Embodied Values

What Is Needed for the Ethical Practice?

A Case Study of an Adolescent Psychiatry In-Door Patient Ward

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Abstract

In my thesis, I approach open dialogue from the point of view of embodied values of everyday treatment. This is, on the one hand, what happened in one in-door patient ward in Helsinki from August 2018 to December 2018 from the point of view of patients and staff members, but, on the other hand, more general reflection what is needed for open dialogue to take place in an organization not very open to dialogue nor to open dialogue. In other words, what could open dialogue practically mean in the context foreign to open dialogue.

Thus, I try to find my way from special facts to general phenomena. The special facts are the questionnaires fulfilled by the 34 patients and staff members. The main conclusion I make of all this is that even if as new-borns we are all ready and even eager for interaction, open dialogue is hardly an inborn capability; instead, it is a result of painstaking cultivation, studying and inquiring. This means that embodying values we claim to be ours is not easy, on the contrary: embodying values is possible only through on-going reflection and doubt, something we hardly have enough time in our everyday practice.

Another conclusion I make of the answers is that the context matters both as something that limits and something that makes open dialogue possible. The urban working environment with hierarchical institutions (like hospitals, policlinics, child welfare etc.) and hierarchical decision processes form a huge obstacle for open dialogue. Patience and passion are needed to overcome those obstacles.

The third conclusion I make of the answers of my patients is the sensitiveness of helpless people. The more fragile you are, the more extreme are your experiences. Thus, in crisis, a little is a lot. You have to mind your words and deeds, when you are helping helpless people.

Introduction

What is "open dialogue"? The usual answer to this question refers to historical and geographical facts like important persons (Yrjö Alanen, Jukka Aaltonen, Jaakko Seikkula etc.) and important institutions (University Hospital in Turku, Keroputaa Hospital etc.). This way of answering the question is important and informative, but from the future perspective it begs the question. Namely, if you are not working at Keroputaa Hospital or some other institution closely connected to Keroputaa Hospital, what does "open dialogue" mean to you?

It is often said that open dialogue is not a method nor an intervention, but a way to be and communicate with people. This is certainly an important point of view and starting point. However, there is a danger within it: if open dialogue is a way to be and communicate with people, it is too easy to say that it is about values, and only about values. Thus, the representatives of hard-line biomedicine can say that "Yes, it is important to respect the patient – and this can be done in the best way following the guidelines of evidence based medicine." In other words, emphasising the ethical side of open dialogue leads too easily to lose concrete content of open dialogue practice.

Thus, when I have discussed about open dialogue with psychiatrists and psychologists with lots of institutional power in the institutions implicitly hostile to open dialogue, they have often answered to me that yes, ethics is important, and it is good that open dialogue people discus the ethics of psychiatry, but then there are all kinds of anti-psychiatric movements involved which should be avoided. In other words, open dialogue is reduced into ethical questions and questionable practices - as if there is no real connection between ethics and practice.

The philosophical background of this kind of thinking leads several centuries backward, and it is called sometimes Hume's guillotine according to David Hume (1711–1776). Hume's guillotine is valid when it is used to separate how things are and how things should be. However, it becomes problematic when the realm of facts and the realm of values are separated from each other as if they would not have anything to do with each other. This is what happens in biomedical model and psychiatric institutions based on biomedical thinking: there are facts, and they biological, and there are values, and they are social – and there is no connection between these two.

If we want to bring open dialogue to the institutions based on biomedical model, this must happen in dialogue. Dialogue is possible only when there is at least a minimal consensus, something that is shared. With biomedically organized organisations, the minimal consensus can be found from the

values, whereas there is an open disagreement about practice, for example, about the use of medicine. Thus, one possible way to approach the disagreement is to agree about values and then think about how to embody these values. This idea was behind this case study. Namely, it is difficult if not impossible to find anybody who would openly disagree about the values emphasised by the authors of open dialogue. However, when we talk about practice, those who reject open dialogue approach outnumber by far those who speak for open dialogue and even practise it.

The junction between ethics and practice has perplexed me since the 1990s, and already my Ph.D. dissertation *Dis-positions* approached it from a metatheoretical perspective (Kurki 2003). Since that, I have been wondering about it, and this thesis continues to do so from a very practical point of view. It is this obscure space between facts and ethics, between theory and practice, that my thesis addresses. In this case, we could call this space the space of embodies values: how do the values we claim to follow embody themselves in the actual work we do with our patients?

