The Importance of Time in Ethical Decision Making

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Departing from a contemporary novel about a boy who is going to die from leukaemia, this article shows how the dimension of time can be seen as a morally relevant category that bridges both 'dramatic' issues, which constitute the dominant focus of bioethical decision making, and 'undramatic' issues, which characterize the lived experience of patients, relatives and health care workers. The moral task of comparing the various time dimensions of a given situation is explained as an act of 'synchronizing' the clocks. Ethical sensitivity and competence are presented as core skills that allow a continuity of care in situations where dramatic issues seem to be resolved, but undramatic ones are still not addressed. A nine-step model of shared decision making is proposed as an approach to identifying critical junctures within an illness trajectory and synchronizing the clocks of the involved actors.

The dramatics of ethics

Ethical decision making is often seen as a dramatic process in which crucial steps have to be taken that always become a matter of life and death. This is obvious when decisions have to be made about withdrawing a brain-dead patient from a ventilator or withholding antibiotics from a bedridden patient who suffers from advanced stage Alzheimer's disease. Although they are not the only ones that shape the moral work of contemporary health care delivery, such 'dramatic' issues arise as dominant themes in bioethical casuistry and research.[1] They look for a balance between ethical, legal and societal claims and the goals of medicine as an enterprise that serves humankind. In order to prevent having to make dramatic decisions, a huge amount of policies, clinical guidelines for ethical decision making and institutional forms of ethics consultation have been formulated. They are either an expression of an existing consensus or, where such a consensus cannot be assumed, of procedural pathways that foster a balanced moral reasoning. Policies and guidelines concern topics such as physician-assisted suicide, access to right-to-die organizations in health care institutions (in countries where this is legally permitted or condoned[2]), declaration of death, distributive justice in the allocation of scarce health care resources, participation of patients and healthy

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people in biomedical research, genetic counselling, etc.[3–5] They are addressed to patients by protecting their rights in various situations, but also to health care workers, acknowledging the moral responsibility inherent in their daily work.

From a narrow point of view, ethics is seen as a way of thinking and acting exclusively in dramatic settings. Testimonies from early nurse members of ethics committees described that they felt excluded. They reported their first experiences on such committees more as 'survival' than active participation in decisional processes.[6] Findings from qualitative and quantitative research show that nurses find themselves acting not only in dramatic scenarios as described by classic bioethics, but also in silent or apparently 'undramatic' scenarios that are only seldom the subject of explicit ethical discourse.[7] These are issues that are present in daily practice, shaping the moral work of nurses and contributing to the 'relational construction of identity'.[8] If addressed, they lead to significant patient and professional satisfaction; if not, there is growing evidence that they lead to professional resignation and distress.[9,10]

Dramatic and undramatic issues: the double focus of nursing ethics

Nursing ethics had to focus on dramatic issues as a part of daily nursing practice shared with other health care professionals. Yet, nursing highlighted particularly the undramatic issues, such as the role of relationships and gender in decision-making processes,[11–13] the distribution of decisional power, and the mechanisms of empowerment and disempowerment of patients, relatives and health care workers[14] because nursing is highly influenced by the caring approach as a normative theory of ethics.

