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The Three Rs of Exceptional Health Care – *A Benedictine Perspective*

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INTRODUCTION: CARE – A COMPLEX CONCEPT

Exceptional care is a key goal in modern health care provision. The Oxford English dictionary gives multiple entries for the noun 'care', the more pertinent of which for health care include: 'concern', 'heedfulness' or 'an object of concern or solicitude' or as a verb 'to look after'.[2] The definition indicates that care is situated both *within* the subject and directed *externally*. The definition hints at great complexity in the provision of care. Interaction with patients involves an external forum of dialogue and exchange but also an internal forum of psychological and emotional processing. External interaction is readily measured. Time is allocated by management and by individual Health Care Providers (HCPs) to set tasks. Internal emotional processes, on the other hand, are not readily observable and often do not receive sufficient time and attention. Over time the emotional burden for HCPs can accumulate. Unsuitable coping strategies may be employed. Some disengage from patients to avoid any further additional emotional load. Others unburden themselves in their home environment, which in the end blurs the distinction between home and work, exacerbating the situation further. Care is a key goal and it is important to get it right so that patients are well looked after at the physical but also the psychological, social and spiritual levels. All such care necessitates committed, balanced and resourceful care givers.

1 This is a modified version of an address given at the Mindfulness in the Workplace Conference at University College Cork, Ireland on September 22nd, 2018. The conference was sponsored by the Bon Secours Hospital Cork and the Catherine McAuley School of Nursing and Midwifery, University College Cork.

2 "care". OED Online. June 2018. Oxford University Press. http://www.oed.com/view/Entry/27899?rskey=UBB112&result=1&isAdvanced=false (accessed June 20, 2018).

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CHALLENGES TO PROVIDING CARE

There are many challenges for HCPs in becoming and remaining effective care givers. Contemporary patients are often less equipped psychologically and spiritually to cope with illness. Nuclear families, the pervasiveness of technology and the atomisation of society results in diminished support networks. Patients arriving in hospital are less prepared for the diverse social interaction in clinical care and management. The dominance of technology in investigative diagnostics and treatment protocols can contribute to further isolation. Technology should be at the service of clinical care, but often it appears to dictate clinical interactions. Hospitals can become alien environments. HCPs may be perceived as citizens of this alien world rather than sharing a common humanity.

HCPs work under an array of additional pressures. Public perception is often negative. The move to degree level education for nurses has led to accusations that nurses are 'too clever to care'. Members of parliamentary committees employ superlatives to criticise HCPs without addressing underlying issues. Much of the Health Service has severe staff shortages due to difficulties in both recruitment and staff retention. Litigation and an increasing burden of administration (form filling, booking tests, phone calls, communication with families and collaborating with various staff grades on wards) lead to further pressures. Protocols can disempower HCPs leaving them with little say in decisions about care and lead to further disengagement. Staff in overcrowded wards work under pressures not only of time but also space. The switch to individualised patient care in nursing practice reduces the sharing of the burden of caseloads with colleagues. Handovers between shifts which provide a forum for sharing of concerns and mutual support are all too often rushed. Administrative tasks absorb much time before and after periods of clinical contact, leaving little chance for HCPs to prepare or process clinical encounters. While fulfilling the duty of care towards patients, there is often neglect of the duty of self-care, which is essential in the long term for holistic patient care.

EXPLORING STORIES[3] – PATIENTS AND HCPS

The interaction of patients and HCPs might be compared to telling stories. There are in fact a number of stories. Usually the first story that emerges is that of the case history of the patient. The case history then becomes a quest narrative, a story of discovery through clinical reasoning to decipher diagnosis, prognosis and

3 Rishi Goyal, "Narration in Medicine". In: Hühn, Peter et al. (eds.): *The Living Handbook of Narratology.* Hamburg: Hamburg University. URL = http://www.lhn.uni-hamburg.de/article/narration-medicine [view date: 20 Jun 2018]

treatment. Often case histories are filtered through preformed typical schemata which allow HCPs to predict likely processes and thereby guide swift investigations. Although dependent on patients' testimonies and inclusive of their expectations, case histories become a construct of HCPs. As medical charts fill up with an array of reports, consults, etc., HCPs tend to be guided by this information, at times leading to neglect of the patients' perspective.