The Principles of Open Dialogue and the Values of Hospital District of Helsinki and Uusimaa (HUS)

Seikkula & Arnkil (2017, 52) summarize the seven main principles for open dialogue approach:

1) immediate help;

2) social networks perspective;

3) flexibility and mobility;

4) team's responsibility;

5) psychological continuity;

6) tolerance of uncertainty and

7) dialogism.

Seikkula & Arnkil (2017, 52) see these principles "as fruitful guidelines for professionals in organizing their work".

One can compare these seven principles to the articulated "values in practice" ("arvot käytännössä") of Hospital District of Helsinki and Uusimaa (HUS):

1) equality between human beings ("ihmisten yhdenvertaisuus");

2) patient centered practices (“potilaslähtöisyys”);

3) creativity and innovative approaches (“luovuus ja innovativisuus”);

4) high quality and effectiveness (“korkea laatu ja tehokkuus”) ja

5) openness, confidence and mutual respect (“avoimuus, luottamus ja keskinäinen arvostus”).

When one compares how Seikkula & Arnkil describe the seven principles and how the ethical workgroup of Hospital District of Helsinki and Uusimaa describes the five values in practice, the similarities and parallels between the descriptions are clear. Thus, it can be stated, at least, that there is no contradiction between these two lists of principles/values, and even more: following the principles of Open Dialogue would mean that one puts in practice the openly stated values of Hospital District of Helsinki and Uusimaa. This does not mean, necessarily and automatically, that the principles of Open Dialogue would be the only way to follow the values in practice of Hospital District of Helsinki and Uusimaa. But to be sure, if the principles of open dialogue are followed, it is very probable that the values of Hospital District of Helsinki and Uusimaa will be embodied.

The Empirical Material

From this perspective, I wanted to get feedback how my unit, the in-door patient ward of adolescent psychiatry B2/N5, is doing in regard to the seven main principles for open dialogue approach and how does this relate to the values in practice of our organization (Hospital District of Helsinki and Uusimaa) from the perspective of our patients and our staff. For this purpose, I modulated the seven main principles for open dialogue approach and the values in practice of Hospital District of Helsinki and Uusimaa into a simple feedback questionnaires for patients and our staff members. The feedback questionnaires were given to all patients during the autumn 2018 from the summer vacation break to the Christmas vacation break, and to all staff members first in August 2018 and then in December 2018. The feedback questionnaires for the patients included their name, but patients were given opportunity to give feedback also anonymously, whereas all staff members gave their feedback anonymously. The feedback questionnaires for patients included names, for I wanted to understand the experience of my patients knowing something about the process they were living through, whereas I wanted staff members to be as open as possible about their perspective.

34 patients fulfilled the questionnaires, 30 with their names on the paper and 4 anonymously. 3 patients did not want to answer or were not able to answer the questionnaires. In August, 12 staff members fulfilled the questionnaires. In December, 8 staff members gave their feedback. There was

a big organizational change within the in-door patient clinic including the ward B2/N5. Thus, only some of the staff members were same the ones in August and in December. It may be that those who continued to work in our unit felt comfortable there, whereas those who left did not feel very comfortable working there. During the autumn 2018, the name of the ward changed: it used to be called B2, but its new name is N5. Thus, some of the patients came to the ward B2 and left the ward N5. The overall function of the ward was not supposed to change: the treatment time was usually about 4 weeks, and it included both the estimation of the problems and some rehabilitation. Besides these 4 weeks treatments, there were usually from two to four patients with serious psychotic breakdown who were there for longer times. Most of the time, there were from 8 to 9 patients within the ward. Most patients spent weekends at home or at their adolescent house, but were at the ward over night from Monday to Friday.

Our ward was exceptionally connected to open dialogue considering that the Hospital District of Helsinki and Uusimaa (HUS) is implicitly, and sometimes openly, hostile to open dialogue. My boss, chief physician Pekka Närhi, is, besides being an adolescent psychiatrist, a family therapist and a family therapy supervisor and well familiar with open dialogue theory and practice. Our wards supervisor Pekka Borchers is an open dialogue supervisor. And I am myself participating in an open dialogue supervisor education. However, nobody else in the ward was trained in family therapy or open dialogue. This is one perspective from which to approach the answers my patients gave to the questionnaires. How well can supervisor's, chief physician's and physician's opinions be seen in the actual treatment and care the patients experience?

Questions and Answers

The seven first questions of the questionnaire were based on the seven principles of open dialogue as explicated above; the five last questions of the questionnaire we based on the "values in practice" of the Hospital District of Helsinki and Uusimaa. Thus, we have 12 questions, and I will go them through one by one with the answers given to them. They same questions were addressed to the patients and to the staff members in different articulations, so I discuss patient feedback and staff member feedback separately.

