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Care giving and nursing, work conditions and humanitude®

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Abstract. Increased lifespan in western societies causes the increase of hospitalization in the old age, notably for patient showing forms of dementia including Altzheimer disease. These patients relate poorly to care givers and nurses, and cases of maltreatment have repeatedly been reported. To prevent abuse and increase patient's quality of life, Gineste and Pelissier (2007) proposed a philosophy of care based on the Humanitude® concept. Acknowledging that being human is being vertical and related to other humans, the pillars of Humanitude® are gaze, touch, talk, and standing. These modes of relation are systematically developed in care giving techniques derived from the concept. After several studies in geriatric hospitals, to assess psychosocial and ergonomic aspects of work, we present an analysis of the gap between the logic of human care and the logic of hospital organization, impacting employees work conditions and psychological welfare. Care giving is not only a "one to one" relation with the patient but needs to be integrated in the whole organization. Psychologists and ergonomists should be instrumental in defining the project and the organization linking human care giving towards the patients and better work conditions for healthcare employees.

Keywords: work analysis, care, maltreatment, humanitude, burn-out

1. Introduction

The care of institutionalized older people and the prevention of maltreatment has benefited from the concepts of Humanitude developed by Gineste and Pellissier [2]. However, the techniques of care are essentially focused on interpersonal relations. Several investigations in Psychodynamics of Work have emphasized the role of organizational environment and tasks distribution to prevent the conditions of maltreatment Esman et al, Molinier [1-3]. The ergonomic approach could help define the organizational environment for a better care.

2. Methods

We conducted work conditions and psychosocial assessment in several geriatric institutions, and related our observations to the concept of Humanitude as applied to the care of older people Gineste and Pelissier [2]. We used the methods of ergonomic work analysis: document analysis, individual and group interview, observations of work activity.

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3. Results

3.1. Dissatisfaction at work

Interviews with employees of care institutions for the dependent elderly (EHPAD) show a common concern: dissatisfaction at work in a system aiming at more humanitude while organizational change for more productivity and cost cuts are the rule.

- "I like my job and I like working with elder people, but the work conditions are deteriorating ».
- "I feel that I cannot fulfill my assignments and that I am not doing my duty as I should"
- "When I leave work, I feel I did not finish the job"
- "When the bell rings, calling from a patient's room, I sometimes do not go… I have no time"

Our observations show that institutions are well equipped and that the staff is trained in postural ergonomics and the principles of humanitude based on touch, gaze and talk in the relation with the patient. Thus complaints are not related to the physical strain of work but aim to the organizational and psychosocial factors.

3.2. Hierarchy and spatial organization

The hierarchical organization is strictly defined and the Medical Doctor is the only person entitled to diagnosis and prescription. The nurse will deliver the treatment and the nurse assistant is in charge of corporeal hygiene. Non nursing staff comprises of catering and animation staff related to the administrative hierarchy.

The pyramidal "top to down" organization is associated with specific space and time during the transmission briefing which occurs between consecutive shifts.

The transmission takes place in the nurses' office, and the MD is not usually present. In the center of the space is the computer which supports the prescription of the MD, history and traceability files. On a first circle around the computer are the nurses entitled to transmit and discuss the patient's status. Around this inner circle, a second circle consists of the nurse assistants. Most of information circulates from the outer circle to the nurses and is recorded on the computer. Nurse assistants which are the closest to the patient provide information to the inner circle. A third circle, including staff not giving care (cleaning and catering staff), is only listening. This staff has extensive relations with the patient but no time is planned for non-medical considerations in the transmission briefing.

3.3. Dissociated organization of work

In elder care institutions, the organization of work separates care, catering, and animation. Employees involved in each of these activities (nurses, nurse assistants, catering and animation staff) work together within a set timeframe and in accordance with the physical abilities of the patients. Each activity is linked to the end and outcome of the preceding activity.

We observed a deficiency in anticipation of work and a subsequent lack of coordination. Different services would cooperate but the frame of their co-activity is not defined and organized.

Humanitude states that all staff relating to the patient are co-actors of the caring process, this does not translate in organization, even though the principles of humanitude are highlighted in the care project.

Integrating medical and no-medical activities in an extended conception of care giving, as advocated in the philosophy of humanitude, demands organization. To promote multidisciplinarity around the patient, one needs to overcome the medico-technical aspects of care and emphasize the integration of all activities centered on the patient.

The patient is not split between care, food and animation; the patient is body and mind, and the elder needs to be treated as an entire person. The failure to organize work for the sake of the patient as a whole leads to discomfort, maltreatment and abuse.

The institutional statements on well-treatment and humanitude have raised the standards of work practice. However, there is a significant gap between this renewed prescription of work and the real activity of work as observed in the care institutions we studied.

