Towards democratic institutions: Tronto’s care ethics inspiring nursing actions in intensive care

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Abstract
Care as a concept has long been central to the nursing discipline, and care ethics have consequently found their place in nursing ethics discussions. This paper briefly revisits how care and care ethics have been theorized and applied in the discipline of nursing, with an emphasis on Tronto’s political view of care. Adding to the works of other nurse scholars, we consider that Tronto’s care ethics is useful to understand caring practices in a sociopolitical context. We also contend that this vision can be used specifically to politicize nurses, by encouraging them to think critically about the context in which they work and how they can participate to change the status quo, notably by prompting the democratization of care in institutional settings. We illustrate this by demonstrating how moral distress that can occur with aggressive or futile treatments in the intensive care unit can be reduced if nurses are systematically included in the decision-making process. By showing some ways in which nursing political actions can begin to change the status quo as it pertains to futile treatments at the end of life, we can help empower nurses to strive to be included in political spaces and voice their concerns to have their professional needs met.

Keywords
Care ethics, moral distress, political action, intensive care, moral/ethical climate, organisations

Introduction
Two years of the Covid-19 pandemic has brought notions of essential workers, universal vulnerabilities, and our interdependence to the forefront of society aspects of collective life which are often downplayed in neoliberal societies. Even before this global public health crisis, contemporary societies were already facing a ‘care crisis’ due to an increasingly ageing population, an exhausted workforce in mostly feminine professions
and jobs and scarce resources being invested in healthcare.\textsuperscript{1} Traditionally, care has been described as ‘only natural’, as naturally feminine,\textsuperscript{2} as pertaining to bodily care or as an innate quality. It is associated with vulnerability and something which is done in the home. In this way, care has been devalued, portrayed as incompatible with what Walker described as the ‘autonomous career man’\textsuperscript{2} of liberal societies. However, independence is relative and cannot be achieved without care, like housework and taking care of children and the elderly, which has historically been the purview of slaves and women.\textsuperscript{3} To this day, women from the working class, immigrants, often in precarious social situations are still solicited for caregiving duties, as nannies, personal caregivers or other caring professions.

Care ethics, especially political frameworks like that of the moral philosopher Tronto,\textsuperscript{2,3} offer an interesting way to examine the political implications of caring practices, especially how they are still primarily valued at the personal level but not at the societal level. For feminist thinkers like Tronto, care is universal. The definition she put forth with Berenice Fischer reveals caring as essential to life:

\begin{quote}
On the most general level, we suggest that caring be viewed as a species activity that includes everything that we do to maintain, continue, and repair our ‘world’ so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web.\textsuperscript{5} (p. 103)
\end{quote}

Through this lens, care is then seen as an everyday practice and a disposition, concerning much of human life. Care not only includes caring for ‘vulnerable’ people like children or the elderly but any intention or action which hopes to better our collective lives. We share Tronto’s view that caring is intrinsically political since it is essential to proper functioning in society. It remains mainly invisible when done correctly, but is instantly noticed when it is missing.\textsuperscript{4} by the closing of a daycare centre, the absence of the cleaning staff in an office building, or nurses short staffed on a hospital ward. Care is essential to life and cannot be the domain of a specific discipline. Therefore, nursing cannot claim monopoly of caring in a professional capacity. Viewed differently, caring is a necessary moral basis for our collective lives and the foundation for nursing, and all other care work to take place. As Falk-Rafael\textsuperscript{5} notes: ‘nurses practice at the intersection of public policy and personal lives: they are, therefore, ideally situated and morally obligated to include socio-political advocacy in their practice’ (p. 222). This intersection between private and public, as described by Tronto, is where all caring professions are practiced. In the case of nursing, the caring discourse is then both an intimate ethic and a socially aware ethic, necessary if nurses are to ‘realize their full potential as ethical agents for individual and social good’ (p. 62)\textsuperscript{6} Understanding care in this way sheds light on how nurses can reaffirm their place in society as an indispensable professional group.