Patients

Question 1: "While I was in the hospital, I got help immediately when I needed it."

The average of patients' answers was 7,1. First I was disappointed and puzzled by what I considered a pretty bad result. I was thinking that while you are in the hospital, you get automatically immediate help. Later, after a couple of months, I realized that, in fact, I do not have any reliable refence point here. We do not actually know how patients experience being in the hospital in general. We do not know even what patient consider as help. What we offer as help may not feel to our patients as help, on the contrary. From this perspective, 7,1 might not be as bad result as it seemed to be at first sight.

The range of answers was from 0 to 10, and 9 patients gave us 10 and 3 patients gave 9. However, one patients gave 0. Thus, unique situation of each patient should be approached to in order to understand her answers. The patient who gave us 0 was in the hospital against her will - which might explain, at least partly, her experience.

Question 2: "People who are important to me (my family, my relatives, my teachers etc.) were paid attention to while I was in the hospital."

The average of patients' answers was 7,5. Again, I felt disappointed for thus result. But it is true that we take to the hospital the adolescent, not her family or network. In fact, it is often very difficult to arrange a meeting with the important others. Especially many fathers seem to be out of reach, maybe because of feeling of shame and guilty and or practical issues. It is also very difficult for professionals like teachers to participate to the treatment of the patient in the hospital. Often it feels like the ward would be a kind of repair workshop: the adolescent is brought to the hospital and people expect us to return her as repaired one, without the symptoms. This does not mean that we could not pay more attention to the important others, but, in the end, it takes at least two to dance tango, as they say. But to be sure, if we were better tango dancers, maybe more people would accept our invitation to dance.

Question 3: "While I was in the hospital, my treatment was arranged in a flexible way according to my needs."

The average of patients' answers was 7,3. Again, the disappointment was big at first sight, for I had tried to arrange everything in the uttermost flexible way. But any hospital ward is an institution with its own structures and dynamics, and our ward was one part of a big system in which the relationships between different parts of the system were rigid and sometimes even hostile to each other. It would be a kind of miracle if this would not have an effect on the treatment and the experience of patients.

Question 4: “While I was in the hospital, the staff members took responsibility of my treatment.”

The average of patients’ answers was 8,4. This was the highest score of all the questions. Thus, it seems that our patients experienced the staff members as responsible professionals. If we did manage to embody some values of open dialogue, it was here and with the question 8, the equal treatment of everybody. And to be sure, it is a very good starting point: it is impossible to build good treatment on the shaky foundation of experienced irresponsibility.

Question 5: “The period I was in the hospital formed a coherent whole.”

The average of patients’ answers was 7.0. This was the lowest score of all the answers. Thus, clearly the hospital periods were experience somehow incoherent. This is understandable from different perspectives: 1) Within the ward, there was often lack of time of certain special professionals, especially our psychologist was now and then pretty busy and our patients had to wait sometimes several weeks before our psychologist was able to meet them. I was also now and then pretty busy, and I did not work full time there, so my patients had to wait sometimes for several weeks before I was able to interview them. 2) Within our organization, the Hospital District of Helsinki and Uusimaa, the coordination between different clinics was poor, both within adolescent psychiatry and between different specialties of medicine, like between pediatrics and adolescent psychiatry. Thus, we had to wait often other clinics do something or decide something before we were able to progress with what we were doing. 3) The coordination and co-operation between our ward and other institutions like child welfare was very poor. We tried to influence this with network meetings, but the results were not often very impressive. Often adolescents were in our ward, because there was no other place for them to stay: nobody wanted to take them.

Question 6: “The staff members helped me to stand the uncertainty of my difficult situation.”

The average of patients’ answers was 7,3. This question goes to the heart of psychiatric work, namely what is used to be called, in Bionian terms, “containing”. The pretty low average tells us, at least, that the walls of the hospital as such are not enough for the patient to feel herself contained properly. The answers were, however, from 0 (one patients) to 10 (seven patients), so it is clear that many patients did feel themselves contained in our ward.

Question 7: “While I was in the hospital, I was heard and paid attention to in planning and organizing my treatment.”

