

ORIGINAL ARTICLE

Medical facilities as moral worlds

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Bioethics is dominated by an emphasis on rule making and quandary solving. Teaching and research in ethics often focuses upon dramatic, controversial issues at the margins of life and death. Much less attention is given to the relationship between moral reflection and the ethos of place. Medical facilities, however, are moral worlds. To discuss the ethos of place is to focus on the character or atmosphere of particular dwellings. Architecture, interior design, and the creation of built environments have moral, spiritual, and aesthetic dimensions. Discussions of “ethics” need to be less oriented to rules and dilemmas, and more attuned to practical matters of everyday social experience. Instead of developing all-encompassing critiques of medical facilities as impersonal, alienating institutions, scholars from various fields need to explore the incremental steps that can make particular settings more decent, humane, and caring.

Over the last forty years, scholars in bioethics and the medical humanities have made little effort to link moral reflection to architecture, the design of rooms and buildings, and the creation of humane social habitats. The ethos of place is not a recognisable area of study in current bioethics research. Unfortunately, for many people, the work of ethicists is identified with rule making and the resolution of moral “quandaries”.¹ The focus upon rules and quandaries fails to attend sufficiently to the prosaic character of moral experience in particular social settings. Furthermore, the emphasis upon rules and quandaries means that little attention is given to the contribution of institutional design, the practical arrangement of rooms and hallways, gardens, works of art, and everyday human interaction to the creation of meaningful, decent, inhabitable places. Scholarship in bioethics is more oriented towards the articulation of principles and rules and the resolution of moral quandaries than reflection upon what constitutes meaningful “local moral worlds”.² Ethics consultations, for example, commonly arise in the context of addressing difficult, contentious end-of-life care scenarios. Regarding bioethics as a rule-making, problem solving discipline that can bring order to messy situations at the boundaries of life and death neglects larger questions about what it means to inhabit a particular institution as a patient, family member, or staff member.

BIOETHICS AS RULE MAKING

Where bioethics is interpreted as rule making and problem solving, a quasilegalistic approach is commonly used to devise rules and regulations for organisations and professionals. This legalistic approach presumes that the most defensible, sensible application of moral reasoning to the realm of medical practice and scientific research is one that devises rules to regulate human conduct. A great deal of contemporary work in research ethics, for example, involves the elaboration of an ever more detailed web of regulations concerning the use of human subjects in clinical trials. The rule-making approach can also be seen in the construction of codes of conduct for physicians, nurses, social workers, occupational therapists, and other health care providers.

BIOETHICS AS PROBLEM SOLVING

“Quandary ethics” describes an understanding of moral reasoning in which the task of the ethicist is to resolve complex cases or policy issues that pose seemingly intractable

“dilemmas”. The language of “quandaries” and “dilemmas” points to an understanding of bioethics where the focus is on the clash of alternative moral principles and the tension between competing moral intuitions. Here, the task of the ethicist is to weigh competing principles, consider alternative courses of action, and examine whether reasons can be given for pursuing one particular course of action or policy initiative over the alternatives. A great deal of attention is given to seemingly irresolvable situations. Quandary ethics emphasises the most complex cases where the deepest normative conflicts are found. Again, it is regrettable if moral reasoning comes to be equated with the discussion of “quandary ethics”, because this means that moral reflection is most closely identified with responding to marginal, perplexing, boundary situations. Within the hospital context, a focus on “quandary ethics” means that ethics rounds and case consultations are reserved for discussions concerning the moral equivalent of exotic ethical “zebras” rather than more familiar “horse” cases.³ Dramatic problems are examined at the expense of the mundane concerns that constantly recur.

Ethicists can usually be persuaded to lecture on physician assisted suicide to a group of geriatricians; it is much more difficult to persuade bioethicists to discuss what practical steps might be taken to improve the quality of food, musical offerings, recreational activities or institutional arrangements in particular health care settings. Somehow, these matters are regarded as health care delivery issues that fall outside the realm of serious moral reflection. These practical considerations—the kinds of concerns that in my experience tend to play an important role in determining whether hospitals and geriatric care facilities are humane, decent places—commonly fall outside the perceptual field of “the moral point of view”.

