


# Ethics of Finitude: Nursing and the Palliative Approach in Geriatric and Forensic Psychiatry

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## Abstract

There is a called-for shift to an upstream provision of palliative care as an overall care approach within a health equity perspective. Our research explored how nurses in psychiatry engage with aging patients and mortality to discern enactment of ethical dimensions of care. Drawing from tenets of interpretative phenomenological analysis, forensic and geriatric psychiatry registered nurses working at a mental health facility in eastern Ontario completed interviews for analysis. Nurses engaged with mortality through a process of recognition and through the affirmation of their values. The affirmed values are aligned with the palliative care approach and within an ethics of finitude lens in that their enactment is partly premised on the recognition of patients' accumulated losses related to human facticities (social, temporal, mortal). This research underscores preliminary insights on a process identifying care practices aligned with the palliative approach and possibilities for expanding upon an ethics of finitude lens.

## Keywords

palliative care, caregivers, caretaking, ethics, moral perspectives, nursing, psychiatry, geriatrics, end-of-life issues, death, dying

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## Background

In the context of an aging demography, access to palliative care is a growing public health issue (Stjernswärd et al., 2007). The World Health Organization (WHO, n.d.) defines palliative care as an approach to care and, within a Canadian care context, the Canadian Hospice Palliative Care Association (CHPCA, 2015) articulated a vision for palliative care in *The Way Forward National Framework* in which everyone who is facing problems associated with aging should benefit from a palliative approach to care. The palliative approach focuses on providing active comfort-focused care, improving quality of life, and meeting patient and family needs (physical, psychosocial, and spiritual) at all stages of frailty or chronic illness in patients' preferred care settings (CHPCA, 2015). While the CHPCA's (2015) Framework specifically includes homeless shelters and prisons as examples of places where a palliative approach can be provided, patients' settings of care implicitly extend to forensic and geriatric psychiatry inpatient units, the care context of the research presented in this article. The need to improve access to palliative care in forensic and psychiatric care settings is

evident and pressing: There is a growing western population of aging inmates in need of palliative care services (Human Rights Watch, 2012; Office of the Correctional Investigator, 2019), there is limited research related to palliative care programs within forensic environments outside of the United States (Fowler-Kerry, 2003; Hudson & Wright, 2019), and there are many barriers to the provision of palliative care to psychiatric patients (Terpstra & Terpstra, 2012) including stigma associated with mental illness (Steves & Williams, 2016) and the lack of experience of psychiatric nurses (Morgan, 2016).

In its focus on a patient care context serving structurally vulnerable individuals, our research responds to the call of Reimer-Kirkham et al. (2016) to philosophically align palliative care as a social justice issue through a

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health equity approach and to account for health-threatening and life-limiting contexts informed by structural vulnerability. Little is known of the process by which nurses engage in a palliative approach to care for patients experiencing multiple marginalities, including institutionalization, mental illness, and advanced age. Keeping this gap in mind, our research explored how nurses in forensic and geriatric psychiatry engaged with aging patients and mortality to discern how ethical dimensions of care, aligned within the palliative approach, are enacted.

The evolving language underpinning the palliative approach is part of a broader and ongoing movement within the international palliative care community for the palliative philosophy of care to be understood and integrated well beyond that of a discrete service offered at end of life. One example of this evolution is the effort to situate palliative care within public health wherein health promotion extends to include a recognition of the universality of loss and the approaches that can be taken to mitigate possible associated harms. While mortality remains a necessary *raison d'être* of palliative care and by extension, the palliative approach, there is a need to understand how nurses engage with this dimension of the human condition in care contexts (e.g., the forensic psychiatric context) that are less evocative and reminiscent of palliative care than the more familiar bedside vigils of dying patients in home or hospice settings.

### Theoretical Influences: Toward an Ethics of Finitude

An ethical lens informed by the work of Brinkmann (2006) to apprehend dimensions of human mortality was employed to help illuminate a process of recognition through which values can be identified in the care of patients. Drawing from the field of psychology, Brinkmann (2006) articulated a way to think about human mortality by proposing the need for an existential-phenomenological “ethics of finitude” which challenges thinking devoid of the referentials of “existential facticity and finitude” (p. 102). Human existence is rooted in what Brinkmann (2006) refers to as “facts,” including human beings’ social, temporal, and mortal dimensions. The concept of facticity refers to “basic facts” of human existence, such as interdependency and mortality (Brinkmann, 2006). This concept draws from existential philosophy and can be contrasted with the notion of transcendence (the possibility of moving beyond what is given) (McKinney, 2019). “Facticities” refer to elements of the human condition that “simply are the case, prior to any conventions or social constructions” including human interdependence and living in community with other mortal beings (Brinkmann, 2006, p. 95). Expanding upon these ideas about finitude, mortality is positioned as a condition for morality in that mortality and the related vulnerability it engenders makes possible the conditions for values, to the extent that what is valued is what is inherently subject to loss (Brinkmann, 2006). From the

facticities of human finitude and vulnerability stem moral demands of solidarity, including compassion and care, which are nonnegotiable (Brinkmann, 2006).

