Submission to Clinical Ethics

Slow Ethics: A Sustainable Approach to Ethical Care Practices?

ABSTRACT

Recent UK reports have revealed extensive evidence of unethical care practices. Older and vulnerable patients, in some areas of our health services, have experienced appalling and avoidable suffering. Explanations for, and solutions to, these care failures have been proposed with wide-ranging recommendations. Many of these have direct implications for clinical ethics with additional frameworks for ethical values proposed, a heightened awareness of the moral culture of organisations acknowledged and a renewed interest in the ethics component of professional education debated. In this paper, it is suggested that we integrate insights from the slow movement into our clinical ethics practice. Distinctions are made between fast and slow healthcare practice and between fast and slow ethics. It is argued that, whilst there is a place for both, slow ethics enables us to assume a more positive stance in relation to 'crisis': and requires that we learn from past accounts and scholarship; and consider the role of clinical ethics in sustaining caring cultures.

Key words: unethical practice, slow movement, crisis, slow ethics, clinical ethics

Introduction

A raft of recent UK reports have revealed that some doctors, nurses and other 'care' practitioners do not practise ethically (1-4). The Francis reports into events at the Mid-Staffordshire NHS Foundation Trust detailed a wide range of individual, organisational and regulatory failings that resulted in the avoidable suffering and deaths of many patients (5-6). The language of 'crisis' is now all too familiar, for example, crisis in the NHS (7), crisis in nursing (8) and a crisis of compassion (9). Health professionals are working in a context of constant change having to make sense of, and respond to, policy, practice, political and professional imperatives. They also have to make sense of a seeming tsunami of values' statements imposed with little space or time for interrogation. The everyday reality of healthcare practice means that health care professionals often have to prioritise speed, task-focused care and quantitative measures. There is, it seems, too little time to reflect on the meaning and value of care, on factors that support and undermine care and, crucially, to learn from history and from a rich tradition of multidisciplinary work on care. This article will examine these themes and propose that in our clinical ethics and healthcare practice and ethics educational activities we can learn from a movement that has, thus far, focused on culinary, travel, sex, medicine, art and lifestyle quality rather than care or ethics: the slow movement.

The Slow Movement

In the opening to his book *In Praise of Slowness: Challenging the Cult of Speed* (10) Carl Honore, describes an experience at Rome airport. He was working as a foreign correspondent and rushing to catch a flight to London. As he queued impatiently at the gate he flicked through a newspaper and came across an article entitled “The One-Minute Bedtime Story”. He writes:

My first reaction is to shout Eureka! At the time I am locked in a nightly tug-of-war with my two-year-old son, who favours long stories read at a gentle, meandering pace. Every evening, though, I steer him towards the shortest books and read them quickly [...] Part of me feels horribly selfish when I accelerate the bedtime ritual, but another part cannot resist the itch to hurry on to the next thing on my agenda – supper, emails, reading, bills, more work, the news bulletin on television. Taking a long, languid stroll through the world of Dr Seuss is not an option. It is too slow (10 p.2-3)

Honore tells us that his initial response to the one minute bedtime story advert is to wonder how quickly Amazon could dispatch the full set. But then he asks: ‘Have I gone completely insane?’ He realises that he has become ‘Scrooge with a stopwatch, obsessed with saving every last scrap of time, a minute here, a few seconds there’ and concludes that he is not alone as everyone around him ‘is caught in the same vortex’ (10 p.3).

Honore traces the development of the Slow Movement and takes us through discussions of Slow Food, Slow Cities, Slow Sex and Slow Medicine. Although the Slow Movement can be viewed as an antidote to ‘a pace of life spinning out of control’ and requiring that we reconsider fast food, fast cities, fast sex and fast medicine, it acknowledges that this is not just about pace but also about philosophy and politics. Parkins and Craig describe *Slow Living* in the following terms:

Slow living is not a counter-cultural retreat from everyday life. Slow living is not a return to the past, the good old days (pre-McDonalds arcadia), neither is it a form of laziness, nor a slow-motion version of life, nor possible only in romantic locations like Tuscany. Rather... slow living is a process whereby everyday life – in all its pace and complexity, frisson and routine – is approached with care and attention, as subjects attempt to negotiate the different temporalities that they daily experience; it is above all an attempt to live in the present in a meaningful, sustainable, thoughtful and pleasurable way (11 Preface).

