

Attentive care in a hospital

Towards an empirical ethics of care

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This article is an introduction to our research on attentiveness in hospital care. It presents the theoretical framework in which we carried out our qualitative empirical research, thereby providing an insight into the combination of the ethical and the empirical perspectives. This is done (1) by exploring the different definitions of attentiveness and thereby developing our own definition, and (2) by explaining our empirical approach to attentiveness. 'Habitus' comes to the fore as a fruitful research instrument, and attention is shown to be part of the core business of medicine. However, attention has many facets, and not all of these are equally present in hospital care. It becomes clear that attentiveness can only have its good meaning and effect if it is the right kind given at the right time. Caregivers frequently succeed in showing the proper attention, yet this is often done tacitly: attention is not an easily accessible subject matter, and caregivers do not always use the term 'attention.' Several fieldwork cases are presented through which the complexity of attention becomes evident.

[attentiveness, ethics of care, empirical ethics, health care, habitus]

The painting *The Attentive Nurse* of the 18th-century French painter Jean-Baptiste-Siméon Chardin invites us to think about the nature of attentiveness. It shows a woman wearing light-coloured clothes and an apron, with white sheets hanging over her arm and an egg in her hand. Next to her are some pans, a table with a jug of water, bread, and a plate. The nurse's face is perhaps the painting's most important element: it is tender, patient, and soft, but also resolute and strong, and extremely concentrated. Imagining being this nurse's patient, who is not depicted in the painting, makes us feel confident, trustful of this woman preparing a meal with such great devotion.

Attentive care speaks to one's imagination. This is illustrated by the many care institutions advertising that they provide 'attentive care'. Attentiveness appeals to people who require caregiving for themselves or a family member. Research shows that, according to patients, attentiveness is a crucial component of good care (Johansson et al. 2002; Radwin 2000; McWilliam et al. 2000). At the same time, however,

attentiveness is being put under more and more pressure in contemporary health care. Attention is a hot topic in care, which is also shown by the rise of concepts like ‘attention minutes’ (*aandachtsminuten*) and ‘attention officers’ (*aandachtsfunctionarissen*). The importance of attentiveness in the context of care might seem obvious; however, there is no unambiguous definition of the concept, which is used in various ways. It is not clear how attentiveness should be characterized, what it consists of, and what is needed for attentive care. Our qualitative empirical study attempts to investigate and analyse the specific forms and aspects of attentiveness found in a hospital in the Netherlands. Such a comprehensive analysis of attentiveness contributes to the understanding of the caring side of health provision, a side that is often neglected in the usual deliberations about quality of care but that seems to be highly relevant from the patients’ perspective. Attention to attention is what we need; and an insight into its specific characteristics may be the first step towards more room for attentiveness in health care.

This article discusses the existing multi-disciplinary literature on attention, from which we extract our own definition of attentiveness. Then we present and explain the research question behind our empirical study: where(in) does attentiveness exist in the work of care professionals and in the experiences of patients? It shows how the concept of ‘habitus’ may contribute to a proper understanding. How does attentiveness relate to habitus? Is attentiveness embedded in the habitus of doctors and nurses? If so, how? And if not, why not? Trying to answer these questions may provide a deep insight into the chances and obstacles of attentiveness in hospital care.

Attentiveness

This section discusses the existing multi-disciplinary literature on attentiveness, thereby exploring the different uses of the concept. This conceptualization, or theoretical framework, provides the researcher with the sensitizing concepts necessary for understanding the broad and complex phenomenon of attentiveness. Empirical qualitative research is needed to understand attentive care in hospital practice.

Both attention and attentiveness are studied in various ways in the different disciplines. In the psychological literature, attention is understood to be the cognitive process of selectively concentrating on one aspect of the environment while ignoring other aspects. Focalization and concentration of consciousness are of its essence. Examples include listening carefully to what someone is saying while ignoring surrounding conversations and listening to a cell phone conversation while driving a car (James 1890; Deutsch & Deutsch 1963; Zomerén & Eling 2004). What we learn from the psychological literature is that attention is involved in the selective directedness of our mental lives. The nature of this selectivity is one of the principal points of disagreement between the extant theories of attention. The instances of attention differ in several dimensions: in some cases attention is a perceptual phenomenon; in others it is a phenomenon related to action. In some instances the selectivity of attention is voluntary; in others it is driven, quite independently of the subject’s voli-

tion (Stanford Encyclopaedia of Philosophy). Attention is of philosophical interest because of its apparent relationship to a number of other philosophically puzzling phenomena. There are views suggesting that attention is closely related to consciousness. It is controversial, however, whether the relationship of consciousness to attention is one of necessity or sufficiency (or both or neither). There are also perspectives linking attention to demonstrative reference, to the development of an understanding of other minds, and to the exercise of the will (Waldenfels 2004; Arvidson 2006; Steinbock 2004).