There is another story to be told. Human beings define themselves through stories. When meeting people for the first time, it is necessary to hear them tell their stories. Everyone has a narrative identity, the story of who they are. When one is sick, this story of the self is challenged and sometimes radically so.[4] The body appears alien, and this is often accompanied by having to go to a strange environment, a hospital, and interact with a whole range of new people. Over time the illness is integrated into the patient's personal story and reconfigures it. However, this can be a very demanding process provoking profound self-searching. HCPs often encounter patients at such points when their life stories are subject to challenge and fracture. The patients' psychological and emotional stress impacts on their relationship with HCPs.

HCPs have their own stories. They do not share them as overtly as patients do, but some interaction must occur for the 'patient – carer encounter' to succeed on the human level. Genuine encounter requires inhabiting a shared space with the other, exposing oneself to the other. The term 'Patient' derived from the Latin verb *patior* ('to suffer') indicates that patients are sufferers. Compassion, whose etymology is derived from the preposition *cum* ('with') and *patior*, involves a sharing in their suffering. This key component of the HCP response to patients comes at the cost of personal suffering. A compassionate response challenges HCPs' own stories; however, it also allows for reconfiguration and learning of adaptive strategies, which may then in turn be shared with patients. Over time, the accompaniment of patients involves a significant amount of internal work within HCPs that often is not acknowledged. HCPs require time and space to process the challenges in delivering compassionate care to others. Although debriefing sessions after major trauma incidents are now commonplace, there are few opportunities for reflection on the everyday patient load. While protocols ideally envisage the accompaniment of patients in the process of reconfiguring their personal stories through their experience of illness, there are often few supports available to staff.

4 See Arthur W. Frank, *The Wounded Storyteller. Body, Illness, and Ethics.* Chicago: University of Chicago Press, 1995.

CARE AND SHARING STORIES

Health care involves sharing not simply patients' case histories but also their stories. For HCPs this implies engaging with the narrative identity of patients, their stories and how these stories are being challenged and changed by illness. Successful reconfiguration of one's story is a key component to achieving the best outcomes. While good communication is rightly stressed, the work of facilitating the recomposing of patients' stories also requires attention. A study of the interaction between Elders and members of indigenous communities in Canada identified four characteristic elements to be employed towards the story by the storyteller and the listener: respect, responsibility, reverence and reciprocity.[5] These four elements inherently imply an active response and an acceptance to enter into relationship with another. This is an important point in a world which is laden with positive sentiment, but which often fails to take a concrete step towards realising change.

PART II – A BENEDICTINE RESPONSE

The traditional *Three Rs*, associated with education, namely, *R*eading, w*R*iting and a*R*ithmetic, constitute the objectively verifiable competencies that primary-level school children are expected to achieve. Standardised charts gauge academic attainment for individual pupils and for schools. However, these three Rs do not address the question of pupils' relationships, to themselves, to others, to the created world or to God. A pupil with top standardised scores may not necessarily attain personal maturity or be able to function in society. Since education involves more than acquisition of knowledge and technical competencies, a foundational set of three Rs has been proposed in the Benedictine educational setting at Glenstal Abbey School in County Limerick, namely, *R*everence, *R*espect and *R*esponsibility.

The principles emerged from a reflection upon what makes a Benedictine school different. *The Rule of Benedict* (RB) speaks of the community of monks as 'a school of the Lord's service' and inspires the Benedictine ethos of both the Abbey and its School. Following a process of reflection on the Rule, the three core principles (Reverence, Respect and Responsibility) of the School's ethos statement were promulgated in 2006.

REVERENCE

The principles are distinct, but they are also closely interrelated. The term 'reverence' signifies awe or deference. The object of

5 Jo-Ann, Archibald, "An Indigenous Storywork Methodology." In *Handbook of the arts in qualitative research: Perspectives, methodologies, examples, and issues.* J. Gary Knowles and Ardra L. Cole, (eds.) Los Angeles: Sage, 2008: 371-393.

reverence is frequently God, where the term often describes worship. Other objects are possible, either people or creation. In all cases, the term reverence contains an element of mystery. The object of reverence cannot be fully comprehended. It is always beyond in some way. Reverence opens us to the central questions of human life: Who am I? Where do I come from? Where am I going? How do I get there? For Christians, men and women have been created in the image and likeness of God. The reverence that is reserved in the first place for God should therefore be extended to all, including ourselves. Society, colleagues, peers, family and even we ourselves too often restrict the mystery of who we are and who we are called to be. A healthy reverence for the self opens to the depths and possibilities within. Reverence implies not only an attitude of awe but practical expressions of awe. Recognition of the immense dignity of each person as created in God's image and likeness implies also that each person be treated with the utmost honour. Reverence is neither temporary nor does it discriminate. Reverence becomes the habit of a lifetime and is extended to all, including oneself.