My engagement with the Slow Movement began when I attended an exhibition on *Slow Art* in Stockholm (12). The art objects exhibited were, without exception, very beautiful demonstrating a fragility, vulnerability and the most acute attention to detail. Robach states that *Slow Art*:

requires not only courage but also integrity to dare to take the time and focus entirely on one single project for weeks, months or even years. (16 p.20)

Moral dispositions or virtues such as integrity, patience, courage and respectfulness are central to the Slow Movement (13). The ethics of the Slow Movement also focus on quality (over quantity) and - in relation to *Slow Food* - the idea of 'virtuous globalisation' which involves, as Andrews writes, 'sustaining local identity and culture in the face of the neo-liberal global market' (14 p.162). Heterogeneity is valued over homogeneity and the local over the global. The *Slow Movement* values the achievements of communities who thrive, sometimes against the odds. Virtuous globalisation requires engagement with difference, with breaking down barriers and acknowledging interdependence with a view to, as Hall puts it, making 'a common life or at least find some common ground of negotiation' (15).

So how might the *Slow Movement* inform the health professions, in response to what appears to be an epidemic of unethical care practices? First, it seems helpful to consider the implications of 'fast' and 'slow' for everyday healthcare practice.

Fast and slow healthcare practice

The epitome of 'fast' healthcare practice seems captured by the image of an efficient healthcare team rushing to the scene of a cardiac arrest. Or perhaps we might consider speedy triaging which gets patients through an emergency department in accord with the time target as 'fast' healthcare. And it seems likely that we would agree that an ambulance team getting to a call within the recommended time is a good example of 'fast'. What becomes clear is that the value of the facts and norms of 'fast' are not necessarily synonymous, that is, meeting a speed target may meet a pre-set objective but may not be considered normatively or ethically 'good'.

Youngson (16), for example, writes:

It may not be written down anywhere but the rules for health professionals are clear: put your head down, complete your tasks as quickly as possible, get the paperwork done, and move onto the next patient (16 p.1)

Despite such unwritten rules, health professionals feel compromised by time constraints and appreciate that it impacts on their ability to deliver ethical care. General Practitioners, for example, have reported that they 'cannot do their job properly' due to increased patient complexity and time constraints (17). The lack of time for reflection on practice is evident in this email send to me by a senior nurse:

We are all so bombarded every day, all day, with information, with demands upon our time, that the opportunity for quiet reflection becomes eroded [...] Coupled with the quantity of information comes demand to get everything done quickly, and finesse is lost, because we are sadly looking for the quick fix, the quick reply, the short cut. And everyone is under so much pressure, so taking time is a luxury (18).

Readers will also be aware of some paradoxes of speed. In relation to resuscitation, for example, there was an understanding of the meaning of “hurry slow” in some situations. Again, the ethical aspects of pace become apparent and the need for open discussion and reflection suggested.

Slow healthcare practice, on the other hand, engages meaningfully with the quality of healthcare interactions, with the experiences of patients, family and healthcare staff and the ethical climate of organisations. Slow healthcare practice does not dodge relationship difficulties, skim over the reality of patient and family suffering and staff distress or accept organisational and professional imperatives unreflectively. Rather it embraces the value of care, the need for time and space and the reality of healthcare complexity and uncertainty. In a Delphi study exploring how GPs negotiated conflicts of interest in safeguarding children, a respondent emphasised the need to ‘listen carefully and judge slowly’ (19). There are many fine examples of everyday healthcare interactions that illustrate ethical care practices where professionals have demonstrated acute sensitivity, creativity and compassion. One such, that has been written about elsewhere (20), relates to a response to an older person who was dying. The older person, ‘Lillian’, wished to have a soft ice-cream and this was unavailable in the hospital. The staff nurse, Sarah, suggested that a student nurse, Ian, drive to a local shop to get the ice-cream. He did so and Lillian had the ice-cream she wanted. She died some hours later. Such small acts of kindness are not unusual in our health services but are seldom highlighted.