Beside this neuro-psychological and philosophical literature on the phenomenon of attention, there is an extensive amount of philosophical and spiritual work that focuses on the moral value of attention. In this literature, attention or attentiveness is understood as a necessary way of acting or being in order to know (or to help) other people (or things). On this view, attentiveness can be good in itself. According to Murdoch (1970) attention is “an imaginative and normative use of moral vision that burns away the selfishness of natural human desire, leaving behind the purified desire of just and compassionate love.” Weil (1951) writes that attention is crucial for every human interaction. Attention is focused on the other and asks for the suspension of one’s own thoughts and opinions. It is waiting, open, and willing to receive the other. It entails a certain passivity, a lack of will, at least initially. Verhoeven (1972) treats the concept of attentiveness when he writes about ‘wondering’, which he describes as a way to go beyond the obvious understanding. When people wonder, they break through established patterns of observing, naming, thinking and handling. In other words: it is not about categorising someone, but about aiming to learn to know slowly and openly. These works make it clear that attentiveness has to do with recognition: it is all about *seeing* the other. Furthermore, attentiveness is an important concept in mindfulness, a Buddhist concept that is now broadly conceptualized as a kind of non-elaborative, nonjudgmental, present-centred awareness in which each thought, feeling or sensation that arises in the attentional field is acknowledged and accepted as it is. Benedictine spirituality also gives attentiveness an important role, with its maxim: whatever you do, do it with attention (Casey 2005).

As has become clear, attentiveness is an interdisciplinary concept. In the ethics of care tradition, attentiveness is described by Tronto in her book *Moral Boundaries* (1993). Tronto analyses care and describes four phases, which, although conceptually separated, are interconnected when put into practice. She first mentions *caring about*, which involves the recognition that care is called for. It means perceiving the existence of a need and assessing that this need must be met. Often it will involve assuming the position of another person or group to recognize the need. The next phase in the caring process is *taking care of*, which means assuming some responsibility for the identified need and determining how to respond to it. It also means involvement in organisational activities. Third, Tronto describes *caregiving* as the direct meeting of needs. This involves physical work, and almost always requires that caregivers come in contact with those in need of care. The fourth phase is *care-receiving*: this final phase recognizes that the person in need of care will respond to the care received; the patient feels better. What was meant to be good care should be experienced as such.

Tronto includes this phase as it provides the only way to determine whether the care needs have actually been met: sometimes it is hard to identify the need, and in this phase one can check whether it has been done adequately. And even when the perception of the need is correct, the issue of how to meet the need can cause new problems. Tronto couples these four elements with four ethical elements of care, namely, attentiveness, responsibility, competence, and responsiveness. She describes attentiveness as the quality to open oneself to the needs of others.

Baart (2004) defines attentiveness as a socially inclusive act in his theory of 'presence' (2001). He states that what can be good for a care receiver is not always clear from the beginning but is shown in the interaction between caregiver and care receiver. Attention lies at the heart of his work as he begins his description of presence as "a practice in which the caregiver attentively concerns himself with the other, thereby learns to see what is at stake for the other – from desires to fear – and in relation to that tries to understand what can be done in the particular situation" (2004: 40-41) [our translation]. Baart elaborates on the socially inclusive act of attention and shows that it has a double character. He theoretically distinguishes instrumental attention (i.e. to come to a good diagnosis) from beneficent attention (attention for the sake of attention). He emphasizes that attention understood in this latter way is a tricky phenomenon, since it can have a violent character as well as a beneficent one: attentiveness might be related to discipline or control (e.g. by governments, insurance companies).

