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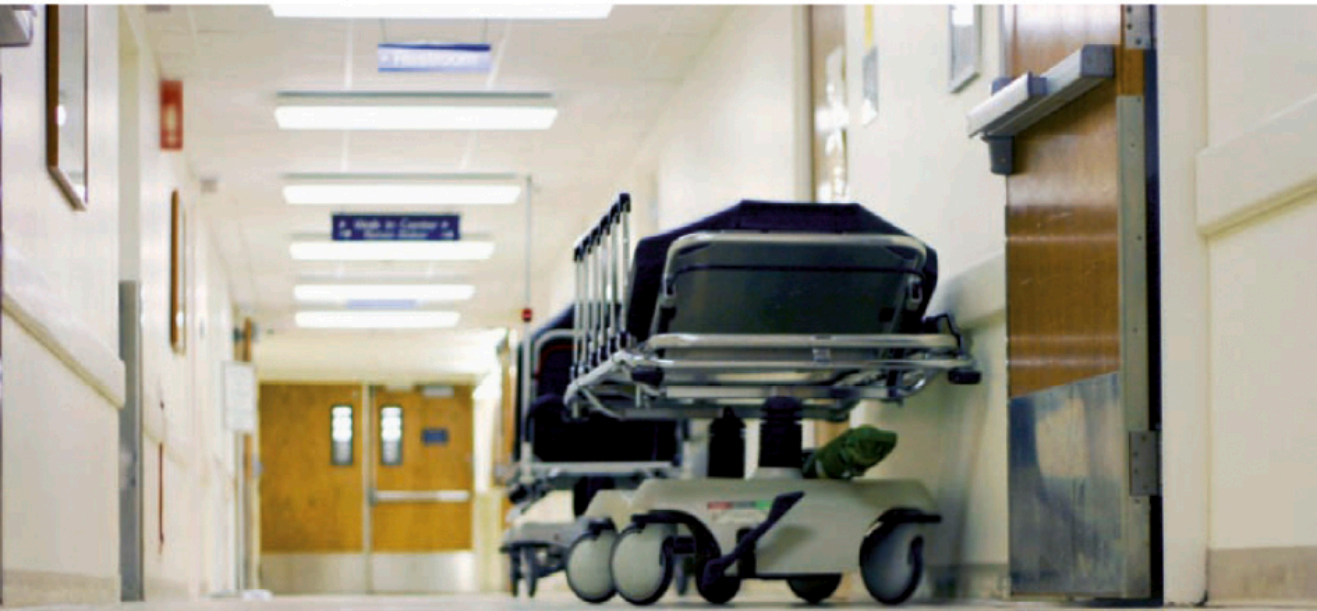
Conflicts of Care

Hospital Ethics Committees in the USA and Germany



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The complexity of the health care system makes it difficult to locate the problems and concerns experienced by nurses. One way of sorting it out is as suggested above, to divide the places of action and decision-making into three levels. Described by an inside-out perspective there can be understood: First, the individual level; second, the institutional level, and third, the societal-political level. While conscientious objection is the resource to take a stand on the individual level, raising one's voice in public debates and going on strike marks taking a stand on the societal-political level. Besides joining the works council, participation in Hospital Ethics Committees offers a way to take a stand on the institutional level. One would expect that taking a stand on caring concerns and conflicts falls into the realm of nurses since they represent the biggest group to be involved in care practices. But, as this chapter will focus on: *Empirical studies* will reveal different findings.

Concerns of Care in Hospital Nursing Practice

Concerns of care in nursing practice are not uniquely a North American or German phenomena. Nurses in countries with distinctly different health care systems like England and Scotland, report similar shortcomings in their work environments and the quality of hospital care. A study in 2001 of more than 43,000 nurses practicing in more than 700 hospitals in five countries indicates that fundamental problems in the design of work are widespread in hospitals in Europe and North America (Aiken, Clarke, Sloane et al. 2001). Several studies have shown: while discontent among hospital nurses is high, a vast majority believes that the competence of and relation between nurses and physicians is satisfactory.

In North America and Germany, nurses reported spending time performing functions that did not call upon their professional training (deliv-

ering and retrieving food trays or transporting patients), while care practices requiring their skills and expertise (oral hygiene, skin care) were left undone (Aiken, Clarke, Sloane et al. 2001). Nevertheless, the problems of hospital nursing do not represent the entire profession. Tasks and settings vary widely.

Everyday Nursing Concerns and Invisibilities

The dominant concerns found in stories and narratives of everyday nursing practice are the ones of caring, responsiveness to the other, and responsibility (Benner, Tanner, Chesla 1996). Since responsiveness and responsibility can be described as elements of a caring practice (see Tronto in Relational Analysis, chapter two), it is the caring practice itself to be the issue of concern. What else has been found about nursing conflicts and concerns?

