Original Article

What is the Right Thing to Do: Use of a Relational Ethic Framework to Guide Clinical Decision-Making

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Abstract

Background: Answering the question "what is the right thing to do?" is, for most nurses and other healthcare professionals, an ethical question. Many decisions in healthcare are based on determining whether or not an action, or intervention, is to be taken. When a framework is used to help guide these decisions patient care can be improved. Relational ethics is an ethical framework that has been developed by an interdisciplinary team to help healthcare professionals answer ethical questions within complex environments. When applying this action ethic framework health professionals are guided to create the moral space where responsiveness and responsibility for yourself and the other is enacted and ethical questions answered.
Aims: The purpose of this article is to discuss and describe the core elements of Relational Ethics and to demonstrate how a relational ethics framework can be used to facilitate ethical healthcare decision-making.
Method: A clinical exemplar, drawn from a mental health nursing setting, is used to demonstrate how a relational ethic framework can be applied within a clinical healthcare context.
Results: Through the use of a relational ethics framework the essential core elements of Relational Ethics are applied which resulted in ethically reflective healthcare decision-making.
Conclusions: Clinicians are able to directly apply an ethical framework to their healthcare practice. Additionally, Relational Ethics is a promising action ethic which can be used to create the moral space needed to enact ethical decision-making.

Key Words: Relational ethics, Relational practice, Ethics, Relationship Centred Care, Patient Centred Care, Clinical Decision-making

Introduction

How can nurses determine what is the right thing to do? This question demands a moral decision. Gadamer (1982) reminds us that "the task of a moral decision is that of doing the right thing in a particular situation, is seeing what is right within the situation and laying hold of it" (p. 259). To determine what is "the right thing" nurses must negotiate the requirements of care and responsibility ***with*** their patients within the context of a relationship. The statement "***with*** their patients" reflects a paradigm shift from a logical positive perspective to a phenomenological critical social theory perspective. The past practice of nurses often reflected an oppositional relationship, one where the nurses had power-over their patients. Nurses would determine the requirements of care and have responsibility "for their patients". Although the difference in these phrases may superficially seem subtle – the difference in meanings is profound. This difference is reflected in the complex power relationship between the nurse and the patient. To negotiate ***with*** their patient requires that the nurse base her interactions on two new presuppositions. One, is a belief that a non-oppositional relationship is possible; and two, the self

is not viewed as individualistic but rather as embodied, interdependent, and connected.

By using a clinical situation as an exemplar, I will argue that nurses can use a relational ethic framework to determine what the right thing to do is. It is through the use of a relational ethic framework that nurses are able to view personhood and the self differently. This enables decisions to be constructed within the context of a relationship. Although nurses have used many well-developed universalistic moral theories to guide their decision making processes, such as utilitarianism and deontology, these theories assume a that the moral self as a disembodied being (Benhabib, 1987), and as a result are incapable of effectively navigating the ethical challenges posed within complex healthcare settings. My arguments rest on the following two assumptions. 1) It is through the use of a moral theory, which recognises an embodied self, which we can find what is fitting or what is the right thing to do. This "right thing" is discovered through meaningful dialogue, which is only possible when nurses understand and appreciate difference as the starting point for reflection and action. 2) Nurses must appreciate the context in which an ethical issue arises and clinical decisions are made. This context is not a mathematical equation to be figured out. Nor is it a black and white phenomenon to be described. It is an experience to be appreciated and honoured. The context is a dynamic and fluid interaction of the participants. It is this interaction that inspires (requires) responsibility (Olthuis, 1997). This responsibility evokes ethical action through our interdependence and connectedness.

Clinical Scenario Exemplar

Professionals working in nursing routinely implement interventions that result in social control whilst they simultaneously hold therapeutic aspirations. This is particularly common within psychiatric and mental health care settings. The experiences of the woman described below (pseudonym used) are used to help demonstrate the importance of considering the philosophical underpinnings of the situation when nurses are making clinical decisions.