Our study of attentiveness in caregiving is conducted from an ethics of care perspective. However, we define attentiveness in the broadest and most comprehensive sense, making use of all perspectives described above. Attention is approached as a social phenomenon, and therefore is located at the intersection of attention as a cognitive capacity and attention that expresses itself as care or love. We focus on the beneficent meaning of attentiveness, but its violent meaning will not be forgotten. Beneficent attentiveness is understood as a practice that can, from two sides, create a space in which a relationship may arise. It is the difference between a care connection simply for instrumental reasons and a relationship between a caregiver and a patient in which *good* care can be delivered, that is, care that is received as care, care that makes people feel better. When attentiveness is understood as creating such an intersubjective space, the focus is on neither the caregiver nor the patient, instead the emphasis is on the relation. Indeed, in claiming the importance of attentiveness in care, we are opposing the dominant contemporary view in which care is no more than providing service in a market-oriented, commercial and effective way. With Van Heijst (2005) and others in the ethics of care tradition, we argue for a different discourse when thinking about care, in which care is anticipating someone's neediness or dependence. Competent, technical, medical care is extremely important, but only on the understanding that caregivers realise that reparation of problems, relief of pain, or curing diseases is never a goal in itself. The overall goal of every form of caregiving is to stand by someone who is in pain or misery (ibid.).

An empirical study from an ethics-of-care perspective

Having developed a broad definition of attentiveness through engaging the existing literature, we now address the research question of our study: where(in) does attentiveness exist in the work of care professionals and in the experiences of patients? To find an answer to this question, we conducted an empirical interpretative qualitative study in a general hospital in the Netherlands. We used ethnographic research methods, such as participant observation and interviews, and we tried to shed light on the perspectives of both caregivers and care receivers.

As noted, this study is undertaken from an ethics-of-care perspective. This seems to be at odds with a qualitative-interpretative research design that aims to understand the experiences and considerations of people on their own terms and in their social and institutional context. However, it has become obvious that it is impossible to conduct a study in a value-free and theory-free way. Interpretative research takes place from a certain perspective, however explicitly that may be acknowledged and formulated. Taking a perspective implies regarding certain questions as more important than others and certain answers as more relevant. Our use of an ethics of care perspective and the theoretical conceptualization of attention interact with our interpretative qualitative research. Reflection on this perspective is the key: on the one hand, the perspective drives our questions; and on the other hand, this perspective is developed further through the input of the collected data (Gremmen 2001).

How are we to understand attentiveness in hospital care? Attention is difficult to grasp, as it cannot be directly observed. This leads to some important implications for our empirical study. As we realize that people do not always consciously reflect on their attentiveness, or their receiving of attentiveness, our study looks not only at people's *action* but also at their *behaviour*. It focuses not only on the reflective aspect of attentive caregiving but also on the pre-reflective or subconscious aspect of it. In other words: as the definition of attentiveness is unclear, we do not merely ask people what they think of this phenomenon; rather we try to gain insight into how they experience it. This means that our study takes into account the influence of contextual factors on the way in which attentiveness takes place in practice: the character of the hospital contributes significantly to the appearance of attentiveness. However, although we explicitly mention the importance of context here, we do not see context as something outside of individuals. We seek to avoid this separation in our approach, as we argue that structural factors do not only exist in the context of the wider social field of the hospital but are also embedded in individuals.

Considering these implications for an empirical study of attentiveness, the concept of 'habitus' as developed by Bourdieu (1990; 1977) proves to be a useful research instrument. The notion of habitus helps us overcome the division between individuals and context, as it provides a framework to understand the embodied character of structures, their generative power and their relation to the wider social field. In this way it may assist our study approach and the ethics-of-care tradition in general, as it helps protect us from two pitfalls: the tendency to regard everything concerning

attentiveness as a hyper-individual matter, and the risk of attributing all that happens to contextual, external structures.

What is habitus? Habitus is a concept developed by the sociologist Bourdieu in relation to the concept of 'field'. The concept of field refers to social space. A field is a relatively autonomous space, built around specific positions and institutions and with an internal logic of its own. A social space can be called a field when there is something at stake and people are willing 'to play the game' (Bourdieu 1989). While the concept of field denotes the external social structure of a world, the concept of habitus refers to the internal model of social reality. The habitus develops through a process of socialization and can be defined as a system of dispositions: durable, often subconscious schemes of perception and appreciation that activate and lead the way to practice. The dispositions of the habitus give rise to a limited number of strategies. These strategies manifest themselves in certain visible patterns of behaviour, manners and beliefs: in practices (Bourdieu 1990). Under common conditions, a common habitus comes into being. A common habitus enables practices to be harmonized objectively, without any conscious reference to an explicit norm. The practices of the members of the same group are always better harmonized than the agents know or wish (Bourdieu 1990).