This section has introduced the distinction between ‘fast’ and ‘slow’ healthcare practice. As with *slow living*, slow practice is a process whereby practice activities in all their ‘complexity, frisson and routine’ are ‘approached with care and attention’. There should be an aspiration to be ‘in the present in a meaningful, sustainable, thoughtful and pleasurable way’ (11 Preface). Practice that emphasises: quality over quantity; appreciates complexity rather than opts for a quick fix solution; and challenges and interrogates rather than accepts top-down or external imperatives characterise ‘slow healthcare practice’. It is, of course, not either/or and there is a place in our healthcare system for both ‘fast’ and ‘slow’ perspectives. The aim should however be to integrate as much of a ‘slow’ approach as possible into our ‘fast’ practices. Reflection on the normative dimensions of fast and slow practice is, however, essential and our approach to clinical ethics will influence how effectively we do this. I will then next consider the components of ‘fast’ and ‘slow ethics’ and the corrosive consequences of a negative perspective on ‘crisis’.

Fast and Slow Ethics

In response to the recent reports of unethical care practice, solutions have been proposed and recommendations made that have implications for ethics education, empirical ethics, philosophical and clinical ethics. Professional education and recruitment practices are two areas that have been targeted and there is a drive to measure aspects of the moral life. Compassion training has been recommended (21)

and a values-based approach to recruitment to professional education proposed (22). Examples of 'fast ethics' in professional education might include educational approaches that focus on transferring single ethical concepts (for example, dignity or compassion) or clusters of ethical principles and algorithms from teachers to students with little or no engagement with previous scholarship and research or the process of professional socialisation. This is not to say, that there is not a place for clusters of ethical values or algorithms but rather than there needs to be a more creative and contextualised educational approach.

There is now an abundance of ethical frameworks, professional codes, constitutions, declarations and pledges designed to guide and prescribe ethical healthcare practice. Nurses, for example, have been directed to defend dignity (23), to adhere to the 6 C's (24) and to the values of the NHS Constitution (25). Nurses also have UK and international professional codes (26, 27) and are required to act in accord with national and international human rights declarations (28). Nurses who are researchers must also accommodate values from research ethics documents (29). These single, or sets of, values are generally imposed with little or no interrogation or contextualisation (how do they fit, for example with existing philosophical approaches?) and no consideration as to how they might relate to each other. Minimal attention is then paid to how already beleaguered educators and health professionals are supposed to make sense of it all, never mind apply these values to their everyday practice. Little attention is paid to the philosophical and historical context and development of ethical concepts intended to guide care. It is impossible to know if frameworks are developed in ignorance of previous work in applied ethics and philosophy or if it is thought that previous work is irrelevant.

In empirical ethics, there is an increasing tendency to quantify ethics, to measure aspects of the moral life. There are, for example, questionnaires to measure phenomena such as moral distress, the ethical or moral climate of organisations, empathy, moral sensitivity and moral judgement. These examples of what might be called 'fast ethics' have a place in professional life but sustainable approaches need to engage with a slower approach. We can and should learn from research in these areas. Quantitative research that demonstrates a correlation between the moral climate of healthcare organisations and the moral distress of nurses is instructive (30). Our understanding of the concept of moral distress enables us to understand the predicament of nurses who want to do the right thing but feel unable to do it (31).