In this paper, we will present care ethics as a political framework for society as it applies to nursing, to encourage political actions in different regards from striving for better work conditions to removing barriers that negatively impact patient care. This starts with encouraging nurses to participate more in civic life and ensuring there is a space for them to be heard. The first section will present a summary of how care and care ethics have been theorized and applied in the discipline of nursing, with an emphasis on Tronto’s political view. While some authors\textsuperscript{7,8} have questioned whether care ethics are an appropriate way to guide nursing practice, we will demonstrate in the second section how care ethics can be seen as an important framework to view nursing in a political way. We will then apply this framework to the phenomenon of moral distress in the intensive care unit (ICU), as it pertains to futile treatments at the end of life. Finally, we will explore how a democratization of decisional bodies in hospitals, like end of life (EOL) discussions in the ICU, can be beneficial for all involved, and even prompt other political actions by nurses.
Care as a nursing concept

The concept of care as central to nursing was developed in the literature in the 1970s and 80s at a moment in time when the discipline was looking to promote its professional identity.9 There are many definitions of the concept of care in the nursing literature, although the result is invariably a means to portray nursing as a profession preoccupied with the care of patients. Despite the historical reality of nurses as healers, today the caring approach is often opposed to curing, to distance nursing from the medical model10 which is primarily concerned with treating diseases.11 Care is then seen as an ethical act, a normative moral ideal of nursing practice12 associated with a certain sacred status used to solidify nurses’ professional identities.13 Starting in the 1980s, caring began emerging as a more refined concept in nurse scholars’ quest to properly delineate the discipline’s interests. For many nurse scholars then, caring is the essence of nursing practice14–18 and a concept that should be part of the nursing metaparadigm.19 However, a certain ambiguity remains, since caring can be used as an adverb, a verb or a name.20 The seminal concept analysis of Morse et al.21 notably illustrated the various perspectives of caring in nursing literature: caring as a personal trait, moral imperative, interpersonal relationship and therapeutic relationship or as an affect. Some authors have even tried to unify these perspectives to operationalize it for research and practice.22,23 In these iterations of care, it becomes clear the principal concern is to integrate this concept into disciplinary knowledge and nursing practice, leaving unexamined the assumptions that link gender, care and nursing,24 and therefore political concerns.

Despite some criticism,9,25 and a perceived lack of theoretical clarity, care remains a concept that is seen as central to nursing, whether it is the essence of nursing or an attitude adopted by nurses. Caring is still widely regarded by some as an intangible concept that can never fully be apprehended empirically, while some observation tools have been developed to attempt to quantify caring acts and results.20 This view of professional caring appears to only be concerned with the relationship between the nurse and patient, or small groups of people like patients’ families. However, these relational, particular and situational aspects of care place it firmly in an ethic of care.6

Care ethics in nursing

Care ethics first appeared in the field of moral psychology with the works of Carol Gilligan, who theorized that feminine morality did not fit the standard view of justice ethics. Women’s responses to a given moral dilemma were seen as less evolved in Kohlberg’s hierarchy of moral development since their lack of objectivity in decision-making was a sign of moral immaturity. Her book In a Different Voice26 showed how girls and women relied on different moral objectives than those described in the more impersonal and universal justice ethics.27 Care is then seen as having a fundamentally feminine nature, since women are drawn to empathy, sensibility to others and a preoccupation for their feelings.28 Gilligan’s work then influenced movements in sociology, political philosophy and even nursing. For some nurse theorists, Gilligan’s care ethics is compatible with the philosophical and historical traditions of the nursing profession and relational care.6,29,30 As a response to complex realities, healthcare now has many alternatives to traditional justice ethics, including care ethics3,26,31,32 narrative ethics33,34 and feminist ethics.35,36 Feminist care ethics tend to share two major assumptions, the understanding of people as relational, interdependent, both rational and emotional, as well as an interest in power and oppression in ethical phenomena.37 Care ethics have been discussed in the nursing literature to emphasize the contextual and relational aspect of nursing which could best be represented by this relational ethic, instead of justice-based approaches more closely associated with objectivity and inflexible values. Notably, feminist healthcare ethics are useful for the profession, since nursing practice is grounded in ‘complex social networks involving health care professionals, patients, families, and administrators, all of whom are further nested in politics, policies, and economics’ (p. 339).38 Despite their perceived relevance, feminist ethics still play a minor role in nursing ethics.37
However, since nursing is influenced by power relations, a political view is naturally interesting, in accordance with the central tenants of feminist ethics. Joan Tronto offers the earliest substantial account of care as a political philosophy, which identifies the traditional boundary between ethics and politics as one of three boundaries to a politically effective feminist care ethic. The other two boundaries are between the particular and abstract/impersonal moral observer, and the boundary between public and private life. These boundaries are obstacles to accepting care as a political concept which effectively highlights the interdependency that characterizes life in society. For Tronto, good care has four elements: attention, responsibility, competence and capacity to respond and is comprised of four phases: caring about, taking care of, caregiving and care receiving. Caring involves a disposition, a responsibility, an act, and a recipient, which is a more integral way of conceptualizing caring from some of the ways it has been described in nursing literature. Tronto associates needing care as being in a vulnerable position, but she describes vulnerability as universal since it affects each person at different moments in their lives. In 2013, to expand on her original thought, Tronto added a fifth element to care: caring with. Essentially, to be a citizen in a democracy requires us to ‘care for citizens and to care for democracy itself’ (p. 8). Citizens then must think about their mutual responsibilities, especially in allocating caring responsibilities. More specifically in institutional contexts, like hospitals, good care has three central foci for Tronto. These are:

Politics: recognition and debate/dialogue of relations of power within and outside the organization of competitive and dominitative power and agreement of common purpose; particularity and plurality: attention to human activities as particular and admitting of other possible ways of doing them and to diverse humans having diverse preferences about how needs might be met; and purposiveness: awareness and discussion of the ends and purposes of care. (p. 162)

Tronto argues these elements require a political space within institutions to address these concerns, involving nurses, families, patients, physicians, allied health professionals and other workers. She further adds that if we are to ‘take into consideration the needs and perspectives of all within the institution […] hierarchies [must] become flattened in caring institutions (p. 168). Nurses can play a part in instigating the changes needed for more democratic institutions and a more democratic society, by bringing their professional knowledge and experiences to these political spaces. Caring then becomes less of a nursing concept, and more of a distinctly political practice to recalibrate power relations, both inside and outside the four walls of the hospital.

**Institutional caring in the current political landscape**

Before applying Tronto’s care ethics to nursing, it is essential to consider why nurses, as care workers, are undervalued and often excluded from decisional spheres. Professional hierarchies in healthcare, most notably in hospitals where most nurses are employed, dictate power imbalances between healthcare professionals and are then an important context to examine under the lens of feminist ethics. Nurses placed in this hierarchy can believe they have little influence over treatment decisions, and conflicts can arise when nurses and physicians have divergent views of the proper care and treatment plans for patients. For Brugère, even the caring practices of nursing and medicine are unequal; physicians, who are responsible for determining care activities for patients have inherent value, while nurses, who enact care activities and tend to bodily functions, are systematically undervalued. The value accorded to the caregiver then decreases as it approaches the physical act of taking care of another, compared to the enviable role of being responsible for determining the ‘care’ plan in the way that physicians are. Tronto points out that while physicians ‘take care of patients’, nurses are the actual caregivers and sometimes will ‘care about’ the patients more than the doctor, and conflicts can arise because nurses – who do the caregiving – do not have a say in how patient needs will be
Caregivers, like nurses, effectively find themselves in a state of double vulnerability because of the difficulties they encounter caring for others and the vulnerability they face in their work. They have little to no symbolic recognition, apart from patients, and little to no material recognition from employers. Moreover, having an essential social role like nursing means more time is spent working than having time off, leading to less time available for emancipation, which could be achieved by participating in civic discussions and forums. As a result, ‘the concerns and activities of the relatively powerless are omitted from the central concerns of society’ (p. 20) since care workers’ voices are left unheard in public spaces.

In accordance with other scholars who discuss Tronto’s care ethics to highlight the sociopolitical aspects of nursing, it is our contention that this political view of caring is important for nurses as professionals, and more significantly as citizens participating in social life. By advocating for better conditions in which to care for patients, they are participating in the transformation of caring institutions, which should consider the needs of all as interrelated and essential for good care to take place. However, like Kagan and Chim, we believe nursing considerations should not be sacrificed to satisfy patients’ needs in institutional care contexts, since in accordance with Tronto’s view of institutional caring, the needs of the care workers are also relevant. Furthermore, Tronto’s call to flatten the hierarchy in healthcare settings, by creating political spaces of discussion, can challenge the current status quo of medical domination in all aspects of healthcare. This proposed lessened hierarchy between physicians, nurses, managers, and patients could pave the way for institutional changes since every actor can share their relevant experiences and suggestions, while being valued for the expertise they bring to the discussion. This can create more opportunities for nurses to exercise power in a positive way, by defending their professional values in their workplace and in public forums. This democratic project is important, especially since nurses ‘seldom reflect about their own ways of exercising power or rarely perceive health care as a political activity’ (p. 564) or do not consider their activities as activism. A political feminist care ethic, like the one theorized by Tronto, can act as a much-needed politicizing agent for nursing and caring. It encourages nursing resistance to unfair and precarious work conditions and unjust practices, including power relations tied to their devalued status that are both harmful to them and consequently impact patient care. In this next section, we illustrate this point with the example of futile treatments at the EOL in the ICU.