Connecting these ideas of Bourdieu to our research project, the field refers to the hospital, or a particular hospital ward, and the habitus is found in the people working in that field, in our study particularly doctors and nurses¹. Habitus proves to be a useful research tool, as it provides a framework in which structures are seen not only in the external space but also as embedded in individuals. Bourdieu, rather than stating that the active subject confronts society as if that society were an object constituted externally, developed the concept of habitus to demonstrate not only the ways in which the body is in the social world but also the ways in which the social world is in the body: "It is a socialised body. A structured body, a body which has incorporated the immanent structures of a world or of a particular sector of that world – a field – and which structures the perception of that world as well as action in that world" (Bourdieu 1977: 81). Bourdieu considers habitus to be potentially generative of a wide repertoire of possible actions, enabling the individual to draw simultaneously on transformative and constraining courses of action (Reay 2004). While the habitus allows for individual agency, it also predisposes individuals towards certain ways of behaving.

How does attentiveness relate to habitus? This is the question at the heart of our study: is attentiveness embedded in the habitus of doctors and nurses? If so, how? And if not, why not? The answers to these questions may provide deep insight into the chances of and obstacles to attentiveness in hospital care.

Attentiveness in the hospital practice

In this section we present some examples from the fieldwork material, which together show, on the one hand, that attentiveness is embedded in the medical habitus and, on the other hand, that the medical habitus can be a hindrance to attentiveness.

Nurse Jane tells me she has the feeling that she is busy and running the whole day. Now, right after lunch, it is a bit quieter at the ward. “Well, since I have some time, I am going to empty the catheter bags in room 3,” she tells me, “and meanwhile I can give the patients some attention.” While emptying the urine bags, she has short conversations with the patients. Later that day, I return to room 3, and talk to the patients about the nurse. They tell me that this nurse has had a very busy day, and that it was friendly of her to come by for a chat when she had the time. When I ask them how they have experienced this chat, they tell me that it is nice to have some distraction, to have this kind of small talk. I nod. “Could I say that the nurse gave you attention?” I ask them straightforwardly. One of the two patients smiles slightly. The other one tells me: “No, she gave us time.” (Fieldwork notes KK, 2011)

With two young doctors I am discussing my research topic. “Attentiveness?” one of them says, “that is something that takes time. We do not always have that time. But well, ok, perhaps it doesn’t always have to take much time. It isn’t always about talking, you can also be attentive through bodily contact, you know.” His colleague nods, and both tell me that they have bodily ‘tricks’ to please their patients: “A hand on a leg always works!” one of them says. And probably reacting to the amazement on my face, he further explains that patients “in general like physical contact with doctors.” (Fieldwork notes KK, 2010)

In the situations above, attentiveness seems to be consciously given by caregivers. However, it is questionable whether patients in scenarios like these actually experience this attentiveness. Our impression is that there is a gap between what patients and caregivers consider to be attention. What is given as attention is not always perceived as attention. And the reverse is also true: what is received by patients as attentiveness may not always knowingly be given by caregivers. This makes clear why the notion of *habitus* can be a useful tool in our study: it acknowledges that attentiveness may happen subconsciously or pre-reflexively. Attention may exist implicitly in the medical *habitus* and in caregivers’ actions and behaviour.

Mr. Balducci is in the room’s third bed. He is 55 years old and has pancreatic cancer. He was admitted to hospital because of ‘total malaise’, as we read in the patient file this morning. Pneumonia, his file further indicates. ‘Backaches’ and ‘broken right arm’. Mr. Balducci is thin and pale. His dark brown eyes show tiredness; they are closed when he talks to us. Mr. Balducci has problems with standing up. His body is in pain. Nurse Sara gives him instructions on how to rise with less pain. He follows her directions, but still cries out loudly when trying to sit on the edge of his bed. I feel uncomfortable. But Sara stands quietly at this side, her hand resting on his shoulder. Together with Mike, a nurse in training, she helps Mr. Balducci into the chair next to his bed. Later on, that morning, when I come back from a meeting, Sara tells me that something bad has happened to Mr. Balducci. When Mike helped him from his bed to a wheelchair, Mr. Balducci pulled himself up and at that moment his left arm made an awful noise. It is probably broken, and his right arm already was... Mr. Balducci’s wife was with him when this happened,

and because she was panicking she immediately called their children. A nurse took Mr. Balducci to the X-ray centre, and now the patient and his family are back on the ward waiting on the results.