4. Discussion

4.1. Aging in care institutions

Aging is a gradual process modifying the structures and functions of the human body as a result of time. In modern western societies, physiological and cognitive changes are perceived

around 35-40 years old but do not affect life organization before much later in life. The steady decrease in physical abilities is balanced by the relative increase of alternate modes of coping and regulations to maintain physical and mental activities without disconfort. However, aging processes differ from one individual to the other and life expectancy varies according to individual history.

We are concerned with specialized care institutions for elder people who cannot perform usual life activities and have to be cared for. The old person in care institutions experiments or will experiment dependency. In a number of cases, the choice of being placed in care home is not his own.

Institutionalization is a real disruption in previous life experience, a disruption of former social and community links. The institutionalized patient needs to build new links inside the institution with the residents and the care givers. Exiting the institution is rare. The physical life environment is also largely different, oriented to care, handicap and end of life. The institution (EHPAD) is a shared space, where intimacy is rare. If individual rooms could be customized to the patient's will, each is freely accessible to nurses, assistants and doctors. The timetable is imposed for most of daily activities (toilet, nursing, cleaning the room, eating etc…).

Thus the institution appears to be a professional environment imposed on the residents. Daily life in this environment is a compromise between different professional constraints, individual care and community management. This compromise could be misbalanced to the disadvantage of the patient leading to maltreatment or abuse.

4.2. The philosophy of Humanitude®

To prevent abuse and increase patient's quality of life, Gineste and Pelissier [2] proposed a philosophy of care based on the humanitude concept. They state that being human is being vertical and related to other humans: the concept of humanitude emphasizes the role of gaze, touch, talk, and standing in the care relation with the older disabled persons. These modes of relation are systematically applied to care giving techniques derived from the concept. Through the review of what makes an interpersonal link specifically human, the authors aim at linking science and conscience.

Before engaging in any care activity, the caregiver should establish and instruct the social link with the patient through gaze, touch and talk. The caregiver should also encourage physical autonomy, since the body is seen as a dynamic construction reinforced by movement. Establishing this human link costs time. Under tension or time pressure, the caregiver is often trading off between doing fast without relating to the patient or taking time to engage with the patient according to the prescriptions of humanitude. The tradeoff could be detrimental to the patient; indeed, Gineste and Pelissier state that social links, dialogue and movement could succeed where mere medical technique would fail.

4.3. Workplace suffering and the conflicting logics at work

The gap between what the nurses and employees should have done, and are willing to do, and what they can actually do generates frustration and workplace suffering.

This is the main source of psychosocial risks, which factors are:

- the non-recognition of work
- professional dissatisfaction and the feeling of not being able to work properly
- paradoxical requirements in performing the tasks

Employees do not lack motivation, nor training or tools, they feel the lack of time to carry out all the tasks they have been assigned to. The prescribed tasks are actually finalized, but not as they should be according to the worker's perception of professional ethics and quality standards.

We observed that, in some cases, well-treatment and humanitude can become a factor of the deterioration of work conditions, although they are supposed to give sense to the work and enrich work activity. Work conditions deteriorate when the worker cannot manage to do what he is asked to do, and what he feels appropriate to do. This is usually defined as the situation of professional stress and could lead to burn-out.

5. Conclusion

We have shown that humanitude cannot only be a different personal contact with the patient. As it is included in a work environment, ruled by time and tasks, it should be integrated in work organization. After the development of specific individual training

on well-treatment, institutions now need a transversal approach across different sectors (medical, catering, animation) to get closer to the expected standards of humanitude.

Individual behaviour is a crucial factor in humanitude, however the act of caring takes place in the interaction of different professional activities. A multisector organisation is needed to inform, regulate and anticipate work activity.

Well-treatment as a goal, is the result of a coordinated and collaborative process encompassing:

- Giving to the institution's employees the ability to make sense of their work by providing a humane care to the elder.
- Develop, organize and activate the means of work load regulation to face variations in the relations with the patients.
- Develop an organizational image of well-treatment and adapt the integration process for new staff
- Include psychologists and ergonomists in the development and implementation of institutional projects
- Reconsider care including all the actors of the relation with the patient, even those now considered as "non caring" staff.

For institutions, it is particularly important to set up and formalize institutional projects including the material means to develop a comprehensive care concept including all professionals. We notably encourage a double headed management system (medical care and catering/animation) which would promote collaborative work.

Organized collective work activity is the key to actually deliver a more humane care to the patient without inducing professional stress. Care institutions need to shift from promoting individual behavioral changes to a real organizational change to provide the concrete means to develop a more human care relation.

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