Rather than thinking of moral reasoning in the health care context purely as a matter of making rules or resolving quandaries, I propose that much greater attention be given to the practical, mundane consideration of the many incremental steps that can be taken to make hospitals, geriatric facilities and other health care institutions more human, decent, aesthetically and spiritually satisfying moral habitats. Much more attention needs to be given to the many quotidian aspects of life that interweave to create the “ethos” of particular settings.⁴

A CAUTIONARY NOTE

In making these observations, I recognise that different kinds of places are built for different purposes. An acute care hospital is

not the same kind of place as a long term care geriatric facility. Consequently, it seems unlikely that the social practices and orderings of human experience that might be found in an exemplary hospice facility should also be found in a critical care unit. Making the case for the importance of gardens, music, and artwork in a particular geriatric facility is not to presume that the nearby trauma centre should be similarly designed. I find it helpful to think of a taxonomy of places, where practices and social orderings suitable in one setting are not immediately relevant to all habitats. Furthermore, even similar organisations can be arranged in different ways in different settings, depending upon the specific needs and understandings of the particular inhabitants of a place. Whatever considering the ethos of a place involves, it is not an attempt to define the singular “essence” of the good hospital or geriatric facility.

PERSONAL REFLECTIONS

From January 1998 to August 2000, I worked as a clinical ethicist at Baycrest Centre for Geriatric Care, in Toronto, Ontario, Canada. Baycrest has strong links to the local Jewish community in Toronto, and both staff members and members of the larger community are very concerned with ensuring that Baycrest is a place where elderly people can live in a safe, compassionate, caring atmosphere.

Part of my work as a clinical ethicist involved providing ethics consultations, contributing to the development of organisational policies, and attending meetings of the clinical ethics committee and research ethics board. With such activities constituting an important part of my work, I was in a position to appreciate the limited but useful contribution of quandary ethics and ethics as a rule-making exercise. Over time, though, it occurred to me that much of what I found most decent, admirable, and ethical about the institution had rather little to do with addressing marginal cases, developing new, improved informed consent forms, or further refining policies concerning cardiopulmonary resuscitation. These tasks had their place, but the more time I spent at Baycrest, the more I came to realise that it was the mundane, background features of the place that mattered to the lives of its clients and staff. Perhaps when thinking about long term care and geriatric facilities, it makes sense to begin thinking about the ethos of place instead of immediately associating geriatric care with “ethical issues in end-of-life care” or some other conventional rubric.

Focusing upon the ethos of place draws attention to the way in which architectural design features of buildings, the interior design of hallways, common areas, bedrooms, and recreation areas, places for plants, pet programmes, arts and crafts programmes, music, and art contribute to the everyday moral life of a particular place. When attention is directed toward the ethos of Baycrest Centre for Geriatric Care, it makes little sense to think of moral reflection as a distinctive intellectual activity performed during ethics rounds and ethics consultations. Rather, creating a moral place can be recognised as a matter of fostering specific practices and affording the opportunity for particular human experiences in specific habitats. Let me provide a few concrete examples that emerged from my time at Baycrest to give a better sense of the way in which the ethos of place matters.

BAYCREST CENTRE FOR GERIATRIC CARE

I am used to experiencing hospitals and geriatric facilities as bright, white, sanitised, utilitarian institutions where little attention is given to the moral, aesthetic, and spiritual dimensions of place. Trudging through most hospitals, it is easy to understand why patients and visitors regard them as such impersonal, dehumanising institutions. There are ways, however, of making hospitals and geriatric facilities more humane and hospitable. At Baycrest Centre for Geriatric Care, for example, colourful, distinctive works of art are found

throughout the corridors and rooms. Many of the murals, paintings, and pictures are created by residents of Baycrest. Other pieces of artwork are donated to the institution. Even though I tend not to be particularly attentive to works of art, I found the visual display at Baycrest quite stunning. Striking paintings adorn corridors and rooms, making the halls and walls livelier, more colourful, more alive with rich textures and images. Black and white pictures of some of the centre’s inhabitants form a small photography exhibit near the centre’s library. An aquarium on the first floor serves as a flowing, ever changing painting, as colourful fish dart to and fro. A quizzical looking Franz Kafka gazes from a lithograph near the old coffee shop.