I follow Sara to Mr. Balducci's room. He has several questions, on how to move properly, what to be careful of, whether he still should go out of bed from time to time, and so on. Sara emphasizes that his accident could have happened any time; prevention is impossible, as his body is so frail. [She later tells me that there is probably another tumour in his arm...] The intern [*co-assistant*] comes in; she has seen the X-ray. The arm is broken indeed, and there must follow a consultation with the surgeon to determine the best option for treatment. She tells us she called the surgeons' department, but they told her it is not appropriate for a student to directly call a surgeon. Consequently, we have to wait until she can talk to the doctor in charge, so that he can contact the surgeon. She starts to explain that two forms of treatment are probably being considered: either they will perform an operation on Mr. Balducci to put a pin in his arm or they will give him a sort of brace, which does not require an operation. Mr Balducci's eyes are closed. His family members tell the intern that they want Mr. Balducci to be operated on. However, the intern does not respond. She tells the family to wait for the surgeon's opinion: he has to decide, together with Mr. Balducci's oncologist. After we leave the room, I ask Sara which factors influence the choice for surgery or brace. She explains that "it is not only about the arm and the fracture; it is also about the progression of the cancer. The physician might choose for a brace if it is expected that Mr. Balducci will not have a long time left to live."

In the afternoon, a surgeon comes to the ward to talk to Mr. Balducci and his family. He hasn't spoken to the oncologist yet. Again, the surgeon explains the two options, and tells Mr. Balducci that he will probably get a brace. "Operation might not be appropriate for you," he says, "perhaps it is better to reduce the pain as much as possible." After he leaves the room to call the oncologist, the family members are crying and embracing each other. Back in the office nurse Sara tells me: "I expect they will not operate on him... his liver is so weak." She asks the surgeon about it. "His liver is not a problem for surgery," he answers, "but we have to wait for the oncologist." I realise that the decision depends on the prognosis: how long will this man live? Is it worth surgery? I get the impression that this whole process is sped up because of the broken arm: the patient and his family haven't yet been informed about the bad prognosis.

After a while the surgeon comes back into the room. He explains that Mr. Balducci will get a brace. The family members do not understand. They keep asking whether Mr. Balducci is too weak for the operation. "Possibly," the surgeon answers, "but besides, the brace is the best treatment option for now." The wife and children keep asking questions. They seem a bit pushy, but this is understandable since the surgeon is ignoring their fear and their questions. They want to know how long the brace has to stay. "For a long time..." the surgeon answers, and after a short silence, "for months." It becomes clearer and clearer to me that this family does not understand that Mr. Balducci will die soon. It feels oppressive. (Fieldwork notes KK, 2010)

Reading these observations, it is easy to say that Mr. Balducci does not experience any kind of beneficent attention here, but it is difficult to put one's finger on just what goes wrong. All of the caregivers involved in this case are in a certain way very attentive, but they all have their own area of expertise. It turns out that everyone is attentive from his or her own disciplinary perspective; however no one is really attending to Mr. Balducci's experiences. Apparently, attention is not always a choice of individuals; in this case it seems to be controlled by various structural factors. In using the concept of habitus as a research tool, we examine the way in which structural factors may be at work, both in the external context and as embedded in individuals. For example, we consider not only the influence of external systemic pressure (Vosman & Van Heijst 2010) in the form of protocols (i.e. who should tell a patient about what news?) but also the interpretations of such protocols by the nurse, the surgeon, or others involved. Other assumptions may play a role as well: for example, the perceptions that go with the nursing discipline. Did nurse Sara act on the basis of her (implicit) idea of the nurse's tasks? Or what (tacit) ideas of professional acting do the surgeons hold? As becomes clear from this case, in trying to understand the conditions of attentiveness, it is useful to study the habitus of the caregivers involved. How are they used to acting? What are the unwritten 'rules' of their getting along? And how does attentiveness relate to these? From this specific description, it seems as if there is no place for attentiveness in the behaviour of the people involved. Using the notion of habitus may help drive the questions in a fruitful direction when trying to discern which aspects may play a role.

The assistant physician (AP), accompanied by an intern, makes his rounds on the ward. In room 2 he sits down next to a patient's bed. The patient is an elderly man whose wrinkled face looks worried.