There are many settings in today's health care practice where dramatic issues seem to be dominant, such as in bone marrow transplants, emergency rooms or intensive care units. Nurses work in a context of *prima facie* settled priorities in order to preserve patients' lives or to recognize circumstances when death can be allowed. Distinguishing dramatic from undramatic issues may be useful in moments when priorities have to be set in the course of an illness trajectory in order to discuss treatment goals. This distinction should not imply hidden presumptions about their relevance or irrelevance from a moral point of view. Owing to proximity to the patient, the moral challenge of nurses consists in special attention to undramatic issues concerning patients' lived experiences. Nurses recognize patients' strategies of coping with life-threatening illnesses and attempts to reconstruct and preserve personal identity, connecting past, present and future in a perspective of continuity and growth.[15] In such a perspective, undramatic issues are deemed of equal moral relevance; that is, they are able to shape the nurse–patient relationship and to guarantee a continuum of care that is independent of therapeutic goals. I will consider a narrative approach to this question. Departing from a novel about a boy who is going to die from leukaemia, I want to show how time can be seen as a morally relevant category that bridges both dramatic and undramatic or silent moral aspects of the work of nurses as well as doctors. This claim is based on Storch and Kenny, who point out that: 'Medicine and nursing share a common history of bringing knowledge and skill to the care of sick people, but with distinct cultures of professionalism' (p. 483).[16] A broader notion of knowledge and skills is here presupposed, including a holistic view of medical, psychosocial and spiritual topics. These are seldom objects of bioethical decision making and are therefore deemed undramatic, but they shape patients' experience and ability to cope with life-threatening illnesses. For health care workers, undramatic issues are highly relevant because they open a hermeneutical window to patients' experiences.

Oscar and the importance of time

The French philosopher and novelist Eric-Emmanuel Schmitt depicts in his novel, *Oscar and the lady in pink,* the journey of a 10-year-old boy who suffers from leukaemia.[17] All curative attempts have failed, including bone marrow transplants. He spends his last days in the children's hospital. He knows that he has to die, and so do the nurses, doctor and his parents. Nevertheless, there is a conspiracy of silence hiding from Oscar how things really are. Granny Rose, an old lady and a member of the volunteers known as the 'pink ladies', visits him every day of his remaining 10 days of life. Two destinies now intertwine, and they become friends, but they become also teacher and student to each other. 'Granny Rose, I feel like no one's telling me I'm going to die.' 'Why would you want people to tell you, Oscar, if you already know?' (p. 9). Granny Rose advises Oscar to keep a diary and to write to God about every day of his remaining life. 'Starting today, you'll treat each day as if it counted for 10 years.' 'So, in 12 days' time, I'll be 130!' 'Yes, can you imagine it?' 'Granny Rose kissed me ... then she left' (p. 27). Oscar follows the advice, and so, in his brief and restricted existence, he lives the peaks and troughs of life. He falls in love with Peggy Blue, a little girl who is scheduled for cardiac surgery. He initiates one relationship after another and tears down the walls of silence between doctors, nurses, parents and other children. The last chapter of his diary is the shortest: 'Dear God, a hundred and ten. That's old. I think I'm starting to die' (p. 86). It is Granny Rose who completes the last pages of the booklet: 'Dear God, the little boy has died. I will always be a lady in pink but I won't be Granny Rose any more. I was only that to him (p. 87).' Time is relative; the intensity of what we live has nothing to do with the measurable chronological extension, for example, minutes, days and years. Physics and philosophy share the same findings, as well as theology, which focus from temporality to eternity. We live *at* the same time, but we also live *in* different times. When there are no more stem cell transplants to offer to Oscar, the language of treatment grows silent, the finitude of life becomes dramatically obvious and the ambivalence of always being busy when entering the sickroom disappears. At first, from the perspective of nurses and doctors, everything important has been said, there are no more dramatic decisions to be made, only to wait and let nature take its course. Just then, Oscar begins to live: he expresses in poetic terms the elements that are considered essential to recognize meaning in life, which becomes daily more important. As fears rose and hopes disappeared, Oscar experienced the gifts of friendship and love, the preoccupations of daily life, even caring for an adopted old teddy bear.

The times we live and the clocks we carry

When no more dramatic decisions had to be taken and everything important seemed to have been said, communication stopped, but Oscar's growth continued. Although he struggled with the decay of his body, in his last 10 days he is experiencing life, and not just waiting for death. The dichotomy between the two perspectives of 'experiencing life' and 'waiting for death' is the dominant theme in which the relationships of Oscar with his parents, the ward nurses and the doctors are depicted. From a moral point of view, one consequence of this dichotomy is that his needs are neither understood nor met by health care workers or relatives, with the exception of Granny Rose. If the metaphor that we live at different times is continued, it is possible to say that we also carry with us different clocks. These clocks tell us what time it is: they orientate us and tell us what we have to do in specific circumstances. These clocks are made up

of our values, created by education, scientific knowledge, professional virtues, and cultural and religious beliefs. For Oscar's doctors and nurses, his hourglass has nearly run through, but he himself had just begun to experience life; he even spent one night in Peggy Blue's room and was not impressed when the ward nurse shouted and pulled him out the next morning.

