotiation between people over their responsibility for things open to human care and response.”^{19(p9)} The way to get at morality’s content, argues Walker, is by tracking responsibilities in order to reveal the contours of moral landscapes and the situation of moral actors. Walker^{19,20} believes that there is an urgent need in moral theorizing to map *geographies of responsibility* that shape our moral lives and to study the ecologies and economies of that responsibility. This perspective has promise for addressing issues in care environments that do not appear on the map of current bioethics theory. Recent research by Peter et al²¹ found that nurses experienced their work environments as morally *uninhabitable*: their social and spatial positioning left them vulnerable to being overburdened by, and uncertain of, their responsibilities.

Other theorists like Foucault also point to the need to understand practices and the relations of power inherent to them.²² The application of Foucault’s thought moves one to see that “bioethics is a social practice which shapes relations of power; his most basic injunction is to think of clinical settings not as they present themselves—as places of treatment and cure—but as scenes in which subjects are being created so as to fit into relations of power.”^{22(p180)} “Institutions have ethical lives and characters just as their individual members do.”^{23(p28)} Healthcare organizations must critically examine how professed values are realized and whether incongruence

between what is espoused and what is done propagates less than ethical actions.²³

The need to understand the “ethical lives” of healthcare environments is gaining recognition. This need is driven, in part, by revelations of the extent of medical errors^{24,25} and the fact that errors reflect faulty systems rather than incompetent/malicious practitioners. What is particularly troubling is what Bird calls “the muted conscience,”²⁶ the apparent silence of practitioners about these errors, although it may be that their voices were not heard or were actively suppressed. The investigation into the infant cardiac surgery deaths at a Canadian hospital exposed the way in which the voiced concerns of nurses and anesthetists went unacknowledged until further deaths occurred.²⁷ At times, fear of litigation is a disincentive for professionals to be honest about error, even though honesty can alleviate patients’ concerns and lessen rather than increase liability.²⁸ Professionals may be reluctant to admit to mistakes, no matter what, because it does not fit with the impression of perfection they struggle to maintain with their colleagues, the public, and themselves.²⁹

Research suggests that the potential risk to professionals as individuals in organizations not receptive to their assertive participation in ethics issues reduces active ethical behavior.³⁰ In healthcare environments, “[t]here is an air of dehumanization, fragmentation, and focus on doing more, faster, and better. Intelligent, caring, and committed people feel alone, powerless, and voiceless in the midst of the demands.”^{31(p19)} The inappropriate application of knowledge from business and engineering have led to such problems as unsustainable staffing reductions and excessive demands on shrinking numbers of practitioners.³² Nortvedt asks whether the question for nurses is any longer “how to give the best care for one’s patients” but rather “how to minimize potential harm to patients created by socio-economic circumstances.”^{33(p12)} Provis and Stack’s³⁴ examination of healthcare studies and the care of older people found that obligations to clients

can be at odds with organizational demands. Simple situations without high drama (eg, being unable to take 10 minutes to help a patient start a knitting project) can create ethical tensions for practitioners. Health professionals, under increasing pressure to uphold the institutional goal of curtailing costs, may find themselves in conflict with their duty to their patients.³⁵ Being unable to answer the call of one's patients can be morally distressing.³⁶

The concept of *moral distress* distinguishes moral dilemmas—situations of not knowing how to act—from what is experienced when one believes one knows how to act but is thwarted by constraints.^{37,38} There is a sense of being morally responsible, but unable to change what is happening.^{36,39–41} Practitioners who are acting in a way that is contrary to personal and professional values or who are unable to translate moral choices into action feel like their integrity is in jeopardy: they can suffer anguish and the lasting consequences of *moral residue*.^{42,43} The necessary fiduciary relationships of healthcare environments are diminished when practitioners cannot fulfill their claim to be trustworthy.

Organizational pressures can also affect the ethical conduct of research within healthcare environments. Patients trust that they will not be harmed by participating in studies⁴⁴ but conflicts of interest when the institution receives monies due to the research, influences on patients to participate, and burdens placed on patients and families are real possibilities.⁴⁵ There can be negative fallout for practitioners and researchers who strive to protect participants—the Olivieri/Apotex case comes immediately to mind.^{46–48} That moral values shape the production of medical evidence is important, but they must also shape the way such evidence is used. “Evidence” alone is insufficient for responsible, responsive policy: values, like equity and solidarity, and patient preferences must explicitly be addressed.⁴⁹ Healthcare environments are systems under serious strain. Like other systems, their ecological integrity needs to be assessed, with deficiencies and points of strain

recognized and adaptively managed in ethical and resourceful ways.³²

HEALTHCARE ENVIRONMENTS AS MORAL COMMUNITIES

Research into healthcare environments as moral communities is imperative, particularly research into their climate and culture,^{50,51} the relationships within them,^{52–54} and the conditions necessary for ethical reflection, such as “power (right to information), trust (ability to disagree with one another), inclusion (relevant groups are involved in decisions), role flexibility (different viewpoints are allowed), and enquiry (questioning and debate are encouraged).”⁵⁵ Research already indicates that problems are similar across clinical settings and that successes at solving them are not sustained. Many haunting issues are not problems to be solved but polarities or ongoing, interdependent matters held in tension. To deal with them effectively, a culture that facilitates dialogue, connection, and respect is needed.³¹ Soderberg et al found that nurses’ ethical reasoning in intensive care units focused on ethical praxis, the need for congruence of thinking, feeling, acting, and being, and the need for professional barriers to dissolve.⁵⁶ A key finding was the desire for healthcare professionals to create an environment that fosters “at homeness.” The idea of “home place” is important in ecological perspectives^{57–59} and applied to healthcare environments can stimulate rethinking of our relations with one another and the spaces we share.^{32,60} Frank’s proposal that healthcare professionals consider themselves the “hosts” of patient/family “guests” grounds the wish for being at home in the moral value of generosity.⁶¹