When the nurse scientist, and director of the Kennedy Institute Carol Taylor (1997) interviewed nurses to get to know their ethical concerns, she had to realize that most of the nurses felt hard-pressed to describe the nature of these everyday nursing concerns that had ethical significance. She states "[…] while some everyday nursing concerns are unique to nursing, most derive from tensions that involve the interdisciplinary team and raise broader issues about the human well-being that are best addressed by the institution or health care system at large" (1997: 69). In order to reveal their concerns, she then analyzed her collected case studies that lead nurses to request ethical consultation. She identified that nurses mostly struggle for (1) the respect for human dignity, (2) a commitment to holistic care, (3) a commitment to individualized care which is responsive to unique needs of the patient, and (4) the responsibility for a continuity of care and the scope of authority, and (5) identifying the limits of care-giving (Taylor 1997: 69–82). Taylor discusses that none of the concerns are unique to nursing although they may be experienced with greater immediacy and urgency by nurses as well as other care givers. She also observed that more nurses described their moral orientation as care-based rather than justice-based (Holly 1986).

The US-American nurse researcher, Joan Liaschenko (1993a) and the Canadian nurse researcher Patricia Rodney (1997)[31] have specifically in-

31 Pamela Bjorklund's article (2004) *Invisibility, Moral Knowledge and Nursing Work in the Writings of Joan Liaschenko and Patricia Rodney* gives an overview of various kinds of invisibilities. She differentiates between "unseen nursing", "unseen costs", "unseen harms", "unseen space", and "unseen knowledge".

vestigated into concerns of practicing nurses. In an ethnographic study of nurses practicing on two acute medical units, Rodney has explored the situational constraints that made it difficult for nurses to uphold their professional standards. Other research (Varcoe et al. 2004) supports her findings of experienced serious structural and interpersonal constraints, e.g. excessive workloads for nurses, the absence of interdisciplinary team rounds, conflicts between team members inside and outside nursing, and conflicts with patients and family members. Rodney gives examples of interviews with nurses where they described their attempt to provide nursing care for the elderly and critically ill patients as a race against the clock (Rodney 1997). She explains that the inability of nurses to arrange space to talk with patients, constrains their ability to truly focus and being attentive to the authentic needs of the patients and families. In a further study with her colleagues (Storch et al. 2002), in addition to a lack of time, another predominant theme was the nurses' concern about appropriate use of resources. They struggled with decisions made by others regarding the allocation of scarce resources. Some of the interviewed nurses in this study, described physicians as not willing to listen or to receive the nurses' point of view and were reluctant to accept that nurses have any independent moral responsibility when caring for patients (Storch et al. 2002). Megan-Jane Johnstone (1989) is convinced: "Anecdotal evidence abounds worldwide on how nurses are continually told by doctors that nursing practice is devoid of any sort of moral implication, and that it is nonsense for nurses assume that they have any independent moral responsibilities when caring for patients" (Johnstone 1989: 3). Yarling and McElmurry cite the case of an American physician who objected strongly to the suggestion that nurses have a moral duty, even though an attending physician has expressly ordered that not information be given out, to disclose information to terminally ill patients who request it (1986: 65–66).

Moreover, the study gave evidence that the organizational climate, including policy development had been problematic for nurses. Sometimes this was related to a lack of policy, sometimes to the presence of a binding policy, and more dominantly, to an ambiguous policy. For example, policies that were considered to be too binding, such as the resuscitation policies were related to patients whose best interest were overseen by following a code (Storch et al. 2002). Central to the concerns given voice by nurses that were interviewed in Liaschenko's study, was their sensitivity to patient need. They were aware of the

"[…] increased vulnerability to loss of […] agency in the face of disease, illness. […] Need was not seen solely in terms of a biomedical model of altered physiology but was conceived broadly to include those things which helped the individual to initiate or re-establish routines of lived experience and to cope with the settings in which they found themselves. […] In this view, need was relative to the realities of the patient's day-to-day life" (Liaschenko 1993: 262).

The meeting of patients' and families' needs for emotional support, Liaschenko (1993a), Rodney (1997) and Varcoe et al. (2003) identified as being undervalued and overlooked in the work of nursing. "Because emotional work is a social transaction and not a product, it is invisible in a product-driven society. New nurses learn very quickly what the 'official' work is and what the unofficial work is. Emotional work is extra, frequently coming out of the personal time of nurses" (Liaschenko 2001: 2). The authors argue that economically driven changes imply that only certain processes are remunerated. Consequently, only certain, measurable aspects of care are accounted for and funded, while other tasks of nursing care are ignored. Hereby, different values underlie what gets accounted for and what is overlooked in an evaluation and a decision-making process that follows economic rules.[32] What also gets invisible in the work of nursing, is their dealing with social issues that have actually no place in the sphere of medicine and the mandate of the hospital like homelessness and poverty (Varcoe, Rodney 2001).

Liaschenko's identifies an unseen gendered space that nurses occupy in the larger bioethical landscape. She has shown how nurses can become actors who speak for others as "artificial persons", for instance, at the end of a person's life (1995b). Nurses bear witness to suffering at the end of life and try to alleviate that suffering when medical intervention stops. Liaschenko begins with the concerns of practising nurses as opposed to the bioethics issues of institutionalized medicine. For her, the concerns of nurses are often dismissed by the social order shaped by institutionalized medicine (Liaschenko 1993a,b).

In Germany, Rainer Wettreck has also used sight as a metaphor. In his grass-roots study he shows that nurses are stowaways in the hospital system, and that every-day nursing concerns are excluded by medically defined ethics, framed by those in a more powerful position (2001: 134).

32 Liaschenko remarks in this context: Since work is a key factor in how cultures differentially value and privilege different kinds of work, it would be central to how nurses identify, define and value themselves (Liaschenko 2001: 2).