The average of patients' answers was 7,9. Considering the general tendency of patients' answers in this questionnaire and the general treatment culture in the adolescent psychiatry services in the Hospital District of Helsinki and Uusimaa, this was quite good result, in fact. This question came close to me as the physician, for according to Finnish law, it was me who was in the end responsible of the treatment plan – while the patients were in the hospital. However, my responsibility and ability to affect things was very limited: I could not say anything about what happened before and after the period patients were in the hospital – and I could not have an effect on the long queue of the patients waiting their turn to get to the hospital, and thus the hard pressure to limit the time spent in the hospital as minimal as possible. In general, we had a psychiatric hospital place for about 0,5 permille of the generation between 13-18 years old adolescents, and our outdoor clinics had as their patients 10 percent of the generation between 13-18 years old adolescents. Thus, we had a place in the hospital for one patient of the 200 patients who were taken to the university hospital setting as patients. And, to be sure, nowadays it is definitively not easy to become an adolescent psychiatric patient in the Hospital District of Helsinki and Uusimaa.

Question 8: "In the hospital, people were treated equally."

The average of patients' answers was 8,3. Considering the hierarchical system that a hospital always is, more or less, and considering the fact that some of our patient were in our ward against their explicit will, I was pretty happy with this result. As I noticed above, if managed to embody some values of open dialogue, it was here and with the question of responsibility.

Question 9: "I was able to take actively part in my hospital treatment."

The average of patients' answers was 7,9. Here, too, one has to remember that some of our patient were in our ward against their explicit will. Our ward was considered to be a rehabilitation ward, so it was important that our patients, no matter what their difficulties were, experienced themselves as active agents of their own treatment. You cannot rehabilitate another person for her; everybody must rehabilitate herself.

Question 10: "People tried to find solutions creatively to the problems which came up while I was in the hospital."

The average of patients' answers was 7,6. Here one must remember what I noted above: in the end, our hands were pretty tied by the organization. The limits within the Hospital District of Helsinki and Uusimaa were tight, and one had to stick to the strict rules and organizational roles. But within these narrow limits, we were looking for creative solutions to the problems we faced every day.

Questions 11: “The treatment in the hospital was effective and had high quality.”

The average of patients’ answers was 7,3. Afterwards, it is easy to notice that the question implies two different questions, so it is impossible to know do our patients comment on the effectivity of the treatment of its high quality – for even high-quality treatment can be ineffective. It has to be remembered that is was very difficult to get to our ward, and most of our patients had had serious problems for years before they ended up to our ward. It is clear that no miracles can be done within a month in such chronic situations.

Question 12: “The treatment was organized in the hospital openly trusting and respecting others.”

The average of patients’ answers was 8,0. Again, in the end, I consider this as pretty positive result. Even if many patients were in our ward against their will and even if they had long-time difficulties with themselves and others, they experienced often trust and respect in our ward. Together with questions 4 (responsibility) and 8 (equality), trust and respect form a pretty good foundation for helping each other.

Staff members

Question 1: “While patients are in the hospital, they get help immediately when they need it.”

The average of staff members’ answers was in August 8,1 and in December 8,0. Thus, staff members estimation was clearly must better than patients’ estimation (patients’ average 7,1). Again, it strikes me, anyway, that the average is only 8,1 or 8,0. For, in the end, you are in the hospital in order to get immediate help. So, there was clearly some kind of problem in the treatment culture.

Question 2: “The social network (parents, relatives, school etc.) is paid attention to while patients are in the hospital.”

The average of staff members’ answers was in August 8,7 and in December 8,9. Again, staff members were much more optimistic than patients (patients’ average 7,5). It may be that staff members interpreted this question from the pretty individualistic treatment culture which is still mainstream in psychiatry in Finland. Compared to many other institutions, our ward tried, at least, to do network working with parents, relatives, teachers, child welfare workers etc.

Question 3: “While the patients are in the hospital, their treatment is arranged in a flexible way according to their needs.”

The average of staff members' answers was in August 7,5 and in December 8,3. Here, in August, staff members were quite close to patients, whereas in December staff members had become clearly more optimistic about this (patients' average 7,3). But, as I noted above, our flexibility had strict organizational limits.

Question 4: "While the patients are in the hospital, the staff members take responsibility of their treatment."

The average of staff members' answers was in August 9,0 and in December 9,1. Our staff members experienced themselves as responsible professionals which was experienced by patients, too (patients' average 8,4).

Question 5: "The hospital periods form coherent and reasonable wholes."

The average of staff members' answers was in August 6,6 and in December 7,9. Here, staff members estimated the question with same lines as our (patients' average 7,0). Clearly, the was problem with the coherence of hospital periods, and I already discussed some of the plausible explanations above.

Question 6: "The staff members tolerate well the difficult situations of the patients and help the patient to stand uncertainty."

The average of staff members' answers was in August 8,7 and in December 8,6. Again, staff members were clearly more optimistic about their containing ability than how patients experienced it (patients' average 8,4). There is always a difference between how you might experience things and how you might react to them.

Question 7: "While the patients are in the hospital, they are heard and paid attention to in planning and organizing their treatment."