A careful economic cost benefit analysis might raise tough “bottom line” questions about the “added value” or “opportunity costs” of these portraits, pictures and murals. Senior administrators cannot be referred to well designed studies confirming that aesthetically pleasing, visually rich, colourful environments lead to better “health status” over utilitarian, functionalist surroundings. There are always new and expensive pieces of medical equipment that can be purchased. What is all of this artwork doing in a geriatric facility? It would be very easy to develop an argument explaining why the artwork should be carted away and replaced with a larger concentrated care unit or new computers. And yet, Baycrest would be a different place if the artwork was removed from the halls and walls and auctioned to purchase new equipment. I suspect that what would begin to disappear from the place is whatever qualities that make Baycrest less a repository for ageing bodies, and more a habitat for humans.⁵ Of course, it would be saccharine of me to attempt overly to romanticise the place. There are sad, tragic dimensions to the many forms of suffering found in geriatric facilities. Still, in so far as geriatric facilities are not just places to grow old and die but places to live, it makes sense to attend to those morally, aesthetically, and spiritually significant features of settings. For many people at Baycrest, I suspect that the artwork plays a small but meaningful part in contributing to the rich moral fabric of the place.

While I found the artwork particularly noteworthy, others might find themselves drawn to the bright fish in the aquarium that is built into one of the escalators. Those with musical inclinations would notice the presence of the guest singers, the visiting piano player, and the festive musical performances that regularly occur. These latter events commonly take place in a large meeting place near the café, on the first floor of the main building. Bird lovers will find themselves drawn to the chattering parrots in the atrium of the new hospital building at Baycrest.

In addition to the artwork and the music, a colourful arts and crafts room provides an opportunity for Baycrest inhabitants to participate in pottery making, painting, drawing, and other activities. Instead of simply sitting in hallways or in their rooms, many of the people who live at Baycrest can visit the crafts room to talk with one another, use their hands and minds, and work with brushes, paint, and clay.

While the artwork lends colour and character to the buildings, music brings the place to life with clapping and singing, and the arts and crafts room fosters creation and engagement, there are other ways in which Baycrest is made habitable. Many individuals who live at Baycrest adorn their rooms with eighty years’ worth of pictures of family members and friends. Religious holidays and special events bring an air of festivity to the place. Volunteers and staff members raise banners and streamers for these special events, and posters quickly dot the walls. “Aquasize” classes, meals, storytelling sessions, synagogue services, and other activities provide opportunities for Baycrest inhabitants to participate in everyday human activities. This bustle of social interaction does not happen of its own accord. The posters, banners, and book displays do not automatically appear. They require volunteers, organisers,

planners, community supporters, and staff members. Family members, health care administrators, social workers, physicians, nurses, physical therapists, and occupational therapists engage in dozens of regular activities that weave together to make Baycrest a particular kind of place.

In addition to the attention given to everyday social activities and the adornment of living spaces, there is a great deal of practical reflection on how particular settings should be designed. For example, a new residential facility was recently completed at Baycrest. While architecture and interior design are rarely linked to “ethics”, the building of human habitats is a thoroughly moral enterprise. Particular human experiences can be fostered or undermined by building particular places.⁶ Create no common places and meeting spots, and the institution risks promoting loneliness and isolation. Create too many public areas, remove the doors and walls that serve to demarcate “public” from “private” spaces, and the building’s design could undermine the possibility for personal moments, solitary reflection, and a sense of privacy. Allow too many personal items in each personal living space, and the safety of the individuals who live in the room could be compromised in an emergency. Allow too few personal items in each room, and individuals risk losing the pictures, furniture, and other personal items that serve as reminders of identity and connectedness.