AP: "How are you?"

The patient lifts his upper lip.

AP: "Not too good, hm? With the diabetes and so on ...?"

Pt: "Hm ... no ... no ... it's not the diabetes." [I realize that the doctor is confusing this patient with another, KK]

AP: "[the diabetes, KK] as well, no?"

Pt: "oh ... it's the breathing ... air ... air ..."

The doctor realizes that he has mistaken this patient for another. He quickly takes a jotter out of his pocket, and reads his notes. Then he remembers. He briefly summarizes this elderly man's case (heart, pneumonia, kidneys) and mentions how difficult it is to find a way to 'swim' through all of his problems.

AP: "Pneumonia, that is quite something, that will last."

Pt: "I've had it before."

AP: "How did it pass that time?"

Pt: "It went well. But now it's a struggle."

AP: "We have to give it time. The body needs time. We can't do much more at this time."

Pt: "That's not what I'm asking, is it?" [short silence] "Have you looked at the medication?"

AP: "Yes. I can't really change anything of it..." The doctor explains that he is being careful not to give too many painkillers because of the patient's heart problems.

Pt: "Oh. Well. Hm. It's not to be sneezed at, you know. Last night... last night I was... I felt like... last night I felt like I was already dead actually."

AP: "Not a very cheering thought. Do you feel better now?"

Pt: "Yes. A little. But now I have to lie on my side, to prevent bedsores. After an hour of lying like this I'm exhausted."

The doctor closes the curtains around the bed and listens to the patient's lungs. The intern uses her stethoscope to listen as well.

Pt: "Now, who of you is the better listener?"

AP: "If it's alright, we are both good!" The doctor opens the curtains again.

Pt: "Hopefully they'll come soon, to move me a little bit."

AP: "Yeah, we have to ask them, to ask them if somebody can move you. How does it work with that button?" He presses the button for a nurse to come.

Pt: "Then another of those... those... those frolicking girls (*'huppelmeiden'*) will come..."

AP: "Yes. Er... er... yes..." He laughs a bit. Then, in a serious tone: "I know what you mean." (Fieldwork notes KK, 2010)

This description reveals a caregiver who is trying to be attentive and a patient who does not experience it that way. What happens in this case? In the first place, the conversation has a false start: the caregiver confuses the patient with another one. Fortunately, he is able to correct his mistake by summarizing the patient's condition, showing that he is on top of the situation. Then, the patient complains about his difficulty breathing, thereby asking for attention. The physician, however, reacts by giving attention to the symptoms of pneumonia. Perhaps he wants to allay the patient's worries by explaining that these symptoms fit the illness. Yet to 'justify' the complaints suggests that there is no need to give attention to them. It looks as if there are two different focuses here: the patient is seeking attention for his poor condition, while the doctor's attention is focused on explaining the symptoms. Further, the doctor tells the patient that there is nothing he can do for him at the moment. The patient responds with "That's not what I'm asking, is it?" which can be seen as expressing a critique of the doctor. However, there is no time for the doctor to react, since the patient quickly shifts to the 'world' of the physician: did he take a look at the medication? After the doctor answers, the patient again starts to talk about his experiences; he tries to draw attention to his horrible night and thoughts. The doctor acknowledges the seriousness of the situation ("not a very cheering thought"), but instead of delving more deeply into the negativity of the thought, he searches for positivity ("do you feel better now?"). The patient seems to reject this positive thinking, continuing to emphasize his difficulties (bedsores, exhaustion). The doctor responds to this by listening to the patient's lungs, which shows that he continues to think in medical terms. The patient's question "who is the better listener?" can be understood quite ambiguously. On the one hand, in making a joke about both doctors listening to his lungs, the patient might be giving up his attempt to get attention. However, his joke might also be regarded as a form of

critique; again attention is being given to the lungs but not to him. At the end of the conversation the patient once again expresses his displeasure by expressing his hope that someone will come to move him. Again, the doctor does not react to the tone of voice nor discern the underlying meaning. He simply reacts in a practical way: where is the button to call a nurse? The final appeal for attention lies in the patient calling the nurses 'frolicking girls', and this time the doctor does hear the tone in which it is said, and seriously reacts to it; however, the patient does not get the opportunity to explain this further, as the intern ignores the need for attention to the patient's bad experiences. He reacts again and again by explaining the symptoms. We do not think the intern does this consciously, as he takes the patient's complaints very seriously, but he seems to ask himself only what the words mean in terms of a diagnosis or treatment.