Tronto’s care ethics to address medically futile treatments and associated moral distress in the ICU

In accordance with Tronto’s fifth caring element ‘caring with’, we all have a responsibility to help determine how care activities and responsibilities should be allocated. A prime example of a more democratic way of caring while meeting the needs of caregivers is to address the practice of aggressive treatments at the end-of-life, as an especially common source of moral distress in nurses. Van Heijst attributes this to the dominant paradigm of healthcare in Western societies with cure and the prolongation of life as its primary aim. She refers to treatments that aim to prolong life at all costs while compromising quality of life as a form of ‘sophisticated cruelty’ (p. 201). Similarly, for Daneault, our medical culture reflects a denial of death and a wish to prolong life, whether by delaying the inevitable moment of death or improving quality of life for only a short period of time. Futile treatments at the end of life have been the subject of research in the last decades and are one of the root causes of ethical tensions and moral distress for healthcare providers, especially nurses. Their constant proximity to patients and their responsibility to relieve suffering makes it understandable for moral distress to occur after a lengthy exposure to patient suffering, coupled with an inability to effectively influence the course of treatments. Nurses are often excluded from discussions concerning medical treatments with patients and their families, leaving them to enact treatment plans they do not necessarily agree with. Pavlish et al. call this response ‘being the eyes and arms of patient suffering (often without a voice)’ (p. 598). For Kentish-Barnes, despite more transparent processes than in previous
decades, death remains medically mediated and constructed, surrounded by a certain secrecy and still wholly dependent on the highly variable cultures of ICUs.61 This persistence of medical dominance within clinical nursing work62 means that in the context of initiating EOL care in the ICU, physicians are responsible for these decisions and are the ones who decide if nurses, and which nurses, can be included in EOL decision-making.63 Furthermore, these decisions often change since there is a perceived lack of continuity between different intensivists.64 Hence, prognostic information is elusive and often ambiguous, while families receive mixed messages by physicians of different specialities.65 There is also a reluctance to tell family that further treatment would be futile, while staff would privately discuss it.65 Evidently, there are ‘persistent tensions around choice and relations of obligation at the end of life […] since dying is a precarious culmination of divergent interests – and that such interests are not necessarily revealed, addressed, or given recognition pre or peri the end of life’ (p. 156).62 Patients, family members and different healthcare providers have notably different views on an appropriate course of treatment during a critical illness. In this sense, we agree with Broom that there needs to be a ‘greater transparency in relations of power, influence and obligation within the spaces where increasingly people are dying in contemporary societies, and for greater reflectiveness around how powerful relational forces shape people’s experiences near death’ (p. 156).62

Therefore, this proposed ‘democratized caring’ in the context of EOL in ICUs means that every actor must have a say,66 and nurses should be listened to by the attending physicians, who currently hold the decisional power.67 If we rethink the power dynamics of doctors sitting atop the professional pyramid and instead value different opinions, we can create a political space where every concerned actor can contribute equally to achieve a suitable and consensual outcome. In hospitals, nurses and other allied health professionals should always contribute to defining ‘good care’, not only in response to a specific case but also when it is time to elaborate policies. By addressing the root cause of the issue and striving for consensual decisions in complex situations, we can greatly reduce or eliminate moral distress,68 adding to other individual strategies proposed for nurses.69 An ethic of care thus has an emancipatory aspect, to envision a new way of caring. Van Heijst64 and Daneault55 notably advocate for a shift from healthcare that aims to prolong life at all costs, to the relief of patient suffering as its primary objective. Tronto also recommends questioning the goals of medicine, so that we pursue the right intensity of medical treatments in accordance with the patients and families wishes.70 The ‘goal is not to eschew intensive care [but] to be realistic about its promise’, since survival and recovery are different outcomes, and decisions to pursue or limit life-sustaining treatments have lasting impact on family members (p. 244).65 Since death and dying are universal concepts, a nursing approach which is interested in changing our social rituals to reduce suffering for all involved, is compatible with a political care ethic like Tronto proposes, in that it aims to positively transform our world by democratizing care practices on a local and global level.

**Implications for research and practice**

Complex situations in ICUs are a clear sign that what is needed is not a more structured and predetermined trajectory for EOL, but rather an opening to the unknown, a willingness to embrace the complexity and the contextual. There are two notable examples in which nursing could be a positive force for change.