Jamie is a 43-year-old woman who has lived with disturbing hallucinations and persecutory delusions for the last 20 years. There have been many times that these experiences have interfered with her activities of daily living. As a result, she has been admitted and discharged from psychiatric hospitals at least 25 times. There have been several involuntary admissions when health care providers determined that she was a danger to herself or others, she suffered from a mental disorder, and she had refused to accept treatment. When Jamie was discharged from the hospital, and she was agreeable, her follow-up care was provided by the staff at her local community mental health clinic. As a result she had been admitted and discharged from the community mental health clinic at least 20 times. At the time the jurisdiction in which Jamie lived did not have compulsory community treatment orders; all of the admissions to the community programs were with her permission. Most of the discharges from the clinic were against medical advice. Her diagnosis varied from admission to admission. She has been diagnosed as having disorganized schizophrenia, schizophrenia, schizoaffective disorder, bipolar disorder, borderline personality disorder traits, and paranoid personality traits.

Jamie was once again "requesting" assistance from the local community psychiatric clinic. (She was discharged from hospital only on the condition that she agreed to see a therapist.) Jamie had seen all the other therapists in the clinic. I was new. Therefore, I received this referral. Questions I asked myself were: should I accept the referral, Jamie is a very ill and I have the least amount of clinical experience? I decided to accept the referral.

When I met with Jamie she was on a long-acting injectable medication to help control her psychotic symptoms. Since the onset of her disease she had never had a complete remission of her psychotic symptoms. With each relapse of her illness her symptoms increased in severity. Jamie also had permanent involuntary movements from the medication used to treat her psychotic symptoms. In the past, within six weeks of stopping her medication she has always been forced to return to hospital. She was thinking again about stopping her medication again. I asked myself - do I try to convince her to take her medication?

On another occasion Jamie was agreeable to receiving her injection. However, only if it was administered as she lied naked outside under the crab apple tree, with her arms raised up at her sided and her legs together (a similar position to that of Jesus on his crucifix). She began to yell "God can see what you are doing to me" but stayed laying down on the grass waiting for the injection. It had been 5 weeks since she has agreed to

take her last injection. I asked myself – do I administer this medication?

Jamie use to phone the clinic several times a day (up to 20 times a day). The other therapists told me to set appropriate limits with this client and that I should not accept her calls. I wondered if should I refuse to talk to her too?

These types of questions are not unique and arise frequently when professionals engage in psychiatric nursing. Answering these questions is not straightforward. Decisions could be made primarily on determining what would keep her out of the hospital and/or what would be most effective to reduce her psychotic symptoms. Decisions regarding what interventions would be most effective and efficient are often beneficently motivated. Nurses want to do what is best for their patients. This is characterized by an attitude that nurses knows what is "best" for their patients.

This type of approach negates the value of the other and the beneficent nurse provides totalitarian style care. Nurses using this approach assume that the other (their patient) is a disembodied, rational, autonomous, separated, and isolated being. It is this view of a disembodied and separate other that leads to an oppositional relationship that views nurses as distinct and different from patients. The seductive charm of paternalism's rationality, "I know best", must be thwarted by a paradigmatic shift which would significantly reshape nursing theory and practice. Nurses must use an approach that has sufficient emphasis on respect and interdependence to ground how we perceive ourselves and relate with others.

The moral categories that accompany these questions go beyond determining what Jamie's rights are or what is my duty as her nurse. In order to answer the questions I have posed, I must see Jamie "as an individual with a concrete history, identity and an affective-emotional constitution" (Benhabib, 1987, p. 87) – a concrete other. I must recognize her humanity and individuality. It is only through the use of a moral framework utilizing an embodied and interdependent self that this recognition is possible. But how can nurses identify and respond to, in Benhabib's words – a concrete other? Relational ethics identifies that it is only within the context of an embodied reality that this will be possible.

Relational Ethic Framework

What is Relational Ethics?

Relational Ethics proposes that there are some kinds of relationships in healthcare are better than others for fostering growth, healing, and health (Bergum & Dossetor, 2005). These are the relationships in which the healthcare professional acts in accordance to a presupposition of the existence of a concrete other, rather than a generalized other. As part of the Relational Ethics Research Project, Bergum and Dossetor (2005) have deconstructed these types of relationships to reveal the tenets of an ethical relationship. Furthermore, they suggest that these tenets are interdependent; but if there is a causal link this has not yet been revealed. However, their research has revealed that these tenets are present in every healthcare setting that fosters embodied relationships.