What does this case tell us about attention? It shows that attention is not simply good 'as such' but that it must be focused on the right object if it is to have a beneficent meaning. Quite evidently, the attention should first find the right object before becoming focused. To achieve this, an understanding of the other person's perspective is needed. Perhaps one could say that in this case the assistant physician interprets too quickly, which causes his attention to focus on what from the patient's perspective is the wrong object. Here, we could refer to the ideas on 'wondering' (Verhoeven 1972), as it becomes clear that attentiveness involves a certain kind of seeking, a searching for meaning. It entails interpreting and re-interpreting signals, 'reading' the signs sent by the patient. How does this relate to the medical habitus? As we know from the literature (Nessa 1996; Burnum 1993), the search for signs, and the interpretation, evaluation and re-interpretation of signs, are the order of the day in the medical field. However, this refers mostly to medical signs, or signs that indicate certain medical conditions. Medical caregivers try to understand and re-understand their patients, often against a background of establishing or excluding the existence of disease. Clearly, this differs from the background advocated by the ethics of care, namely, helping patients in need. On the one hand, this shows that there are opportunities for attentiveness – experienced as beneficent by patients – since the medical habitus allows for the search for and interpretation of signs. On the other hand, however, this sign-work is propelled from a certain motivation that only allows for those signs which caregivers feel they can professionally deal with. Medical caregivers appear to be very attentive to what patients show, but their attention is not completely open to the various kinds of signs. Some signs are more often seen and explored than others. This impression drives us to further investigate the hierarchy of signs related to the attention of caregivers.

The observation that the attentiveness of hospital caregivers is often medically driven does not exclude the possibility that patients experience beneficent attention. Sometimes, although their attention seems to be in a medically-driven mode, caregivers succeed in making space for patients to open up and truly show themselves. The following description is an example.

The oncologist tells me about one of his patients, a 38 year-old woman with breast cancer. He tells me that he finds this a distressing case: the cancer was found when this

patient was pregnant with her second child. She received chemotherapy during her pregnancy to make the tumour shrink in preparation for a mastectomy. After she had given birth to a healthy child she had to undergo the operation, which she suddenly refused. The oncologist and several colleagues have tried to convince her, but she sticks to her decision. Now the oncologist explains to me that he wants to keep her in treatment. "I don't understand her. I can't stand her refusing this probably life-saving operation. Her children are so young. [Short silence] Yeah, and what is it? I don't know. She says it isn't fear. You know, this woman thinks she will die of this disease. And she doesn't want to be *both* dead *and* maimed. That's what she says. And well, you've seen it yourself: she is very feminine... she has beautiful breasts... [Short silence] You know, I want to continue treating her. I want to keep her from feeling rejected. In the end, autonomy is the most important thing. I don't want to transfer her to another doctor... Hopefully, there will come a moment when we understand each other. Or when I can convince her." "This must be very difficult for you," I reply. The oncologist nods. "Do you try to convince her every time she comes to the polyclinic?" I ask. "No," he answers, "I just keep talking to her and continue to see whether she will change her mind or not." (Fieldwork notes KK, 2010)

The oncologist decides not to transfer this patient to another doctor. He wants to continue treating her so that she does not feel rejected. He states that it is her autonomy that is most important in the end, and at the same time he admits hoping to be able to convince her one day. From an ethics-of-care perspective, in which human beings are seen as being interconnected and giving meaning to each other's lives, one would also emphasize the importance of maintaining the relationship, and autonomy would get a more relational interpretation. This seems to correspond with the oncologist's remarks: he regards self-determination as important, but he is also concerned about his patient, and so using his expertise and beliefs, he hopes to convince her. Most important here from a care-ethic perspective is that the oncologist does not want his patient to feel rejected; he does not want to abandon her. This may be a crucial aspect of attentiveness: it is creating a relationship in which the patient may express her- or himself. Therefore it is essential that the oncologist admits that he does not fully understand the patient, but it is equally essential that this is not a settled position for him. Continuing to see whether she will change her mind, he keeps trying to read her signs. This involves two things: first he puts himself aside and suspends his own beliefs; and second he turns off his active way of doing and replaces it with a passive one. This 'waiting' for the good to come may be another key component of being attentive in care. The work of Weil (1951) could be important to understand this aspect of attentiveness. An attentive caregiver must not always actively search, interpret and re-interpret; sometimes he has to realize that attention is not always controllable, but that the 'good' will show itself. Attentiveness may require a certain 'un-knowing', a swaying with what happens, and a loosening of the reins in view of the good. That seems to go against the rules of medicine, in which everything should be mastered, controlled, and preferably evidence-based. Nevertheless, it happens in the hospital. Attentiveness requires a certain flexibility that is not always oriented towards results or targets.