First, by thinking that vulnerability only concerns certain groups, like children or the elderly,71 we take away opportunities for citizens to envision their own vulnerability and discuss their healthcare plans with their families. Every adult should think about what kind of treatments they wish to receive once/if they find themselves in a greater state of dependence and are unable to make their own decisions. There has been notable sociological research and medical commentary into EOL care in recent years, showcasing an interest in sharing with the public what constitutes a good death, and how to prepare for one’s own EOL.62,72,73 Nurses can play a significant role here, throughout life and especially when a chronic illness is diagnosed, by initiating these discussions, normalizing talk of vulnerability and mortality, especially before a critical illness.
and hospitalization. Since finding the right surrogate is an important part of adequate EOL care which respects patient’s wishes, nurses could help people understand the importance of choosing their surrogates and help them navigate through these difficult decisions. They should also have the chance to be more involved in healthcare discussions with physicians, patients and their families, especially when those discussions occur in the ICU and pertain to the goals of healthcare, since their professional values and role at the patient’s bedside make them an important source of information, and a valued ally. They are ideally poised to accompany family members in those difficult times. Finally, their role as communicators can go beyond clinical practice, by engaging dialogue of vulnerability and death in the public sphere.

Second, nurses should participate in this drive to democratize caring institutions. When democratic processes are not respected, which keeps nurses from practicing according to their professional moral and ethical convictions, they can employ different means of resistance to attempt to shift power imbalances. According to Essex, ‘resistance [is] any act, performed by any individual (or collective) acting as or explicitly identifying as a healthcare professional, that is a response to power, most often in opposition to contentious, harmful or unjust rules, practices, policies or structures’ (p. 484). More specifically in the ICU, power can be exercised directly in response to perceived aggressive and inappropriate care, especially at the EOL. This power through resistance can be exercised as much through action as inaction, where political action is fuelled by a moral responsibility. Several direct and indirect acts of resistance as ethical action have been described in the literature, like speaking up, whistleblowing, calling on ethics committees or refusing to participate in care. While resistance was sometimes ineffective at changing the situation for individual nurses, it often brought about systemic change. A recent study found that nurses use resistance to practice morally, to open spaces where dominant discourses could be challenged, and where they could practice on their own terms, in a morally authentic way. Nurses should then feel ‘comfortable with their own appetite for power, implement their power strategies, and after feel satisfied or “full” because they did what they believed was necessary’ (p. 186). While nurses need to act in accordance with their professional values by resisting unfair power relations, they also need institutional support. For Garon, this resistance can be an ‘ethical safety valve’ that can even be beneficial to administrators, since it contributes to safer work environments, and allows them to be informed of nurses’ concerns (p. 249). Research needs to continue documenting how nurses resist in the face of unjust practices, especially as working conditions continue to be impacted by healthcare organizations that normalize chronic work overload, an increasing speed and pace of work and systematically resort to mandatory overtime. By capturing these informal narratives of nurses in different settings, we can add important data to motivate democratic change in different healthcare settings and in the political sphere. If we are to live together in the way described by Tronto, we need to be concerned with the needs of all, including nurses, by democratizing institutions, which is ultimately the change that nurses wish to see.

**Conclusion**

In this paper, we have briefly examined how the concept of care has been used in nursing literature, as well as how feminist care ethics have been accepted by certain nurse scholars. Nursing has primarily described care as a disposition and an action, the manifestation of a moral ideal in nursing practice or an affect. However, care cannot be reduced to such narrow views. In accordance with Puig de la Bellacasa, we presented a framework where ‘caring is more about a transformative ethos than an ethical application. We need to ask “how to care” in each situation’ (p. 100). Similarly, for Brugère, in a time of crisis and segregation like the current situation caused by the coronavirus pandemic, care ethics can be seen as a theoretical precept that aims to transform society into a more pluralist entity where true emancipation is possible. The purpose of this paper was then to see how this transformative ethos could be applied to nursing practice, with the example of a more democratic EOL process in ICUs. It was our goal to demonstrate how Tronto’s political care ethic, as a
framework which erases the boundary between ethics and politics, can positively influence not only nursing practice, but also promote nurse activism, particularly during ethical conflicts and the EOL when democratic processes are not observed. As populations continue to age, resources diminish and life-saving technologies continue to be developed, moral distress during EOL care is likely to increase unless we drastically change some beliefs and practices.\textsuperscript{38} Using a care ethics framework, theorizing care as a political activity involves standing up for what’s right, what’s good for all actors and relieving suffering in the face of unjust practices. By demonstrating the importance of power relations in how care is given and how these responsibilities are allocated, it opens the door to conceptualizing this power in a positive way and recalibrating uneven distributions of power in daily life. Backed by this vision of care ethics, we encourage nurses to speak up and take their place not only in their professional relations to advocate for better patient care but also in public forums to influence the course of healthcare reforms towards more democratic processes and institutions.

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