Slow Ethics requires a broader view of ethical competence (32) that pays attention to: ethical perception: the acquisition of knowledge of moral philosophy and other related disciplines to understand ethical and unethical practice; the development of critical thinking; ethical action; and the conditions that enable professionals to flourish and demonstrate virtues. *Slow Ethics* involves reflection on the relationship between professional socialisation, leadership and role modelling in the university and in practice. Time and space is required in the classroom for students to reflect on the meaning and implications of ethical concepts and theories and for

opportunities for rehearsal of ethical practice in the curriculum utilising, for example, simulation. In healthcare organisations, clinical ethics groups or committees, whereby practitioners make space and learn from each other, can contribute to sustainable ethical practice. By all means, have an ethicist in attendance but do not assume that they have a monopoly on moral wisdom.

A *Slow Ethics* approach to empirical ethics will place value on qualitative research and personal perspectives from literature and the arts. Quantitative work is important and indeed may be necessary to persuade authorities that problems exist that go beyond individuals and to persuade funders that improvements can be measured. However, a positivist paradigm cannot be the whole story when engaging with explanations for, and responses to, unethical practices. Why, for example, does one nurse in a particular organisational context manage to deliver exemplary ethical care to a particular patient and his family when another responds with indifference or callousness? Why does one doctor raise concerns about unethical practices when another does not? Responses to such questions require engagement with more than moral philosophy and we have much to gain by learning from disciplines such as social and organisational psychology, sociology, neuroscience and the humanities.

Perhaps the most valuable aspect of thinking in terms of slow ethics is to counter any complacency resulting from the view that as we now have initiatives in place - perhaps compassion training, a clinical ethicist with a beeper, an ethics checklist or a dignity measurement tool – that all will be well. Slow ethics reminds us that sustaining caring practices in challenging times is tough. However, there are rich traditions to draw on and there is much to learn from the past. Perhaps, most significantly, that although there have been many recent reports of unethical care practices, this is not new and in many important ways, our healthcare practices are more humane than they ever were. Slow ethics also reminds us that we can and should engage constructively with the idea of ‘crisis’.

Crisis and care

Consider the following extracts focusing on values and care practices:

Ours is a society in crisis [...] Our society has been labelled “decadent” and characterized as one which “worships man and his material needs”. It has been described as a society assaulted by a “false scientism”, and one in a state of “spiritual exhaustion”. It is a society in which the idol of individualism replaces the ideal of human community. When the potential within expanding knowledge, science and technology requires a comparable development in ethical sensitivity and moral clarity, it is claimed that the moral sciences are lagging behind (33).

To recognize the value of care calls into question the structure of values in our society. Care is not a parochial concern of women, a type of secondary moral question, or the work of the least well off in society. Care is a central concern of human life. It is time that we began to change our political and social institutions to reflect this truth (34).

There is a crisis in caring for persons that cuts across the boundaries of the helping professions. Patients in hospitals feel depersonalised and processed, students suffer from inadequate attention, clients wonder if therapists really care about them [...] Caregivers are rewarded for efficiency, technical skill, and measurable results, while their concern, attentiveness, and human engagement go unnoticed within their professional organisations and institutions (35).

These three extracts come from texts published in the United States in the 1980's and 1990's and show that concerns about values and care are not new. In Simone Roach's slim volume (33) thinking about caring is advanced. She engaged with what she considered a 'the crisis of values' and also introduced the idea of five C's (compassion, competence, confidence, conscience and communication). Joan Tronto presented a 'political argument for an ethic of care' in 1993 and her work continues to influence ethicists, particularly those working in nursing (34). It reminds us that care is generally devalued in society and taken to be a concern of women. It suggests that we should engage politically to improve the status of care work and the conditions of care-workers rather than continuing to berate and blame care-givers as in our current climate. The third quotation, from a text published almost two decades ago, reminds us of the value of inter-disciplinary work in the affirmation and restoration of 'caring practices' (35).