Ethical sensitivity and competence

A first ethical stance may lead us to realize that we live in various times. Not only do we each carry different clocks, but our own clocks vary in different circumstances. Yet for the quality of human relationships it is essential that we understand in which time the people around us live. This is what is meant by ethical sensitivity.[18] The professionals around Oscar did not realize that, after the dramatic decision not to proceed to a further bone marrow transplant, Oscar lived in just a few days the undramatic and silent highs and lows of a whole lifetime, and experienced an abundance of impressions that prepared him for his imminent death. Unfortunately, none among the doctors, nurses and his parents was able to read the face of this clock; only Granny Rose did that.

A second stance, ethical competence, is the essence of ethical reflection because it can lead to synchronizing the various clocks by recognizing the values that are at stake and preparing any course of action.[19] Sensitivity to what we hear and feel, but also competence in facilitating good decisions, are the main ethical skills required for daily medical and nursing practice. Both are necessary for understanding the 'ethical metastory' that precedes any nursing action. Metastories can be shaped by dramatic changes in a person's life. They can also be shaped by silent changes or by convictions and values that are not subject to change. They are ways of putting things together, connecting experiences and constructing meaning. Nurses can be active parts in this construction of meaning.

> When someone, such as a patient, tells a nurse a story, however short, this nurse and patient together create a bigger story, however limited. This metastory enables the listening, reflection, challenge, and perhaps re-ordering of values and beliefs that are called for and which will constitute the *telos* [goal]' (pp. 65–66).[20]

Thus, both ethical sensitivity and ethical competence are rooted in the relationship as the basis and vehicle for ethical action. Using the clock metaphor, ethical sensitivity and competence are ways of recognizing what time patients' and professionals' clocks show, and what steps can be taken to bring them closer together.

Reasons and values

Time is pivotal, not only for understanding which goals medicine should pursue following an individual course of illness, but also for discovering how individuals cope with illness and become able to develop new perspectives.[21] The combination of both dimensions is essential for understanding the context of such decision making, where the dramatic issues are quickly solved, but the silent ones remain unanswered because nobody feels able to speak for the persons who experience them. Oscar proved that this applies also to a child. Through fiction, the author used his own experiences with illness and the silence of an intimidated world faced with the life-threatening condition

of a child. Patients, relatives, doctors, nurses and co-workers all lived in varying times and argued in different ways.[22]

Reasons are never actor neutral; explanations and justifications are rooted in personal, medical, scientific, professional and cultural values. They make evident why we think and act as we do. There cannot be any 'medical' reasoning existing independently from the reasoning of the patient or the nurse, because every 'set' of reasons stands for a perspective on a certain situation. The task of ethics is to bring these perspectives together, to initiate a dialogue by considering and comparing values and ways of reasoning. In the case of Oscar, this did not happen. The clocks had not been synchronized. It was the missing dialogue that caused him suffering, loneliness and exclusion from the adult world, with the exception of Granny Rose, and not the fact that he was dying from an incurable illness.

