Relational Ethics of Comfort, Touch, and Solace—Endangered Arts?

Patricia Benner, RN, PhD, Thelma Shobe Endowed Chair for Ethical and Spiritual Dimensions of Nursing

A fellow healthcare worker was recently hospitalized for eye surgery. For 24 hours following the surgery and anesthesia, she experienced extreme nausea and dizziness. Her husband stayed with her for assistance, but her problem was complicated by the fact that she had to keep her head in a prone position because of the eye surgery. Despite pain and nausea medications, any head movement could cause dizziness and vomiting. At 3 AM, her husband had fallen asleep, so she called for a nurse to help her get to the bedside commode. The nurse quietly and gently assisted her, trying not to wake the patient’s husband, as this was his first time sleeping since the surgery.

Upon moving back to bed, my colleague again experienced vomiting and extreme dizziness. She had been given anti-emetic medication before getting up, so the nurse gave her a cool cloth and sat holding her steady in a sitting, head-down position. She had muscle spasms in the neck from the extended time lying in a prone position, and she was discouraged and distressed by the vomiting and dizziness. The nurse rubbed her shoulders to relieve the strain until the dizziness and nausea subsided enough for her to return to a prone position. My colleague, knowing that I am a nurse educator, recounted this experience to me, explaining that it was the first time during this hospitalization that anyone had offered anything other than medications to soothe or comfort her. She greatly appreciated what she considered to be a central nursing art and asked me if nursing students were no longer taught how to comfort with touch and presence.

I believe that we still do teach the arts of gentle touch and comfort measures, such as being present in a reassuring manner as was this nurse. However, there are many threats to this central nursing practice. First, it is invisible, rarely charted, and almost never suggested in a nursing care plan. Comforting touch, solace, and presencing (i.e., being present and available to the patient) are left in the region of the art of nursing practice, yet few would deny their importance when confronted with a situation like the one just described.

With culturally diverse patient and nurse populations, there can be cultural confusion and even barriers to the nursing tradition of comforting practices such as touch and presencing. Touch itself may be endangered by concern for crossing cultural boundaries of either the patient or the nurse. There is also the technological imperative of providing more technical interventions such as medications for pain and nausea or tranquilizers. Such “ordered” and charted interventions remain expected and highly visible therapies.

Despite the endangerment of comforting touch and solace, my colleagues and I found many examples of comfort measures in a recent study of critical care nursing. The goal is to articulate these marginalized, invisible practices in order to make their crucial contributions to critical caring evident and open for discussion and renewal. An example is given in the following observational interview:

Nurse J. was taking care of a 55-year-old man. He told me immediately that the
main problem was the man’s psychological condition, and that he had taken steps to deal with that at the beginning of the shift. Before going into detail about those steps, he gave me details of the man’s medical history and current hospitalization. (NB, this was 45 minutes into the shift)... “But now we know the anatomy,” Nurse J. said. The patient had just returned from an emergency cardiac catheterization. The 3 grafts from his previous coronary artery bypass graft (CABG) surgery plus 2 of his major arteries were completely occluded. The third was barely perfusing. Nurse J. told me that the attending physician had talked with the patient about the results of the catheterization, telling him that he was getting all the medications available for his disease, and that the medical staff would be talking with him over the next couple of days about a heart transplant. Nurse J. saw the patient take off his oxygen mask in his sleep a few times. He would go into the room and tell the patient directly that he was putting his “oxygen back on,” and that he should try to keep it on because it was good for his heart. Nurse J. said to me that if he were “going by the book,” he’d tape the mask to the patient’s face, or maybe restrain him. In this case that didn’t make any sense and it would just backfire making the patient angry and upset. After a few attempts to keep the mask on, Nurse J. mentioned to the resident that he was going to try a nasal cannula. This would deliver less oxygen per minute, but the patient would get more oxygen with the cannula because it would be more comfortable and the patient would leave it on. He did this, explaining to the patient that it would be a lot more comfortable, and that “we’ll try this to see if you get enough oxygen this way.” The patient agreed.