Engagement with mortality has a long cultural history in which humans are entreated into a process of remembrance and reflection. Remembrance of mortality, in the cross-cultural and trans-historical motif of “memento mori” serves as another entry point into an ethics of finitude; it is a mechanism to negotiate both cultural norms of predictability and control and the cognitive appeal uncertainty can represent in the face of possible negative health outcomes (Mishel, 1990). *Memento mori*, Latin for “remember that you must die,” is a theme of human remembrance of mortality and the shortness and fragility of life (Delamothe, 2007; Wellcome Collection, n.d.). Creative representations of this theme include statues, architecture, engravings, drawings, paintings, and writings (Wellcome Collection, n.d.). Brinkmann’s (2006) articulation of an ethics of finitude is premised upon concern for conceptualizations devoid of the facticities of human existence (social, temporal, and mortal), including a decline of referentials, which is “the tendency of signs and meaning in consumer society to become disconnected from their worldly referents” (p. 100). For example, while physical manifestations of aging have long served a social function in the remembrance of mortality, this process is also vulnerable to subversion through its problematization and commodification, as evidenced in global industries profiting from the medicalization of physical aging. The articulation of an ethics of finitude also reflects central elements of the palliative approach and public health palliative care, with its emphasis on the importance of social and familial connection, dying as a normal part of living, and the mandate of compassion that comes from a concern rooted in the universality of loss (Public Health and Palliative Care International, n.d.; WHO, n.d.).

### Method

The research was a qualitative study undertaken at the University of Ottawa which examined the palliative approach to nursing care in forensic and geriatric psychiatry at a mental health facility in eastern Ontario. Utilizing convenience sampling, eight registered nurses (7 women and 1 man) working in forensic ( $n = 4$ ) or geriatric ( $n = 4$ ) psychiatry completed interviews conducted by the first author. Participants were aged between 24 and 54. The length of experience in nursing ranged from 2 years to over 30 years. In-depth, semistructured interviews were used to structure data collection. The interviews occurred from April to June 2016. As part of the interviews, participants were asked to describe a typical day as a nurse on their unit, to speak to the overall role of nursing in this environment, to elaborate on the nurse–patient relationship, and to reflect on their vision of “ideal” nursing care. Findings from a subset of these interviews (forensic nurses only), as well as further detail about the methods employed in our study, are reported elsewhere (Wright et al., 2017). Our focus is to elucidate how nurses in forensic and geriatric

psychiatry engage values that underpin the palliative approach in the care of aging patients. The process of engagement with mortality underlying this approach was explored through the proposed ethical lens, which offers an alternate conceptualization to the values of the palliative approach.

Data were analyzed using Smith and Osborn's (2003) approach to data analysis—an interpretive-phenomenological method that is at once idiographic, inductive, and interrogative. Detailed examination of the first interview included reading this transcript several times to develop familiarity with the account (Smith & Osborn, 2003). Free annotations about interesting and significant passages were made (Smith & Osborn, 2003). Annotations included thoughts, related experiences, initial reactions, assumptions, and values emerging in response to the content. Next, ideas were identified in the interviews, in reference to our specific research aims exploring how nurses engage with mortality as both an antecedent to adopting a palliative approach and as a phenomenon capturing their continued engagement with patients within a palliative approach while staying close to the meaning communicated. Text excerpts were extracted from each interview to substantiate the ideas identified, and to establish a grouping of categories and/or subcategories. This organization of data and ideas underwent reorganization as ideas developed from across our data set were examined together.

This research was submitted for review by the Research Ethics Board (REB) of the University of Ottawa and the research site.