Healthcare environments, however, are places where value resides in the scientific, the efficient, the economical, the impartial, and the procedural. Protocols and routines provide the parameters of practice, not generosity of spirit. Standard *modus operandi* coupled with professional expertise offer

predictability and the means to respond quickly to emergency situations, but responses can become rote and the ability to see what is actually before one can diminish. Professional and organizational structures can actively constrain practitioners from perceiving the ethical.⁶²⁻⁶⁴ In a study of nurses' perceptions about physical restraints, the researcher, Quinn, concluded her participants' willingness to accept patient suffering and their own misgivings about restraints was a consequence of fulfilling their perceived role obligations.⁶⁵ They "routinized" such situations.

Halpern finds that time pressures, a pervasive organizational problem, contribute directly to ethically inappropriate treatment (eg, by forcing patients to decide quickly).⁶⁶ Physicians, Halpern argues, need time to reflect and to connect with patients, but this is not supported in the way medical care is organized. Practitioners are ethical by remaining responsive and engaged with patients, including "suffering with," rather than being disengaged in a technical form of care.^{67,68} Vetlesen, a Norwegian philosopher, finds that for moral performance there needs to be a receptivity, an attentiveness to action.⁶⁹ If we do not perceive the ethical demands of a situation, we fail to be addressed by those demands. "Attentiveness, however, does not arise in a vacuum," says Vetlesen, "it needs to be learned, cultivated, maintained."^{69(p9)} Sensitivity to the perspective of others and the capacity to be aware of the ethical implications of one's acts brings attention to the moral domain of practice.⁷⁰⁻⁷²

Although clear, straightforward answers to ethical issues are desired,⁶³ ethics is fundamentally a matter of questions, questions that require openness, deliberation, self-questioning, uncertainty, and contemplation.⁷³ It is in asking good questions, not in having all the answers, where morality resides. *Being ethical* is never something one possesses. It is the recognition of the messy and expanding interdependence of decisions, interests, and persons. "Ethics," says Frank, "needs to shift its orientation from

decisions to identities—that is, *who I become* as a result of making this decision."^{74(p357)}

DIALOGUE AS THE WORK OF ETHICS

Ethical action takes place in community. A healthcare professional's response to the ethical question "How should I act?" needs to be understood in relations with clients and colleagues. Hatab believes that it is in dialogical encounters that one's ethical understanding takes shape and that these must be true encounters, not a matter of learning to argue from premises to conclusion, critiquing dispassionately.⁵ "The ethical space is filled with dialogue, embodied dialogue, which includes silence as well as speech."^{75(p501)} Thus, communication is a part of the work of ethics.⁷⁶ But it is conversation, not the transmission of information, that is the nature of this communication.^{75,77} Reaching with mutual respect across a diversity of beliefs—cultural, religious, and other—is increasingly important for ethical action.⁷⁸ Being able to see the possibilities of others' points of view involves the cultivation of the moral imagination.⁷⁹ Frank asks how we can open our imagination to one another's stories and thus make healthcare space more habitable.⁷⁷ He points out that dialogue is possible because of differences in stories, not made impossible by those differences. "The dialogical task—and the profoundly ethical task—is for people to see themselves as characters in others' stories."^{77(p21)} Although Frank is addressing patient-physician relationships, it seems true for all relationships within healthcare environments.

The need for dialogue among healthcare professionals, themselves, seems pressing. The healthcare team can be an exceptional source of support for its individual members, but when that team support is unavailable, the consequences can be described by words like *lonely*,⁵⁶ *betrayed*,⁸⁰ *misunderstood*,¹¹ and *ignored*.⁸ Practicing as members of their discipline, healthcare professionals' actions are shaped by the codes, values, and

responsibilities of their occupational group. The language and concepts, common to that group, frame and delimit their approach to ethical practice.³ Being ethical, however, is grounded in relationships and involves perpetual responsiveness to others.⁶¹ It must involve more than a single-minded focus on one's own moral agency.⁵ An interdisciplinary understanding of the moral space of healthcare environments and the multifaceted challenges arising within them would open new ways of thinking, of inquiry, and of methods for addressing those challenges.

For some practitioners, the dominant approaches to healthcare ethics that focus primarily, if not exclusively, on moral reasoning are insufficient. They are neither relevant nor responsive enough to day-to-day experience. Although developing a separate, distinct nursing ethics is a feasible route to follow, and one that will, no doubt, contribute substantially to the field of ethics, another route is available. An interdisciplinary exploration of moral ex-

perience and interaction in healthcare environments would allow the questions, doubts, disagreements, and challenges that shape ethical practice to surface and be heard. It would move attention to practices and the institutional processes involved in making healthcare environments morally habitable places. It would provide a way for the many voices of the healthcare community to be heard. It would allow our understandings of moral reasoning to be furthered by situating those understandings in context. An interdisciplinary approach would allow shared meanings to be created and knowledge critical to the opening and sustaining of genuine dialogue to be acquired. If healthcare environments are truly microcosms of general social existence⁸¹ that contribute to the form and function of society, itself, then this exploration becomes particularly important. Understanding healthcare environments as moral communities can help us understand much about living ethically together.

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