These are but three quotations from relatively random texts published three and two decades ago respectively. Their messages are as pertinent today as then: a message that challenges us to consider the relationship between individualism and solidarity in our practice; that invites us to be politically active in countering the devaluation of care; and to consider how we can most creatively challenge the technical rational model of care opting instead for a model that promotes humanistic values. Few, however, appear to take the time and trouble to learn from such scholarship. Our current inclination being to invent (or re-invent), roll out and impose new frameworks and to overlook insights that have been available to us for decades not only from nursing and political philosophy but also from social psychology, psychoanalysis and sociology. The philosopher GJ Warnock, for example, writing in 1971 explained that the 'tendency for things to go very badly...morally badly' is part of the 'human predicament' (36). Humans, he explained, are limited in rationality, limited in sympathy and in competition with each other for limited resources. Whilst this may not be a very positive view of human nature, it seems plausible and reminds us of our fallibility and vulnerability.

The opening discussion in this paper and the extracts here suggest the need to engage with the idea of 'crisis'. A helpful definition is: 'the point of time when it is to be decided whether any affair or course of action must go on, or be modified or terminate; the decisive moment, the turning point' (37). The current 'crisis' discourse in relation to care may have negative or positive consequences: prompting the attribution of blame and the imposition of short-sighted quick fix 'solutions' that do not engage meaningfully with those on the receiving end; or create space and time for bottom-up values-based conversations so that professionals can work towards consensus regarding strategies to sustain ethical care practices. Clinical ethics can have a constructive role to play in the latter, positive response to the idea of 'crisis'.

Conclusions

Slow Ethics provides the opportunity for a more sustainable approach to professional ethics. It resists: seduction by quick fix solutions; complacency by the latest ethical concordat, charter or algorithm; and reassurance from simple explanations for unethical practices. Rather, we need to learn from the extensive body of multi-disciplinary scholarship and research that exists and from reports that detail how and why things have gone wrong in healthcare practices. We need to engage meaningfully with what Schön called the 'swampy lowlands' of everyday professional practice (38), with the messiness of our emotional lives and the complexity and speed of every-changing professional practices in our very particular and diverse practice contexts.

We need to take time in our practices and personal lives to more fully appreciate the importance of what we do and the impact of our actions and omissions on others. We need to 'listen carefully and judge slowly': practitioners to patients, families and colleagues; teachers to students; researchers to those on the receiving end of treatment and care and of professional education; and policy-makers to researchers working in philosophical and empirical healthcare ethics and other related disciplines.

Slow ethics does not dictate a particular philosophical approach but rather signals a mindset that engages in an in-depth manner with existing and developing philosophical approaches. Whereas the four principles approach suggests a 'fast' approach, it very much depends on the manner of engagement. Similarly virtue ethics (39) or care ethics (40) approach would appear to be more compatible with slow ethics but may be engaged with superficially and with too little reflection. As with other aspects of the slow movement, slow and fast ethics are not just about speed. It is not the case, for example, that fast is necessarily bad and slow necessarily good. Although fast food is generally thought to be bad for us there are times when it may be necessary but, we would agree, not sufficient for healthy living. Recognising 'fast' and 'slow' ethics may not be so straightforward. There are artefacts to illustrate the outputs and value of slow art, for example, but seemingly no clear way to recognise *slow ethics*. Perhaps the best we can do is ask: how does this

approach to ethics contribute to the flourishing of patients, families and professionals?

Slow Ethics assumes a constructively critical stance to the practices of healthcare, encouraging questioning of the meaning, appropriateness and fit of imposed ethical concepts and frameworks. This will include: planning professional curricula that promote professionalism and moral resilience; putting people and systems in place that acknowledge and celebrate sensitive interactions; and preparing professionals to challenge practices that promote quantity over quality and speed over kindness. Clinical ethics committees also appear to be a good fit with slow ethics providing the time and space to reflect and the opportunity to learn from previous cases and to share previous scholarship. We need to engage at all levels: giving and inviting feedback on our *individual* practice: implementing *organisational* initiatives that prioritise quality of care and relationships over speed of flow; and challenging *political* imperatives that thwart the flourishing of patients and care professionals and undermine caring practices.

Words: 3989 including abstract but not references

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