## Findings

Nurses' engagement with patients was revealed through multiple processes of recognition: recognition of mortality, recognition of the increased vulnerability of patients, and recognition of a correspondingly increased responsibility for vulnerable patients. Nurses expressed a recognition of increased vulnerability by acknowledging the cumulative losses experienced by aging patients, including their disconnection from family and familiar settings. One participant drew parallels between life changes associated with the beginning and end of life and affirmed a sense of responsibility for the integration of families into care:

Integrating them [families] into the care [. . .]. 'Cause you're establishing a new relationship, just like a mom with a baby [. . .] for some parents, they're like what do I do [. . .]? The same with dementia, your father isn't really the same person anymore, you have to [help the family] establish a new relationship with them. (Geriatric nurse 7, 218–221)

Nurses' engagement with patients and families appeared to enhance in proportion to perceived cumulative losses incurred in the care context. Expressed was an underlying recognition that families are in the process of losing loved

ones from their previously known frames of reference and are also coming to apprehend newly revealed finite dimensions of their family members. The process of recognition of patients' losses serves as a cue for deeper and more involved engagement with patients and their families as well shifting the orientation of goals of care.

Nurses engaged with mortality by affirming the values of human connection, dignity, comfort, family, familiarity, and personhood. The importance of family, for example, was affirmed by one participant in their recognition of the displacement and loss that can occur within a family as it relates to the mental illness and forensic diagnosis of one of its members:

The family is also part of the care. And educating them. And telling them [. . .] certain things about like, when they do the index of offence. Which is whatever they [patient] are charged with. Originally, the person was sick. So telling the family you know, that's part of the illness. [. . .] It's not just [. . .] your mom waking up one day and doing those things. (Forensic nurse 2, 205–209)

The statement illustrates how the nurse, in providing the family with informational support, acknowledges the importance of the family itself and also acts to buffer both family and patient against the possible threat of stigmatizing processes such as those related to the constructions of a forensic identity.

While the values articulated and upheld by the participants through a process of recognition corresponded to those aligned with a palliative approach (CHPCA, 2015), these same values can also be understood within a lens of an ethics of finitude in that their enactment is at least in part premised on the recognition of accumulated losses related to the *social*, *temporal*, and *mortal* facticities described by Brinkmann (2006). Each facticity is considered next to illustrate how engagement with these dimensions serves in the recognition and enactment of values underlying the palliative approach.

## Social

On an individual level, social dimensions in the recognition of values were identified by nurses drawing upon their own social connections; for example, a nurse reflected upon their own social connection to loved ones to identify the value of dignity and the importance of the personal care of patients:

The personal part of it for me is making sure that the people in your care have, yeah, I'll just use, you know, hygiene, I think is a big concern for these individuals. And it's more like how would I want my loved ones to be treated. I would want them to be clean, and to have, you know, to be well dressed, and to be to be treated well, right. . . . for me at least, that's the most important. (Forensic nurse 1, 436–440)

Nurses communicated a recognition of the social facticity by affirming the communal dimension of the care; in the context of a patient affected by neurodegenerative disease, nurses expressed the need to know who the family knew the patient to be, to provide patient and family driven care:

I think for me, safety and comfort, and again it depends on the person, it depends on the family. I can't, I can't say what's ideal for someone else's loved one. I can't. (Geriatric nurse 6, 366–367)

The information provided by family members helped nurses to understand what was comforting to the patient by gaining a better understanding of what was distressing to the patient. Similarly, family presence was found to play a humanizing role such as by providing a nurse with a richer patient history for a challenging patient:

[. . .] to kind of see it, people in different lights you know [. . .] maybe we have this literally aggressive angry difficult patient but then you see their families . . . [families] tell stories about them [patients] or what they used to be like and stuff and that gives you a different perspective, having more compassion and maybe not taking it personally when they are aggressive. You realize what they used to be [. . .]. (Geriatric nurse 7, 233–238)

Families' knowledge of the patient served a role in substantiating nurses' approach insofar as to support whether patients were indeed cared for in a manner that brought them comfort and was aligned with their values. Nurses expressed that without validation from external sources like patients' families, they lacked reference points to ensure the appropriate care of patients. As such, recognition of the family's social knowledge helped nurses to actualize values by knowing what was comforting and meaningful to the patient.

The social context provided by patients' families helped to orient nurses in the care of the patient. From these examples, of which participants provided varying iterations with respect to values, it is possible to discern that it is not only the disease process itself that threatens patients' ability to live with dignity, comfort, and personhood but also the extent to which these same values are socially sustained by individuals caring for them. This observation finds footing in the notion of relational autonomy in contrast to more traditional individualistic understanding of autonomy (Pritchard-Jones, 2017). Relational autonomy or socio-relational autonomy recognizes that "the ability to act autonomously is not black and white" but rather rests on a spectrum—to this end, this understanding of autonomy accounts for the reality of those, such as aging patients with neurodegenerative disease, who regularly depend on others to live their choices, such as the personhood value identified in our findings (Pritchard-Jones, 2017, p. 77). This understanding of relational autonomy intersects with the moral demands of human interdependence identified by Brinkmann (2006).