RESPECT

Respect flows from reverence. The term functions both as a noun and a verb. The Oxford English dictionary entry has: 'Deferential regard or esteem *felt* or *shown* towards a person, thing, or quality'. Respect is rooted in the subject but manifested towards another. It is accorded to the known, that which is within view. While it does not have the connotation of mystery included in reverence, it prepares the ground for reverence. By honouring what we know and see, we become open to what we cannot know, the mystery within each person. There is a synergistic reciprocity between the principles of reverence and respect, each reinforcing the other. Both are inherently relational.

RESPONSIBILITY

The *Rule of Benedict* fosters personal responsibility among the individual monks, who must account for their behaviour, their use of the tools of the monastery and so on, not only to God and the Abbot but also to each other. Responsibility is not the prerogative of those in charge but extends to every person in a Benedictine community. However, limits of responsibility are drawn: individuals are not to take on responsibilities which are not theirs, nor are they to shirk their own. As with reverence and respect, responsibility is relational. The root of the term, 'response', implies two-way communication. Monks are responsible *for* themselves and others, but also responsible *to* themselves and others. Neglect

of relationships with oneself or others is an abnegation of one's responsibility.

The three principles are all practical, by which is meant, they are to be employed in daily life. Each term implies an action and can be readily transformed into a verb: 'to revere', 'to respect' and 'to respond'. Each term is contextualised by *re*lationship, *re*membrance, *re*cognition and *re*ply. The concise and easily recalled principles help and support all the individual members of the school community in the understanding of their own worth and role and also the worth and role of those around them.

THE WORKSHOP

The *Rule of Benedict* envisages the community not only as a school but also as a workshop where monks use the tools of their trade (Ch.4). The structured environment of the monastery enables monks to practice their trade of prayer, work and communal living. While the monastery provides the physical space, and the Rule structures time and relationships, the three principles foster an environment for the expansion of hearts. The tools of the workplace are necessary as in any workshop, but they are to be employed with reverence, respect and responsibility to oneself and to others. In a world swarming with soft sentiment, the principles point beyond positive thoughts to actions.

The Field Hospital

The *Rule of Benedict* recognises that communities encounter difficulties and that measures to restore personal and community harmony are required. Those with physical illness (Ch.37) or those in the dependency of youth or infirmity of old age (Ch.38) are to be cared for. In addition, many chapters are devoted to helping errant monks correct their behaviour (Ch.23-28; 43-46). These chapters frequently employ metaphorical language appropriate to a field hospital. The Abbot as a wise physician (Ch.27-28) draws upon many resources to assist in the healing of an errant monk. He may enlist the help of some senior monks or, if that fails, of the entire community. The various measures are compared to poultices, ointments, medicines and even surgery. Every effort is made to restore a sick or errant monk to the community. Responsibility for the errant monk ultimately devolves to the whole community who must pray ardently for his recovery.

The *Rule of Benedict* legislates for an environment conducive to the wellbeing of all. The three principles distilled from the rule may be applied in every chapter and injunction. They are operative in the training phase (the school), the daily round of work (the workshop) and also when things go wrong (the field hospital). The

principles may be applied to HCPs for patient care in their training or workplace, and for self-care. They have the merit of attending to the needs of both staff and patients, ensuring a healthy balance that optimises wellbeing of HCPs and patients.

VIRTUE ETHICS – WHO SHOULD WE BECOME?[6]

Contemporary ethical discussion often emphases the concept of virtue ethics, where the question is no longer limited to what is morally acceptable, rather it is about who one is, or might become? The new emphasis is more upon moral agents than about their actions. The key question of virtue ethicists "Who should we become?" can be expanded into three: Who are we? Who ought we become? How are we to get there? The concept of narrative identity, explored above, facilitates the exploration of the impact of the virtues on the person. The inherent dynamic of stories allows for possible responses to all three questions. Personal stories are ongoing and susceptible to constant change, growth and development. Although not listed among the traditional virtues, such as prudence, courage, temperance and justice, the principles of reverence, respect and responsibility do functionally approximate these. The principles may be employed as an aid to reply to the three questions.