The central tenets of Relational Ethics are mutual respect, engagement, embodied knowledge, environment and uncertainty. The most important of these is mutual respect, followed closely by engagement. Responsibility for the other is inherent in the relational ethic concept of mutual respect. Responsibility is inspired (required) by our interaction with another, thus precipitating ethical action (Olthuis, 1997). From a relational ethic perspective it is the fulcrum for ethical action (how to be, how to act) is the relationship (Austin, Bergum, & Dossetor, 2003). Understanding our relationships with others, and the ethical actions to be taken, requires knowledge of traditions, universal principles, rationality, our subjectivity, and our interconnectedness (Austin, 2001; Bergum, 2012; Gadow, 1999; Rodney, Burgess, Phillips, McPherson, & Brown, 2012).

The basic premise of relational ethics is that ethical decisions/actions are made within the context of a relationship. This is a substantial shift from the previous nursing practice regimes as viewing the individual as a static bearer of rights to perceiving the patient and the nurse as interdependent agents. The fundamental nature of relational ethics is that ethical commitment, agency, and responsibility for self and to the other arises out of concrete situations which invariably involve relations between two or more people and affect two or more people. Within this relationship exists embodied selves that are interdependent and connected.

The patient and the nurse must engage and be present with each other. Moral responsibilities and norms of equity govern the interactions within the relationship. The concrete other is then seen in the moral space provided by the connectedness between the patient and the nurse. It is essential that the face of the other, in other words – the personal identity, or the humanness of individuals remain intact for moral action to be initiated. Should it not, dehumanization occurs and people are cast

at the 'receiving end' of action in a position at which they are denied the capacity of moral subjects and thus disallowed from mounting a moral challenge against the intentions and effects of the action. In other words, the objects of action are evicted from the class of beings who may potentially confront the actor as 'faces'. (Bauman, 1993, p.127)

For example, if the nurse only sees Jamie as a schizophrenic/bipolar/borderline individual that must be managed with an ultimate goal of minimizing the costs to the healthcare system, Jamie has been unequivocally dehumanized. This dehumanization would be consistent with obtaining the best outcome for the majority of individuals (there would be additional healthcare dollars for others if she did not require inpatient care as often). However, determining treatment using such a strict utilitarian approach would not be acceptable, from a relational ethic perspective, as the responsibility nurses have for particular others would be negated.

Mutual Respect

Mutual respect is inspired by responsibility to the other. "When we respect something [someone], we heed its call, accord it its due, [and] acknowledge its claim to our attention" (Dillon, 1992). Mutual respect is the means to mitigate power differentials. This does not mean that the nurse and the patient have equal power. It means that the nurse and the patient have different power. Within the relational ethic framework mutual respect provides a means of interacting with others that are not equal, through recognition that "our differences complement rather than exclude one another" (Benhabib, 1987, 87). Mutual respect develops from an intersubjective experience arising from a non-oppositional perception of difference. This is achieved by acknowledging the phenomenological experience of the selves in the relationship. The non-oppositional nature of mutual respect solicits interactions related to responsibility, bonding and sharing. It is based on the norms of equity and complementary reciprocity.

This perception of difference generates affective, behavioural, and cognitive responses (Callahan, 1988; Dillon, 1992) all of which evoke ethical actions. For example, the nurse recognises that Jamie's telephone calls are a "litmus test" she is using to determine if the nurse recognizes that she is also an individual to whom one should respond. These telephone calls are also Jamie's way of sharing her daily experiences with the nurse. When the nurse chooses to phone Jamie back she demonstrates that Jamie and her experiences have value. As the nurse negotiates with Jamie when and how often telephone support is needed, Jamie also has responsibilities within the relationship. These include honestly discussing the needs that she has, identifying the issues that are better discussed in person rather than on the telephone, and recognizing that the nurse, like herself (Jamie), has competing demands on her time.