## Temporal

In our analysis, the temporal facticity was understood to pertain to the dimension of time, including time periods evocative of the passages of human life. For one nurse, the recognition of the plurality of losses incurred by older patients, such as those related to the care setting, including unfamiliar social environments and food, served to recollect the importance of comforts as buffers against losses:

So when a patient gets a little bit agitated. Sometimes we say. You think like at lunch time you will be worried, is this the food you eat in your home? Maybe it's the food. Maybe they're irritated by all these people around them. Maybe this food isn't anything comparable to their traditional food. (Forensic nurse 2, 133–136).

For this participant, the traditional diet served a symbolic function in recollecting the importance of home and comfort. This example also reveals that what is valued in human connection is what is sustained in connections and interactions that occur *over time*. The process of recognition is operationalized in engagement with patients, which includes observation of and developing familiarity with patients as described by a nurse with experience in both forensic and geriatric psychiatry, when describing the care of a geriatric forensic patient prone to confusion and vulnerable in relation to this:

I would always sit in the nursing station while we were doing report so I could see him walking by because he was always up in the early morning. He almost always did this everyday. You direct him at 0713 or whatever to go the washroom. But if you don't have staff that is familiar with this. Or, in this case, I was very familiar with this patient. So it was easy to move him around, to redirect him. But if you don't have staff who is used to being vigilant in that sense. Hmm, in the sense that, hmm, because, he's not, he's confused, he's not intending to, you know, get into girls' rooms and stuff. (Forensic nurse 1, 284–289).

This nurse identified the vulnerability of the patient in the ease with which the presenting behavior could be misinterpreted by those unfamiliar with his routines and by those who would omit similar close observation. In so doing, the nurse underscored the temporal dimension to enacting the value of familiarity as well as the embedded process of recognition it entails, with implications for care planning and documentation. In addition, nurses' recognition of vulnerability itself extended to apprehending vulnerability related to cumulative losses engendered by advanced age and vulnerability compounded by living in an institutionalized setting.

## Mortal

An open awareness of death is recognized as significant in the conceptualization of the palliative approach (CHPCA,



2013, 2015; WHO, n.d.). The third facticity identified by Brinkmann (2006) pertains to the mortal dimension of human existence. Nurses' engagement with mortality emerged with respect to the idea of recognition, expressed by reflecting upon mortality itself:

It's because personally I'm on a different, my expectation of what can be done is different. [ . . . ] I know the limitations of the medical field, I know there's no magic pill to fix things, I know with my family history, I could be diagnosed with dementia or Alzheimer's, but knowing that helps me plan ahead, helps me talk about it to my loved ones. (Geriatric nurse 6, 675–680)

This nurse communicated that their heightened mortal awareness came in part from the experience of working with patients with dementia and a recognition of the limitations of medical science. The participant also referred to speaking openly about death “like I'm going to buy my groceries”; for this nurse, communication about dying and death functioned to alleviate harms such as suffering related to the fear of death and the related lack of preparation and planning. This echoes Sinclair's (2011) study on the impact of dying and death on the lives of palliative care professionals whereby participants expressed that facing their own mortality was “perhaps a necessary prerequisite” to effectively caring for patients at end-of-life and enacting elements of a good death (p. 185). Remembrance of mortality via nurses' own processes of reflection on mortality (of self and of patient) could be an entry point into apprehending mortality and an example of a mortal remembrance (*memento mori*) motif.

Another example of reflection on mortality can be discerned in the forensic psychiatry setting; the contrasting populations of older and younger patient demographics served to render older patients more visible. This arrangement helped to contrast the limitations in physical functioning and fragile health of older patients relative to younger, more able-bodied, patients. Nurses found that the contact this arrangement fostered created conditions which allowed some younger patients to “practice” skills related to compassion, empathy, and concern for older patients—care values that could be found to rest within a palliative approach.