Synchronizing dramatic and undramatic issues around life and death

For little Oscar, the dramatic situation in which different time notions collided is the situation of relapse of the disease. The term 'relapse' indicates a falling back, stumbling, not fighting any more against an enemy and even yielding to the enemy. This martial metaphor is not free of a sense of guilt: the patient does not prove to be a good fighter despite the efforts of professionals or of a stem cell donor. Generally, the challenge of relapses in the haemato-oncological context is that it forces professionals to make dramatic decisions, to look at the next step and to search for co-operation with patients.[23] This decision has direct short-term consequences for the survival of patients. There is no delay possible. In such situations, even the definition of palliative care formulated by the Word Health Organization is not much help: 'Palliative Care provides relief from pain and other distressing symptoms, affirms life and regards dying as a normal process, and intends neither to hasten nor to prolong death.'[24]

Is it possible that dying in the bone marrow transplant context can be seen as 'normal'? When are we hastening or prolonging dying? Does it not depend on the clock we work by, which tells us whether it is 'too early' or 'too late', whether the patient is too well to die or too sick to live? Objective data are based on clinical experience and research and refined risk assessments exist. Yet, every answer to this question that is apparently objective and scientifically sound is also a matter of values and therefore an expression of silent issues that hide behind the dramatic ones. The underlying assumption of the World Health Organization definition of palliative care is that there is a normal process of dying that should not be hastened or prolonged. How does the notion of normality of the process of dying fit into the bone marrow transplant context? Life and death are mostly a matter of decisions to treat or not to treat. A large European study about end-of-life decisions in intensive care units showed that 70% of all intensive care unit deaths were preceded by a decision either to discontinue life-sustaining therapy or to refrain from commencing it at all.[25] When the means for prolonging life are available, death is primarily a matter of decisions and not of 'natural processes' that occur without human interference. At first sight, this finding is neither good nor bad; it is simply the consequence of the medicalization of life. It shows that behind every dramatic decision about life and death are silent decisions about the value of life, the patient's will, and the search for meaning within suffering.

Illich criticized medicalization as an act of incapacitating citizens.[26] However, this assertion fails to recognize that society itself creates myths, hopes and fears about longevity and a life devoid of suffering. From a constructivist point of view, medicine can be seen as an enterprise that strives to get close to the vision society has about its goals. We should therefore be considered victims of medicalization only as far as we are considered victims of our own visions. There are not victims on one side and authors on the other; we are victims and authors at the same time. This closeness of hopes and fears becomes particularly evident in the haemato-oncological context, where Oscar's journey takes place. It is not the dramatic fact that our life is medicalized and depending on decisions about technology, drugs, treatment, etc. that is ethically controversial. Rather it is the fact that we have the moral obligation to continue to care once dramatic decisions have been taken. In Fry and Johnstone's words, 'the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected' (p. 212).[27] Thus the nursing profession has a genuine moral calling to consider not only dramatic issues concerning life and death, but also silent issues and 'soft' skills such as communication and patient empowerment, and also the organization of work. Only by considering both at the same time can nurses achieve a balanced moral reasoning and a synchronization of the clocks whose dials they read.[28]

Dramatic decisions and the continuity of care

For the assessment of dramatic decisions, as in Oscar's case, to refrain from further stem cell transplantation, there are classic, well-described pathways. When there is a therapeutic rationale the patient can give informed consent and the required means and skills are available, and stem cell therapy may be performed, but also the treatment of opportunistic infections or blood transfusions. In dramatic situations, the main questions are:[29,30]

- What is the goal we want to achieve? What is the benefit to the patient of this treatment? What are the risks and burdens being imposed?
- What are the information level and will to live of the patient? What are his or her values? Which interventions are needed to make him or her able to decide? What are the benefits, risks and burdens of reaching these goals?

If a dramatic decision has been taken (e.g. that there is no rationale for continuing a particular therapy) there remains a moral duty to offer the patient adequate symptom control and care. In the bone marrow transplant context, there is no moral distinction between a relapse-related or a transplant-related death, as in situations of graft-versus-host-disease or aplastic pneumonia. In such situations the cause of death is always the illness itself.[31] The British Medical Association[32] and the Swiss Academy of Medical Sciences[33] repeatedly state that there is no moral obligation to begin or continue life-sustaining therapy when the course of illness shows that further treatment is not appropriate. Why then do nurses experience difficulties in such situations? Why can communication within the team be so difficult? I do not think that there are 'sentimental' nurses on one hand and 'rational' doctors on the other. Rather, there are different 'rationalities', that is to say, different ways of giving good reasons and explanations for personal opinions and behaviour.