In making the decision to return Jamie's telephone calls a nurse guided by the Canadian Nurse's Association Code of Ethics (Canadian Nurses Association, 2008) recognizes that there are responsibilities related to health and well being and justice. Within this model nurses are responsible to assist individuals to achieve their optimum level of health, and to uphold the principles of equity, fairness, and social justice as they assist individuals to receive the share of the health resources proportionate to their needs.

For example, Jamie's mental status would be examined and then the nurse determines what level of contact is best meets Jamie's needs. However, this may or may not coincide with what Jamie thinks her needs are. But, the nurse has recognized that Jamie has needs that need to be cared for; and follows an evidenced-based treatment plan. This approach would not include negotiating with a patient the type and style of interactions with the nurse.

The theme of mutual respect outlines the importance of attending to the overall quality of the relationship (Bergum, 2012). In a quality relationship, based on mutual respect, healthcare providers can suppress their tendency to assume that they know what is best for the patient due to their technical knowledge (Crowe & Alavi, 1999; Holmes, 2001; Meleis & Im, 1999; Sherwin, 1998; Watts & Priebe, 2002). Although mutual respect is central to relational ethics it must occur within an engaged relationship.

Engagement

To understand engagement from a relational ethic perspective nurses must reshape the traditional nursing understanding of the self as an independent and autonomous entity. To establish an engaged relationship nurses must position ourselves ***with*** the other (Olthuis, 2001). This tenet requires a true movement toward the other as a person (Bergum, 2012). With this type of movement the traditional modernistic paradigm is shifted. Engagement is not a decision but a consequence of an embodied self – a self that can only be present in the context of a relationship. Engagement requires an understanding of the complexity of each situation, each person's perspective, and each person's vulnerabilities. When using traditional nursing paradigms nurses could decide if they would or would not engage with a patient. However, when a relational ethic framework is used to guide decision-making this is not an option. This presumption is based on the belief that engagement is not an autonomous or individualistic activity. Again, this is a result of the premise that individuals do not exist in isolation – the self is embodied. The self is a product of the relationship with others.

Relational ethics requires that professionals not imagine themselves in the place of their patients; they must identify the unique needs, talents, and capacities of their patients. When nurses put themselves in the place of their patients, this type of "imagining" maintains the dichotomy between the nurse and the patient. This type of empathy discounts the phenomenological experience of the patient. For example, if the nurse in the above clinical scenario imagined herself in Jamie's position and ascribed her own values and believes to Jamie's experiences the nurse would ask herself the following questions – Would I want to be readmitted to hospital? Would I want someone that I had called to return my telephone calls? Are the side effects of this medication worse than being psychotic? All of these questions assume an individualistic existence of self and represent an unengaged relationship. From a relational ethic standpoint a relationally engaged nurse would ask – How can I better understand what Jamie wants? How can I assist Jamie in achieving her goals? Does Jamie think being a bit psychotic all the time is ok? What is this experience like for Jamie? Once health care professionals are engaged they are able to nurture an understanding of their patient's humanity and individuality. Engagement allows us to hear the other's voice.

Embodied Knowledge

Embodied knowledge is another central theme in relational ethics. This type of knowledge is multidimensional. Due to the multidimensionality of decision-making, from a relational ethic perspective, the healthcare professional must use their cognitive, affective and emotional experiences. This is compared to decision-making being a strictly intellectual exercise as it is from a deontological or a utilitarian perspective. Bergum (2012) describes embodied knowledge as an integrated consciousness. Embedded within embodied knowledge is our past learning. Embodied knowledge is not merely a series of rational choices, made based universal rules applied systematically to each situation, it also legitimizes the need to make concrete situational judgements based on perception (Nussbaum, 1990). For example, we may choose to use our knowledge of the ethical principle of justice and our experiences with compassion to help guide ethical action.

Embodied knowledge is demonstrated in the clinical exemplar when the nurse is deciding whether or not to administer the medication while Jamie is lying naked under the crab apple tree. For example, the nurse considers that it has been 5 weeks since Jamie accepted her last injection, Jamie's decisions are now more heavily influenced by her delusions, Jamie describes the voice of the devil becoming louder and more frightening to her, and Jamie has described, in great detail, how much she hates being in hospital. When using a relational ethics framework the nurse considers all of these factors. If using principlism to guide decisions, within the western culture autonomy is the most important principle, Jamie has not given her informed consent for the nurse to administer the medication. As a result the medication would not be given. Previously when the medication was not given Jamie's illness exacerbates until she becomes a danger to herself and/or others and is then involuntarily conveyed and detained in the hospital.