This kind of accommodation and comfort measure is common practice, but invisible unless the nurse does “go by the book” and inappropriately uses physical restraints. In this example, the nurse uses good judgment and ethically chooses the least necessary restraint. This is the ethically demanded care in this situation. It is not clear what the nurse has in mind when he mentions “going by the book,” but presumably, he believes that restraints and taping of the mask could be done in following the mandated therapy. This common practice of adjusting therapies for the patient’s comfort and well-being remains invisible, unless it is not used and the patient’s condition deteriorates as a result. In the following observation in a recovery room, the nurse makes a similarly judicious withholding of restraints, and uses touch and comfort measures instead:

Nurse: I was taking care of an elderly woman in her late 80s. She had a femoral popliteal bypass and she was intubated. We needed to restrain her because she was very active, and there was a possibility of extubation. We restrained her and we then extubated her. She remained restrained in the bed for a little while, but she was clearly very uncomfortable. I gave her pain medicine, which helped for a little while, but she really seemed like she wanted to be in a fetal position, and restraints disallow that. I said, “I’m just going to take the restraints off and see what happens” (whispers this last line). So I took them off and she tried to get out of bed, so I calmed her and patted her back. I told her she had to stay in bed, and if she stayed in bed I wouldn’t have to put any restraints on her, but she was nonverbal. Even though she probably was capable of speaking, she couldn’t speak postoperatively. I could see that she couldn’t take being restrained. She was petite and not thrashing too badly, so I elected to leave the restraints off, even though it was a little bit difficult for me to manage her with them off. I just felt that freedom of her extremities was more important to her well-being than it was to restrain her. All I needed to do was put her down in the bed every 5 minutes, or she would try to get out of the bed. I didn’t feel that she was in any clinical danger, that she could move about in the bed as she felt she needed to, and I thought that a lack of movement would be to her detriment. She clearly wanted to be in a fetal position. I was not going to restrain her hands in that sidelying position, and because she was dysphoric and confused, it was making her worse to be restrained. I very rarely feel it’s necessary to restrain people. Usually kind, gentle words, and caresses, and giving them the understanding that they’re safe and healing seem to work a lot when they are not in danger of actually altering their clinical course by extubating themselves and endangering their lives.

Interviewer: You seem to put a lot of emphasis on the fact that she wanted to be in a prenatal position. What’s your understanding of this?

Nurse: I’m sure she felt very threatened, and she wanted to be in a safe position. I didn’t want to take that away from her. That was her way of comforting herself. And, she’s like a primate after all, right? (chuckles) In a way, she was acting that way. [Referring to the early stages of waking from anesthesia.] I didn’t want to take away her natural instincts to protect and comfort herself. I know my colleagues were looking at me, saying (whispers), “What is she doing? She took the restraints off, you know.”

It is evident that the nurse is breaking informal rules about using restraints in the recovery room, but this is an ethical stance. She rarely finds it necessary to use physical restraints. Instead, she relies on touch and verbal reassurance. She can do this in the recovery room
Infants need to learn to be comforted by human touch and physical comfort measures. The absence of soothing touch causes sensory deprivation when the infant is old enough to tolerate soothing touch. The absence of soothing touch, change in position, swaddling, or a decrease in stimulation can also inappropriately increase the need for pain and sedation medications. This kind of problem solving related to comfort measures for premature infants is demonstrated in the following observational interviews.

**Nurse 1:** When the patients come in, I usually touch them and say, “Mr X., your surgery is over. You’re in the recovery room now, things are going well, you’re just waking up. You may be experiencing some very different sensations, but they will go away as you wake up. I’m going to take your blood pressure now, and the doctor is going to give me report.”

**Interviewer:** How was your care of this baby different from a baby that isn’t psychiatrically disturbed? I’m wondering about comfort procedures, and you’re talking about having a hands off approach with this baby, and I’m wondering about other babies. You don’t think about being hands off with babies, you think of comforting them. It seems to be a very different framework you’re working with.

**Nurse:** It depends on the level of illness of the baby. A lot of times we’ll turn babies who have an illness, or who maybe had surgery. We’ll be hands on with them and they find it comforting when they’re crying or making crying faces or whatever. You can pat them and give them a pacifier, put them in a comfortable position, get them flexed and things like that, and those interventions do help. With very fragile babies...
or small preemies, they appreciate it more if you keep your hands off them; they
don't like the comforting, it agitates them.²

Interviewer: Does that cause problems with the parents? ²

Nurse: It can. We do try to explain to them, particularly with the preemies, that there
are touch times and non-touch times, and you have to try to explain to them it’s not
that the baby doesn’t like them, but that preemies aren’t sufficiently developed
neurologically to be able to process the handling and it can cause them a lot of
autonomic instability. We watch the monitors and teach the parents to watch the
monitors, to know when the baby has reached his or her limit and when it’s time to
leave him or her alone.²

The relational ethics of touch for premature infants, infants, young children, adolescents,
and adults vary, just as they vary with the patient’s condition, preferences, and needs.
Intrusive, boundary-crossing, inappropriate, and unwanted touch must be avoided, but the
dangers of inappropriate touch must not prevent comforting touch and human comfort
measures.