The design of eating spaces, bedrooms, hallways, washrooms, and meeting areas does not determine the ongoing flux of everyday life, but it can play a role in fostering environments for particular kinds of experiences. In short, if attention is given to the ethos of place, consideration needs to be given to what makes particular places warm, comforting and inhabitable, or cold, impersonal, alienating, and unbearable.⁷ Much greater consideration needs to be given to the background features and everyday social routines of particular institutions. It is this tacit, everyday character to moral life that makes for better or worse human places of habitation.

Of course, the ethos of a place is not just a product of architectural design, interior design, the provision of gardens and paintings, and the variety and quality of the food. The ethos of a place is also connected to the kind of people who inhabit a particular setting. Staff members are not as interchangeable as some health care executives might think. Doctors, nurses, music therapists, occupational therapists, physical therapists, and neighbourhood volunteers are not just replaceable “cogs” in “health maintenance organisations”.

THE CHARACTER OF PEOPLE AND PLACES

By focusing upon rules, policies, and principles, ethicists risk failing to attend to the atmosphere or tacit character of places. Sensible hospital executives are not, however, looking for employees who can recite verbatim organisational mission statements or legislation concerning informed consent and advance care planning. Discerning administrators understand the importance of hiring good, decent people who can be trusted to provide care in a compassionate, attentive manner. While moral theorists might quibble about the definition of “decent”, and “compassionate”, many of the semantic ambiguities disappear in the practical setting. The staff member who harshly treats frail elderly persons, who constantly hurts their arms and legs by moving them in a rough manner, is not treating people in a “decent”, “compassionate”, “respectful” manner. Differences in understandings of moral principles or moral theory seem beside the point in this context. Prudent managers look for staff members who understand what it means to provide care in a sensitive, attentive manner, and make the habitats where they work better places. Finding the right kind of characters for a place means hiring people who have the imagination and heart to recognise what “doing good” and “avoiding doing harm” mean without having to read the *Principles of Biomedical Ethics*

for justifications of beneficence and nonmaleficence.⁸ While it is important to address those boundary situations where what counts as “beneficence” or “maleficence” is a matter of dispute amongst reasonable people, it is vital for decent health care settings to have staff members with sufficient generosity of character and everyday practical wisdom to perform caring acts in the vast majority of circumstances where what constitutes moral practice is not a matter of serious dispute. Codes of conduct and statements of organisational ethics can provide clarification and serve as helpful reminders of what constitutes “acceptable” moral conduct. These codes are, however, dependent upon the decency, moral sensibility, and good will of the physicians, nurses, social workers, occupational therapists, family members, and other participants in the life of a place.

Hiring decisions, then, are profoundly moral acts because the choice of who is permitted to participate in the everyday practical activities of a setting plays an important role in determining the unfolding ethos of the place. The ethos of a place is closely connected to the characteristics of the many different people who inhabit a particular setting. Most of us would much rather inhabit a health care facility with compassionate, sensible caregivers but without a documented “mission statement” or code of conduct, than we would a hospital or geriatric centre with an elaborate code of ethics and indifferent, uncaring staff members. Specific people filling defined social roles play integral parts in determining whether a particular place has a more or less caring, compassionate, and trustworthy atmosphere.

DESIGNING PLACES

While it is important to attend carefully to the way in which the particular characters who inhabit a place contribute to the ethos of the setting, it is also crucial to consider the tactile, arranged character of a particular place. Thinking about the ethos of place serves as a reminder that architectural decisions, the layout of units and wards, and the creation of meeting places and private spaces, all matter.⁹ While architecture and habitat design are rarely linked to bioethics, the practical arrangement of human settings is a profoundly moral enterprise. Architectural designs and choices of interior design can serve to create meeting places and improve opportunities for social interaction, or they can promote loneliness and isolation. The integration of gardens, greenhouses, reading rooms, and other social niches into the fabric of a geriatric care facility or hospital can serve to respect privacy and the need for solitude, recognise the need for reverie and introspection, and provide opportunities for a sense of community. Decisions about how geriatric centres will accommodate people play an important role in enabling friendships and human connections to persist. Such choices can also lead to fragmentation, alienation, and frequent moves from unit to unit within an institution.