Within the framework of nursing action, nurses waver between two fundamental intuitions that arise spontaneously.[34] At best, they lead to reflection and dialogue; at worst, they lead to moral distress. The first intuition is that, when caring for severely ill people, we have first to give time to enhance a 'natural course' of life or to permit a natural course of death. The second intuition is that we first have to alleviate present suffering and avoid future suffering. This implies that we will not impose the burdens of a risky treatment without a possible benefit. We may intervene and in our wish to alleviate suffering we may also shorten life. Should we wait, giving nature a further chance, or act to relieve suffering? The contradiction of these two moral obligations characterizes situations of relapse and the setting of priorities in deciding about the next step. They explain the moral challenge of dramatic contexts of decision making.

Withdrawing a life-sustaining treatment often seems to be morally less controversial because it is the course of the illness that seems to determine the logic of treatment. We gave time; we did our best; we offered further treatment in situations of relapse. Now, the condition of the patient is worsening and there is evidence that the illness trajectory cannot be influenced by treatment and 'nature' seems to intervene. The underlying assumption is that any further treatment will be futile. Considering a course of action as futile can be scientifically or statistically proved and we may also reach a consensus about it. This always includes a value judgement of a given situation, that is, the remaining quality of a given life.[35]

Withholding life-sustaining treatment is the opposite of giving time: we are not willing to grant further time to achieve an unreachable goal. By limiting curative treatment, we set a different goal: we want to give a human response to suffering because the underlying assumption is that every further treatment will be futile.[36] A value judgement of a given situation or life is made. The price of following this intuition is the feeling that we cause death and provoke an unnatural or perhaps premature ending of an individual's life.

In 1969, Kübler-Ross formulated a vision of a patient-centred approach in palliative care, with a network of different professional skills in which the words 'death' and 'dying' were not marginalized.[37] The transition between cure and palliation was not yet part of the self-understanding of modern medicine, although it was part of its daily practice and experience. The presence of suffering, death and dying could never be eliminated, and medicine never aimed to do so. It was only the concept of palliative care that opened eyes to more research and development of knowledge and skills in this field. A continuation was suggested between cure and care, which was a dramatic change in the logic of treatment for patients who were like homeless people when curative options stopped.[38] In these classic situations (many of them oncological), the underlying assumption is that there is a transition, and that there is time to go from cure to palliation.[39]

Transitions in the goals of care

In the bone marrow transplant setting and situations of relapse, however, this linearity does not exist. Life and death are matters of decisions from the beginning of the first symptoms of leukaemia. We always give time or take time away. There is no transition, as palliative care suggests; but there are many transitions from curative to palliative. We often do not know under which banner we carry out a treatment. Some of the transitions are invisible, small and silent. There may be curative islands in an

apparently palliative context. An initial good response to stem cell therapy and the successful treatment of stomatitis are important examples, as are the treatments of pain, anxiety and psychological suffering. Disagreements between doctors and nurses about the goals of the therapy they want to offer to the patient is often the first source of conflict among team members. Such conflicts arise when the patient's perspective is not included.[40]

Continuous relationship awareness

As Oscar's story shows, after the verdict that nothing more can be done for him, clocks begin to run separately, communication stops, and the embarrassment of the parents, doctors and nurses grows. They do not realize what Oscar is experiencing in his remaining days and the intensity of what he is living with Granny Rose. What are the reasons for this failure? From a medical point of view, there seems not to be an indication for further treatment, but the silent issues behind these dramatic issues are all ignored. Oscar's capability to cope with this situation is neither strengthened nor are his resources acknowledged. Therefore it is not surprising that not a single positive professional relationship experience with doctors or nurses is mentioned. Although the narrative context is fictional, it is clear that even when dramatic decisions have to be taken, silent issues are still of moral relevance and part of professionals' commitment in order to guarantee a continuum of care. 'Data in the literature have consistently highlighted major deficiencies, particularly the risk of ''abandonment of the patient'', where DNR [do not resuscitate] orders are given in order to limit the use of cardiopulmonary resuscitation' (p. 351).[41] A continuum of care is not only related to the physical aspect of care, but to all aspects that shape the nurse–patient relationship.[11]