The relationship between healthcare providers and patients creates a “disclosive” space,
where solace, trust, and reassurance can occur. By disclosive space, I mean the social
space created by human relationship and interaction that makes it possible to disclose
and notice some things and not others. Suspicion and fear create a constricted disclosive
space focused by fear and suspicion. Touch and other physical and emotional comforting
measures are central to creating safe disclosive spaces. This involves good relational
ethics and skillful ethical comportment. Such skillful comportment is evident in the
following observational note:

Nurse A. drew up the medication and mixed in the intravenous solution for the
infusion pump. She was quite unobtrusive in her work. She eased in quietly, looked
at them [the husband and wife] so that if they wanted anything she would recognize
it, but did not make distracting conversation. I got the sense she had a deep respect
for them both and for their need for privacy. In an unusual way, she helped maintain
their privacy and preserved their dignity. She conveyed a different message from
most healthcare providers. The way in which most nurses go about their work
conveys that this is their room in a very subtle way. I had the distinct impression
that Nurse A. felt more as if it was the patient’s room. That difference in
understanding changed her way of being in the room. One could see respect,
honor, and humility. The only times her way of being changed back to the typical
perspective was when she had to do a procedure, which required her direct
interaction with them. Then she entered and initiated communication in a very
confident and knowledgeable manner. Otherwise, she took her cues for
psychosocial intervention from them.²

The nurse-patient relationship sets up the conditions of possibility for patients to disclose
their concerns, fears, and discomforts. If the nurse is too hurried or too task-oriented to
notice the patient’s and family’s experience, then the level of disclosure on the part of the
patient or family will be constrained. Likewise, the nurse’s attunement and engagement
with the patient allows the nurse to notice subtle changes. Caregiving relationships may
open up possibilities or close them down. But even with the best intentions and ethical
comportment, the one being cared for may not be able to respond to care.

Outcomes in caregiving relationships are necessarily interdependent and mutual. Some
types of influence are morally unacceptable such as manipulation, coercion, or misuse of
professional influence in persuading a patient to accept a treatment. When things go well
and the patient or family is able to respond to caring practices, the practitioner cannot
attribute the good outcome solely to the efficacy of some technique he or she may have
used. The current focus on “prespecified outcomes” and identifying and evaluating
nursing outcomes in case management is based on the premise that only technique is
involved in healthcare, that one knows the outcomes to expect, and that all things can be
fixed. Herein lies the fallacy of thinking that what can’t be counted doesn’t count. The
problem is further complicated by institutional constraints to good caregiving. Meeting
and responding to the other may clash with the bureaucratic goals of care for the many in the
most cost-efficient manner. All of these aspects of rationalizing practices within an
organizational setting push comforting practices to the margins, devaluing them and
rendering them invisible.

We can make comforting touch and human solace more visible by observing and
articulating the skillfulness of comforting measures. Endangered arts of comforting,
reassuring, and providing solace in the midst of human distress are too life giving and
restorative to be squandered by inattention and lack of visibility. How do we teach them?
By noticing and valuing them, acknowledging them, and providing examples of excellent
comforting practices. The examples cited in this article are given in the hope that they will
be extended and valued by others, bringing the artful practices of comfort, presence,
touch, and solace back from their precarious position of invisibility and endangerment.
Touch can be nurturing, comforting and warm. It can also be invasive and violating. This paper examines what touch would mean within the therapeutic relationship for the client who, for example, has suffered traumas of commission in early childhood. Finally, I will discuss the role of the therapist. There are therapists who touch and those who do not. Touch may help the therapist to provide real or symbolic contact and nurturance, to facilitate access to exploration of, and resolution of emotional experiences, to provide containment, and to restore significant and healthy dimensions in relationships.

REFERENCES