WHO ARE WE?

This first question requires standards and criteria. The standards of reverence, respect and responsibility can be asked of the HCP. Is the HCP reverent, respectful and responsible? Are the principles limited to the self or to others or are they applied universally? The principles require some self-examination, but they help HCPs to understand who they are. Self-delusion is possible and so criteria are necessary to confirm personal intuitions. A good option is to examine how one responds at short notice without warning. This allows for an accurate and truthful assessment of how reverent, respectful and responsible one is.

WHO OUGHT WE BECOME?

Often the principles are not as developed or present as one might hope. Accurate assessment often reveals deficits. The principles are both standards to assess who we are, but also goals pointing to who we should become. There is inevitably a gap between who we are and who we ought to become. The principles provide a goal and a direction. The focus is not limited to individual actions

6 For this conclusion and its three guiding questions I have drawn heavily from James F. Keenan, "Virtue Ethics and Sexual Ethics" *Louvain Studies* 30 (2005) 180-197, here 182-185.

and whether they should be done or not, whether they are right or wrong. The focus is much broader, taking in the whole life story of the person and in particular the desired end. The principles of reverence, respect and responsibility invite ever renewed growth and development, as goals are reached, and new goals set.

HOW ARE WE TO GET THERE?

The gap between where we are and where we ought to be implies a necessary journey. The person with the end in sight can take concrete steps towards the goal. Every action impacts the person and shapes him or her. There are choices to be made among various possible actions, some of which should be pursued, and others avoided. In daily practice, carers might assess the possible options in relation to the principles of reverence, respect and responsibility. Does the option cultivate these principles or not? For instance, a paternalistic approach, where the HCP makes all the decisions for the patient, does not foster these principles and in addition places excessive burdens on the HCP. Alternatively, HCPs might inform the patient about the illness, provide time for dialogue and assist in coming to a decision on treatment. Here the virtues of reverence, respect and responsibility are fostered. With respect to HCPs themselves, they might choose to spend their rest periods checking emails, texts or phone messages. If this becomes the norm, there is little evidence of the exercise of the three principles towards the self. HCPs might also make time before and after difficult encounters, exercising thereby the three principles as much towards themselves as towards the patients. Prudence is required in every case to discern each individual's situation and context, and to interact appropriately, but always in line with these principles. Whatever the context, it is necessary to look carefully at the choice of action, whether it contributes to the three principles or not. The principles of reverence, respect and responsibility that are cultivated become something of a mission statement, and carers reflect on their actual choices in the light of them.

There is inevitably some trial and error, but over time carers become accustomed to what cultivates these principles. The principles all imply actions but require the virtue of prudence to discern appropriate timing, balance and setting. With practice, HCPs become more accustomed and indeed transformed. The concept of narrative identity facilitates discussion of this life journey and the role of the principles at each stage.

The concept of virtue ethics is exciting as it is not reactive or restrictive ("don't do this or that") but is rather proactive. It leads individuals onwards to grow, develop and mature. The key principles of the *Rule of Benedict*, namely reverence, respect and

responsibility, can helpfully assist HCPs in their professional and personal lives. They finely balance self-care and care for patients. Shared among HCPs, the principles could serve as arbiters of accurate and truthful self-assessment, an unrestricted vision of one's self-worth and purpose and finally a realistic pathway towards growth and development. Attention to one's personal story and an appropriation of the three principles allow for better self-care and work and home life.

The Holy Spirit at work.

But the Spirit has also reminded us strongly at the Synod that young people are not simply the OBJECTS of our evangelisation and pastoral ministry; they are also the AGENTS of evangelisation to each other and, indeed, to the whole Church. With proper formation and accompaniment, our young people can be the missionary disciples who will bring the light of faith to their peers and even to those who are far away from Church. As this Synod put it, they are PROTAGONISTS, called and gifted by the Spirit in their own right to be active participants in the new evangelisation. As volunteers at home and abroad, they can be missionary disciples among the poor, agents of social action, advocates for the protection of Life, builders of a civilisation of love, contributors to ecumenism and reconciliation, apostles to young migrants, leaders and advocates in addressing grave issues like human slavery and trafficking, and, carers for our common home.

– Address by Archbishop Eamon Martin at the Synod of Bishops.