The remembrance of mortality helped to identify values at risk, including comfort—values seemingly engaged by some younger patients, such as in the description of a younger patient regularly sitting with and singing to an older patient. Reflection on mortality also emerged more directly, as illustrated by a nurse in forensic psychiatry, who observed upon the vulnerability of some of these patients to early death:

I've termed people to be palliative in nature even when they're young. [ . . . ] Early twenties in that they are more than likely never going to survive for long in that they're very very difficult to treat and the insight, the judgement isn't there and there are other determinants or grounds, this person, environment, and housing, and relationships, and whatnot, they are palliative in nature, and you know there's gonna be suicide, homicide, or

they'll die of some sort of circumstance. (Forensic nurse 5, 240–246)

This participant's awareness of the potentially life-limiting circumstances of some younger patients with schizophrenia is expanded upon in the recognition that these patients rapidly exhaust treatment options:

You are just sort of ticking off [ . . . ] we've tried it, we've tried it, we've tried it, we've tried it. (Forensic nurse 5, 293–294)

As the above excerpts illustrate, participants' reflection on mortality and recognition of patients' vulnerabilities serve not only to identify values and inform priorities guiding nursing care but also operate as an antecedent to the identification of individuals amenable to a palliative approach. Of relevance to the psychiatric care context is not only the care of aging patients with life-limiting illnesses but also the life-limiting dimensions affecting those living with mental illness and involved in the correctional system, such as accelerated physiological aging (Burles et al., 2015).

## Discussion and Implications

While the values articulated by the participants corresponded to those aligned within a palliative approach (CHPCA, 2013, 2015), these same values can be understood within the lens of an ethics of finitude in that their enactment is at least in part premised upon the recognition of accumulated losses related to the social, temporal, and mortal facticities described by Brinkmann (2006). The approach underscored by an ethics of finitude lens can be contrasted with normative ethical claims (e.g., patient and family driven care, autonomy) and while such claims do not imply the absence of a personalized process to the enactment of values, an ethics of finitude lens is an approach that is inductive in that it begins with the person and recognition of their human facticities, to possibly identify and engage broader normative claims.

A central insight that emerges from an ethics of finitude lens is that of a complementary process to engagement with values aligned with the palliative approach. A process that supports the recognition of vulnerabilities as they relate to the social determinants of health can serve to identify challenges and opportunities to the enactment of values at the heart of the palliative approach. For example, reflecting upon the relational dimensions of autonomy and social vulnerabilities can help to discern how some patients may have had limited opportunities to develop decision-making capacities (Pauly, 2008) and are thereby constrained in their ability to access palliative care, such as in limitations related to advance care planning.

Beyond this, the interrelated nature of facticities is such that questioning related to social dimensions can help to identify patients at risk of early death given their life-limiting social contexts, as exemplified by a participant reflecting upon quickly exhausting options in the care of some younger patients

with schizophrenia. Reimer-Kirkham et al. (2016) critiqued current palliative care approaches that “do not make explicit the additional attention needed to address social and structural inequities” (p. 2); through critical questioning, the proposed lens helps to put into focus socio-political forces that engender unique vulnerabilities in aging patients, including stigma. The proposed ethical lens can provide insight into the identification of forces contributing to stigma and the reproduction of vulnerability through critical questioning. Given the socially constructed nature of stigma, questioning related to the social facticity for patients amenable to a palliative approach can be considered, such as: “How vulnerable or sustained is this person socially/societally?” and “How does this social/societal context shape the possibilities for the enactment of values for this person?” The degree to which nurses engage with patients in their facticities may correspond to the extent to which nurses engage patients within a palliative approach.

Engagement with mortality is profoundly challenged by a future in which scientists, equipped with the tools of biotechnology and computer algorithms, can alter biological life so as to fundamentally change human physiology, immune systems, life expectancy, as well as intellectual and emotional capacities (Harari, 2014); from this perspective, death becomes an increasingly technical problem rather than an existential necessity (Harari, 2016). At a time when such foreshadowing of human immortality is imagined, and yet so far removed from the reality of most, the need for remembrance of mortality becomes more salient, as a counterpoint to the privileged promise of scientific progress. An appreciation of the tension between remembrance of human finitude and its erasure may help to account for strains in diverging care approaches, whether from more palliative or curative modalities. This tension may be more evident in forensic and geriatric psychiatry, care contexts typically deemed acute and not commonly associated with palliative care.

As with most qualitative research with nurses about their practice, participants self-selected into this study. As a result, the perspective of nurses who are less passionate and/or knowledgeable about the care of aging patients is likely underrepresented.

## Conclusion

The process of recognition explored through the ethics of finitude lens and in our findings illuminates values that underpin the palliative approach. The recognition of values such as connection, dignity, and comfort expressed by nurses is paralleled with a recognition of patients’ unique proximity to loss embodied by these values; these losses can in turn be conceptualized along interconnected axes of sociality, temporality, and mortality. Conceptualizing the enactment of the values of the palliative approach through a lens of engagement with mortality serves to inform appropriate care for Canadians aging with life-limiting conditions in diverse nursing specialty environments.

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