Environment

We are social beings constantly affected by our connectedness – in other words, our relationships. Within the context of the environment we are not separate entities, but exist at the very least, as a part of a connected dyad. This dyad is then influenced by a larger society. Several authors have reflected on this

connection and the interdependence we have with each other. For example, Cassell (1991) has written: "there is no person without others, virtually no idea, belief, or concept which, when traced to its origins, will not entail a peopled world" (p. 26). Sherwin (1998) goes on to describe that all people are "to a significant degree, socially constructed, that their identities, values, concept, and perceptions are, in large measure, products of their social environment" (p. 35). Researchers using a relational ethics framework have a slightly different viewpoint. However, this difference has profound meaning. In relational ethics we are the environment, "we are the system" (Bergum, 2012). This contrasts to the above ideas on the environment as the core essence of the environment, from a relational ethic perspective, is mutuality. The self is an interconnected entity that cannot be detached from others. Bergum's (2012) opinion closely parallels Olthuis's claim that "there is no I without a We" (1997, p. 147) which reflects the necessity of mutuality. Mutuality is seen as a way to negotiate the power differential between nurses and their patients.

However, the following questions have yet to be answered – Is there ever a time when a self does not have an ethical voice within an embodied relationship? For example, when Jamie is grossly psychotic does she still have power within the relationship? Does Jamie still have an ethical voice?

Uncertainty

Uncertainty occurs when value-based questions create difficulty in selecting a course of action or decision (McPherson et al., 2004). Ethical quandaries are also a result of differing cultural values. The multidimensional nature of ethical quandaries may bring on a potentially debilitating anxiety (Tarnas, 1993), meaninglessness, despair, ironic detachment, lost hope (Downing, 2000), fearfulness (Olthuis, 1997) and ethical numbness. As a result of these experiences, Scofield (2000) describes healthcare practioners, patients and their families, and the courts being caught in a storm of values. This storm has been generated by competing ethical frameworks, which (from their perspective) are to form the basis of "correct" ethical decision-making. Each school of thought is "as certain that it is right as it is that the others are wrong" (Scofield, 2000, p. 335). Uncertainty is a truth that asks for humility rather than power, understanding rather than information, and relationship rather than ideology (Bergum & Dossetor, 2005). Through uncertainty " we move to select the best alternatives, all things considered – in other words, realizing that we may not achieve either certainty or perfection" (McPherson et al., 2004). Ipperciel (2003) suggests that ethical uncertainty does not arise from the facts of the situation, but are in the "subsequent hermeneutical identification of the *relevant* factual elements that will give form to the *contextual* aspect of decision-making" (p. 215). When using a relational ethics framework one is completely aware that our knowledge is constructed within the context of the situation and is incomplete. There is a constant need for the clinician to be self-reflective by asking "what should I do?" and "who are we"? This can be done through conversation with colleagues or reflexive writing. It is also done through negotiating the care that will be provided with the patient. However, answers to these questions must be structured by the ethical imperative of the concrete other.

Conclusion

Through the use of a clinical exemplar I have demonstrated that clinical decisions are complex and can be viewed from multiple perspectives. When nurses use a relational ethic framework to help guide their decision-making their final decisions may not be easier to make but they will be more fitting. To use a relational ethic framework in clinical practice requires that nurses make a paradigm shift. This paradigm shift requires that people be seen as interdependent and connected. People are not individuals – they are products of relationships. The traditional notions of autonomy, equality, and the self as an independent entity are challenged. As a result norms of nursing decision-making change to embrace an embodied self. Ramifications to practice are significant. Nursing care can no longer be interpreted as caring for the patient. Nurses must care ***with*** the patient. The norms of equity and moral responsibility preside within the relationship. The ethical imperative becomes that of a concrete other.

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