Gilligan coined the term 'relationship awareness' in the context of adolescent girls.[42,43] Translating this into a context of professional ethics, it is possible to describe the therapeutic commitment of professionals to remain aware of the silent issues even after dramatic issues have disappeared. Patients feel abandoned when there is no relationship awareness.[44] No matter how dramatic or silent decisional contexts are, nurses have the moral obligation to guarantee and/or promote a continuum of care in which the needs of patients are at least recognized, responded to and, if possible, met. By synchronizing the clocks in this way, nursing ethics discovers its original endeavour to point not only to 'strong themes' like illness, disease and care options, but also to 'soft themes' such as the effects of illness, disease and treatment decisions on the life of individuals.

Illness trajectories, critical junctures and reassessment

Every illness trajectory has critical junctures or newly occurring circumstances in which a decision about treatment and care has to be made. Usually, critical junctures are perceived and described in medical terms. Relapse is a typical critical juncture in a bone marrow transplant setting, because it forces a reassessment of treatment; but so also are opportunistic infections, severe bleeding, or depression. Critical junctures are not only medical occurrences; they range from dramatic situations of relapse to undramatic but burdensome social, psychological and spiritual issues. The first and most far-reaching critical juncture is the disclosure of the diagnosis itself and the experience of a life-threatening illness. The sensitivity to critical junctures considers every medical assessment as part of an ethical assessment.

Owing to their proximity to the patient, nurses experience at first hand the variety of critical junctures when haematology patients are struggling with the implications and complications of their illness. Discussing values, rights and duties that are at stake is basic to their work. If this is not possible or not desired, moral distress will be the consequence. This is also the case for physicians, social workers, psychologists and chaplains.

Critical junctures: steps for shared decision making

Only models of shared decision making can integrate the particular views described.[45] Such models centre around the patient's perspective and regard respect for patient autonomy as central. When the degree of patient autonomy cannot be assessed or is not sufficient to meet the prerequisites of liberty and agency, ways of surrogate decision making have to be sought. Shared decision making contextualizes medical facts with legal, social, biographical and spiritual values by involving all the relevant actors. In this holistic approach all the different clocks by which professionals, patients and relatives orientate themselves can be recognized and synchronized. Models of shared decision making include round-table or bedside meetings with all the actors involved, but also ethics committees or case discussions among experts. The role of nurses is essential in such contexts. Owing to their proximity to patients, relatives and doctors, they contribute to the visibility of the different clocks of all the involved actors, expressing their values in dialogue. When values become visible, a consensus or synchronization of different times may succeed. In an acute setting such as haematology, this synchronization may consist of the following steps:

1) *Identify critical junctures* with all the involved actors and assess their importance for them. Are they of the same importance for the patient? If so, have we set the right priorities? If not, what consensus can we reach and where do values differ? In Oscar's situation, this first step would have broken the dichotomy of views between health care workers and parents ('He is dying') and Oscar ('I am living').
2) *Evaluate current treatments* with all involved actors. What burden does the current treatment impose on the patient and what benefits can be expected? For Oscar, an evaluation of the current treatment would have implied a break in the wall of silence, a discussion about adequate methods of palliation and a sensitivity to his unmet needs.
3) *Discuss possible alternatives* with the patient and/or surrogates. Is he or she able to give consent? Are advance directives available? What were his or her former wishes? Are they specific enough and applicable to the current situation? What do we know about the presumed will? Thinking about Oscar, this step would have signified that Granny Rose and how she approaches Oscar is not part of a kind of conspiracy against the established way of approaching patients, but an integrative and essential part of it.
4) *Make out the values* that are at stake from the perspective of the patient, relatives, surrogates, physicians, nurses and co-workers; what is the individual time dimension for each of them? Where values underlying human behaviour are not expressed, human needs cannot be met and the times of these clocks cannot be read. As a consequence, in Oscar's situation, fears, a sense of guilt and betrayed hopes are not addressed by the parents or the health care workers, only by Oscar.