The average of staff members' answers was in August 8,3 and in December 8,0. Here, the experience of staff members seems to be quite close to that of our patients (patients' average 7,9). Again, one must remember that some of our patients were in our ward against their explicit will.

Question 8: "In the hospital, people are treated equally."

The average of staff members' answers was in August 8,4 and in December 9,3. Thus, the staff members' experience was in the same line with the patients (patients' average 8,3), even if staff members were even more optimistic than our patients.

Question 9: “The patients can take actively part in their hospital treatment.”

The average of staff members’ answers was in August 8,6 and in December 9,1. Here, too, staff members' and patients' experience were parallel, even if staff members were estimating things in a more optimistic way (patients’ average 7,9).

Question 10: “People try to find solutions creatively to the problems which come up during hospital treatments.”

The average of staff members’ answers was in August 8,2 and in December 8,5. Here, the same phenomena can be seen: staff member's were more optimistic than patients, but the line was the same for both (patients’ average 7,6).

Questions 11: “The treatment in the hospital is effective and has high quality.”

The average of staff members’ answers was in August 7,8 and in December 8,6. Here, again, staff members were more optimistic than patients (patients’ average 7,3).

Question 12: “The treatment is organized in the hospital openly trusting and respecting others.”

The average of staff members’ answers was in August 8,7 and in December 8,6. Here, too, staff members are more optimistic than patients, but stay on the same line (patients’ average 8,0).

In the end, here is the summary of feedback:

Patients

7,06 7,45 7,29 8,44 7,03 7,27 7,88 8,29 7,88 7,62 7,32 8

Staff Members in August

8,08 8,67 7,5 9 6,58 8,67 8,3 8,4 8,6 8,2 7,8 8,7

Staff Members in December

8 8,88 8,25 9,13 7,88 8,63 8 9,25 9,13 8,5 8,63 8,63

Discussion - Being Dialogical

What can be concluded from all this? What does it all mean in regard to our possibilities to be dialogical? It seems that being dialogical is not self-evident. It does not take place just because we

have good will. Great majority of the people working in health care have good will towards their patients. Basically, people do not act because of immoral intentions.

Looking through the classical dichotomy between nature and nurture, being dialogical seems to be more on the side of nurture than on the side of nature. We are born to interact and communicate with the others, but we are not born to be dialogical. Being dialogical is something you must learn. You must not learn it just once in your life, but you have to keep on learning it when you and your life situation keep on changing. As speaking beings, we might have as a kind of birth right the possibility to become dialogical, but in order to embody this birth right we have to keep on educating ourselves to the end.

It is essential to notice that one is dialogical always within certain context. Each context means some kind of limits for being dialogical. Our ward located in the middle of contemporary urban society. Practically this meant that we were working within a big hierarchical organization, and the organizations with which we tried to collaborate we often big and strictly hierarchical. Thus, the dialog was often more between two or three hierarchical organization than between people: people who participated in network meetings, for example, were not able to decide or promise anything; the only thing they were able to do was to take message forward within their organization. This kind of urban service culture is, of course, non-dialogical and non-transparent. In the questionnaire reported above the questions 3, 5 and 11 were, for example, affected greatly by this urban bureaucratic milieu.

This last point leads back to my original question: what does it mean to be dialogical in the very context I am working. It cannot be the same thing as it is in the Keroputaa Hospital. According to answers given to the questionnaire, at least the principles of trust, respect, equality and responsibility seem to be achievable even in the urban, hierarchical and non-dialogical working environment.

Last, but not least, I bring out what I paid attention to first in the answers given by my patients. Namely, it seemed that the more severe was the psychopathology (for example, early or very early onset schizophrenia or severe borderline disorder) of the person, the more extreme were her experiences in the ward. I interpreted this as a kind of general thumb rule: in helplessness, we experience things in an extreme way. One word or a small gesture can mean a world to us, both in a

negative way or in a positive way. Thus, in an emergency situation, you do not have to say a lot or do a lot, for even the simple things you say and do may have an huge impact.

In the end, I would like to return to the point of view of this thesis. Namely, I wanted to approach open dialogue from the perspective of ethics. The reason for this was contextual: in the working environment which does not follow the institutional basic principles of open dialogue, what is available is ethics. For ethics can be found everywhere where you find human beings. Human being as such opens up the ethical dimension and questions of life. Universality of ethical demands cannot be silenced in any context. Thus, it is quite logical that, in the non-dialogical discourse environment, the best results come from the experience of what could be called ethical nucleus ideals: equality, respect for others, and responsibility of one's own actions.

References

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