These explorations are some examples of how attentiveness is tacitly interwoven with the medical habitus. Attentiveness may be given but not called attentiveness. One assistant physician explained that “we doctors have certain medical knowledge that others don’t have, and that is why we should especially focus on that. Attention can also be given by nurses or by the patient’s family members” (fieldwork notes KK, 2010). However, as the previous descriptions show, attention can have a beneficent meaning, but it is not simply good ‘as such’. It is all about being attentive *in* the specific care relation that a caregiver may have with a patient. For example, some patients have told us (KK) that they feel very closely connected to their doctor, which could be the reason for showing (part of) themselves to him or her. An attentive caregiver does not overlook this. That does not mean that one has to spend a lot of time on it; in the case of attentiveness it is often enough to let the patient know that his or her (implicit) expressions are being noticed. This seems to contradict the medical habitus, in which all things irrelevant for diagnosis or treatment are often considered unimportant; nevertheless it is what makes patients feel better. Perhaps this attentiveness as a way of swaying with the patient, or this ‘letting come’, may seem a lot easier to realise for doctors than for nurses, as doctors do not have to justify their work as often. However, nurses also manage to make space in which the patient can show him- or herself, and to be attentive to what is shown. Attentiveness can be very complicated, but it can also be given in very simple ways: it may be hidden in a question like “why are you frowning?”

It becomes clear that attention comes by *seeing* the other. At the same time, one can never see another person in his or her entirety; attention therefore always means reduction. What stands out, however, as a major finding of these data is that when a patient feels seen, or understood, the caregiver’s attention is focused on what the patient wants it to be focused on. This means that patients benefit from *shared* attention. Furthermore, a caregiver may help a patient by being transparent about the issue on which the attention is focused. This softens the fact that attention can never be directed at everything at once. When the caregiver is more open and transparent about the gap between what is seen and what is focused on, the patient may more often experience receiving attention.

Conclusion

The previous descriptions and analyses shed light on attentiveness in the hospital care. Attentiveness in care is often dismissed as a bonus, something extra, or as something that one can be good at besides one’s real work. This study shows that attention is part of the core business of medicine. However, attention has many facets, and not all of these are equally present in hospital care. It becomes clear that attentiveness only has its good meaning and effect if it is the right kind given at the right time. Otherwise an unsatisfied feeling remains. Caregivers frequently succeed in giving the proper attention, yet this is often done tacitly. Attention in its broad meaning is not easily accessible, and caregivers do not always refer to it as ‘attention’. This calls for a more elaborate study of the way attentiveness works in the hospital. From the examples

presented above the complexity of the phenomenon of attention is evident. Attentiveness may be embodied; it may be hidden in a small question; it may be experienced though not intended, or the other way around. Sometimes attention can be managed, but it will always be characterised by a certain uncontrollable aspect. Our attention surpasses our own projects, and it surpasses the various techniques and practices by which our attentive behaviour is modelled. On the one hand, being attentive calls for constant exercise; on the other hand, remarkably it seems to be a 'gift'; something that just does or does not happen. Or, as Waldenfels (2004) puts it: "If there is any primary form of attention which plays its special role [...] in the course of our life we must admit that it keeps certain features of a savage attention." Habitus comes to the fore as a useful instrument for studying attentiveness in hospital care. The question of how the medical habitus is related to attentiveness calls for further fieldwork. More research on attention is necessary, in which both the amount of data collection should be expanded and further steps should be taken to 'uncover' the data material. In this article a first preparatory study of the material is presented, which should be followed up by a thorough revision and comparison with other cases. Further study of attentiveness may correct the generally superficial perceptions of it. This way attentiveness can be described in its broad and important meaning, as it deserves, which may be a first step towards the giving and receiving of more attentive care. Hence, attentiveness no longer only speaks to the imagination; rather, its practical face is being painted.

Notes

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1 Patients do also have a habitus, but this is beyond the scope of this article.

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