5) *Search for priorities* that meet the needs and wishes of the patient and the values of the involved actors, including morally relevant medical, legal and cultural facts; look for a consensual decision and decide the next step. Reading the different hourglasses and recognizing in which time the involved actors live would have permitted a continuum of care from the start, planning meaningful interventions for Oscar, including Granny Rose, and avoiding a sense of therapeutic abandonment.
6) *Plan possible further critical junctures* in the illness trajectory with the patient or the surrogate. Describe first in a positive way all the levels of the continuum of care that are applicable (measures that may be taken), and then measures that may be withdrawn or withheld in case of futility. For Oscar, this step would have given him the opportunity to discuss the process of dying and the possibilities of palliative care and searching for meaning with the professionals.
7) *Implement the chosen measures* within a personalized plan of action.
8) *Evaluate the measures taken* with all the actors involved in order to prevent complications and enable other patients in similar situations to have similar benefits. In such a perspective, Oscar's situation would not have been considered an isolated incident, but a possible trajectory of illness that deserves an adequate human response, also from a professional point of view.
9) *Reassess the situation* and return to step 1. Although part of professional competence and standardized good practice, such a response always has to be related to an individual person, following the course of the illness and the needs to cope with it.

When critical junctures remain unexpressed, ignored or hidden, nothing else can be offered to patients but the logic of treatment or an embarrassing silence. In Oscar's words:

> With Peggy Blue I read a lot of the Medical Dictionary. It's her favourite book. She's fascinated by illnesses and she likes working out which ones she could have later. I looked for the words that mattered to me: 'Life', 'Death', 'Faith' and 'God'. You're not going to believe this but they weren't in it! Mind you, at least that proves they're not illnesses – life, death, faith and you. Which is good news, really. Still, in a serious book like that there should be answers to the most serious questions of all, shouldn't there? (p. 76).[17]

If we do not have answers to the most serious questions, we should at least search for them together. This attitude is a small virtue, but it has a large preventive effect on professional satisfaction, quality of care, perseverance and professional attrition.[46] As well as that, this is the core of ethics.

The moral dimension of time

An important discovery of nursing ethics in the context of biomedical progress was that dramatic and undramatic issues are of equal importance because both shape human relationships, the rights and duties of patients, health care workers, institutions and society. In mapping the wider context of nursing ethics, Thompson *et al*. distinguish between 'micro, macho, meso and macro issues' in the ethics of health care (p. 127).[29] The micro level is the only one where the relationship with the patient is explicitly mentioned. The levels do not exist independently of each other, but fit closely together, like a Russian doll, with the nurse–patient relationship as the core dimension. As the authors note, 'observation and research in nursing has brought to light the fact that the

issues perceived as important by practitioners and patients may be quite different from those perceived as important by the public' (p. 127).[29] Following Oscar's experience, in a pluralistic, intercultural and fast-changing world there is seldom unanimity about which questions are the most serious. In a health care context that is continuously reflecting about its aims and goals, serious questions will hardly decrease. They may be dramatic or undramatic, such as demographic changes and the growing need for long-term care, the availability of benefits of biomedical progress in a globalized world, justice in the distribution of the burdens of human research etc. Ethical sensitivity is the core skill to answer this question, making nurses and other health care workers able to synchronize the clocks and to recognize the moral dimension of time in their daily encounter with patients.

Conflict of interest statement

The author declares that there is no conflict of interest

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