I want to emphasise here that I am not attempting to make the case that architectural firms now need ethicists, or that a bioethics consultation is needed when choosing what plants to grow in the garden of a geriatric facility. Rather, I am suggesting that the way in which places are designed, built, and sustained over time has an important effect upon the moral, aesthetic, and spiritual lives of the inhabitants of these settings. How habitats are built and inhabited has a profound effect upon the kinds of moral experiences that occur in these settings. Whereas bioethicists often focus upon particular “cases”, the kinds of moral issues these cases raise can often be traced to the way in which places are made inhabitable. To give just one practical example, think of a situation where an elderly woman requests that a geriatrician assist in her suicide. Now, imagine that the woman asks the question in a setting where she lies alone in a spartan, antiseptic smelling room with no pictures or other personal items on the walls or

her table. There is no garden, arts and crafts room, music room, or reading lounge in the building, so she spends her days either lying in bed or sitting alone in her wheelchair in the hallway outside her room. There are no opportunities to leave the geriatric setting for brief excursions, and life unfolds entirely in this one setting. The woman, because of her declining health, moves through three different units in three months. She does not know the members of the health care team, and she does not recognise any of the other individuals on the floor where she lives. Whatever we might think in general terms about the subject of physician assisted suicide, how we make sense of her particular request is dependent, at least to some degree, on what we think of the kind of social world she inhabits. The ethos of a place can play an important role in creating a sense of warmth, security, trust and comfort, or promoting experiences of loneliness, isolation, and despair. The ethos of place matters.

CONCLUSION: FROM RULES AND QUANDARIES TO THE ETHOS OF PLACE

Developing rules and responding to difficult cases are two worthwhile activities for ethicists. In real life, however, moral reflection encompasses more than making rules and addressing quandaries. Much more attention needs to be given to the kinds of social practices and habitats that ought to be constructed and maintained. For the inhabitants of geriatric facilities and most other health care settings, prosaic moral concerns form the stuff of everyday life. The character of the places they inhabit affects the quality of their lives. There is a difference between living in impersonal, utilitarian, cost-efficient warehouses for elderly people, and inhabiting distinctive, colourful habitats with gardens, artwork, meaningful human activities, social gathering spaces, and areas for quiet reverie. Instead of giving so much attention to rules and quandaries, we should better attend to what makes particular settings and social practices better or worse for specific people.¹⁰

We need to be far more attentive to the kinds of architecture, interior designs, artefacts, and social activities that make for better or worse places. Moral reflection needs to be less oriented toward principles and rules, and more attuned to exploring the character of prosaic settings where mores are embedded in particular practices and ambient settings. Moral reflection is not just about ideas and concepts that chiefly exist at some cognitive, intellectual level. Morality is also about the ebb and flow of human experiences in particular places. Architectural designs, the construction of private places and public spaces, the daily unfolding of social practices, paintings, gardens, and reading rooms have embedded in them particular understandings of how people should live their lives. The shape, texture, and character of settings have a great deal to do with the kinds of experiences that occur within local moral worlds.

Of course, caution is needed when making generalisations about what constitutes “good” habitat design or “caring” social practices. What is sensible for one place and community might be unsuitable in another setting. There is an irreducibly local character to such discussions, just as good architectural designs take into account features of the local landscape and the particular needs of a future building’s inhabitants.¹¹ Still, taking the variability of places, practices, and the distinct needs of particular communities into account, there is room for more reflective discussions about the many different steps that can be taken to design, build, and preserve meaningful, distinctive, sensible human habitats. Perhaps it is time, then, to better attend to the ethos of place, and to recognise that moral reflection requires much more than devising clever rules or ingeniously resolving complex moral quandaries. Attending to the ethos of place means learning to appreciate the way gatherings for meals, recurrent activities, social events, music, paintings, rooms, and gardens flow together to constitute meaningful forms of habitation within particular human dwelling places.

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