



# RELATIONAL NARRATIVES: SOLVING AN ETHICAL DILEMMA CONCERNING AN INDIVIDUAL'S INSURANCE POLICY

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Decisions based on ethics confront nurses daily. In this account, a cardiac nurse struggles with the challenge of securing health care benefits for Justin, a patient within the American system of health care. An exercise therapy that is important for his well-being is denied. The patient's nurse and an interested insurance agent develop a working relationship, resulting in a relational narrative based on Justin's care. Gadow's concept of a relational narrative and Keller's concept of a relational autonomy guide this particular case. As an ethics framework influenced by feminist ethical theory, Gadow's, Keller's and Tisdale's ideas demonstrate the fluidity with which the nurse and others can work while maintaining both autonomy and engagement without being self-sacrificing.

## Introduction

Cardiac rehabilitation is a restorative process that attempts the physical reconditioning of patients after a cardiac event by means of a prescriptive exercise programme. The goals of the programme are individualized and the objective is to increase physical exercise tolerance over a period of 6–12 weeks. American insurance companies specify clearly which diagnoses qualify for reimbursement. Three diagnoses currently reimbursed for cardiac rehabilitation are recent myocardial infarction, stable angina and coronary bypass surgery. Justin, the subject of this article, did not fall into any of these categories. His diagnosis was cancer. The surgery being cardiac in nature, however, did necessitate the use of a heart–lung bypass machine. The fact that Justin's diagnosis was not heart related, but involved cardiovascular procedures, placed Justin in a financially precarious situation.

A discussion of feminist ethical theory is beyond the scope of this article, other than to acknowledge its impact on the shift away from traditional objective, ratio-

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nal, universal and paternalistic biomedical ethics as the only option in deciding ethical questions. The development of feminist theory has brought about an emphasis on personal experience as defined by the person living that experience, leading to the creation of a relational rather than rational ethics. Relational narratives specific to each individual situation are the tools by which relational ethics are expressed, and have been written about by several authors.<sup>1-5</sup> Two relational narratives are described in the story presented here. The primary narrative occurs between a cardiac rehabilitation nurse and an insurance representative. A relational narrative is also formed between Justin and the cardiac rehabilitation nurse. The relational narratives described in this story depict how an uncovered insurance benefit eventually becomes available to Justin through a process of deconstruction, a process of chipping away at an ensconced traditional insurance policy. Expressed in postmodern terms, what occurs is the deconstruction of Justin's pre-existing policy. The authors believe that there is a practical fit between Gadwo's ethical framework and Keller's concept of relational autonomy that is clinically useful not only between patient and nurse but between nurse and, in this case, insurance company. This article attempts to show how Keller extends Gadwo's work and this becomes a conceptual framework for Justin's story, an example of the creative use of relational narratives. We believe more will become evident as this framework is used in clinical settings.

## The story

Justin is a 28-year-old man, married, and a junior executive in Corporate America. He is also a marathon biker. After seeking medical advice for increasing 'shortness of breath' when biking, eventually, over a two-month period, he was diagnosed with a sarcoma that extended from the ascending aorta to the right atrium of the heart. The cancer had also metastasized to the lungs. Soon after the dreaded diagnosis he underwent surgery. His hospital recovery was uneventful, in the sense that he had no postoperative complications.

Several days after surgery, the cardiac rehabilitation staff received an order for cardiac teaching to include chest wound and sternal healing precautions. During the teaching, the cardiac rehabilitation nurse, Kathy, noted in his history that he had always been an avid exerciser. Kathy and Justin spent time exploring what was significant to him. During this relational narrative they discussed his activity and exercise regimen after hospital discharge. The issue of Justin's participation in the outpatient cardiac rehabilitation exercise programme came up during the teaching. Justin and his wife Melissa were interested in the prospect that Justin would soon be able to return to exercising in a safe environment. A major obstacle was recognized early on: who would pay for the outpatient exercise programme since his diagnosis did not warrant rehabilitation? Outpatient rehabilitation programmes without insurance are costly, particularly if the individual has to pay themselves.

Justin decided to sign up one week after discharge, with the understanding that he may have to cancel the appointment if attempts at financial reimbursement were unsuccessful. Justin's case would be the first attempt at trying to bring a patient without underlying heart disease into the cardiac rehabilitation

programme. The staff were convinced that, based on the type of surgery carried out, he had a chance, although remote, of receiving the benefit. In previous years the staff had successfully rehabilitated several individuals with a diagnosis of heart disease who were concurrently undergoing chemotherapy. The cardiac rehabilitation staff were convinced that, given a chance, Justin could regain his strength sooner and begin to focus on the positive aspects of healing and health through his participation in this comprehensive interdisciplinary exercise programme.

Next, Kathy began a dialogue about this dilemma with an insurance representative from Justin's health plan. Annie, the representative, checked the insurance policy manuals. Unfortunately she discovered that Justin's case did not fit into any of the guidelines under which cardiac rehabilitation would be covered. Given these circumstances, the dialogue between Kathy and Annie could easily have ended here; however, it did not. It was at this juncture that a relational narrative developed between the nurse and the insurance representative. The uniqueness of Justin's situation touched Kathy and Annie, and prompted them not to file the case away but to pursue seeking additional benefit for him. Together they engaged themselves in Justin's situation and became his advocates. Numerous phone calls between the nurse and the insurance representative ensued to make this happen. Letters of medical necessity followed the calls. At Annie's instigation, Justin's case was eventually taken before the insurance company's board of appeals. As a result, approval came from the medical director of the insurance company. Justin would receive not only some, but all, of the services provided by the cardiac rehabilitation programme.

Kathy, Justin's nurse, and Annie, the insurance representative, initially became involved in this situation as part of their routine responsibilities. They agreed that Justin's situation presented a dilemma and they pursued solutions. Had they accepted an insurance denial, they would have been responding from a modern, positivist perspective. Autonomy within a relational narrative – the ability to maintain self-respect and be fully engaged without losing one's self – guided their actions in a postmodern contextual way. This led them through a process of the deconstruction of a traditional insurance policy into a creative reconstruction, which allowed Justin to receive the benefits he clearly needed.

First efforts undertaken to obtain reimbursement for the exercise programme equated with the deconstruction of the policy. A shift from a positivist paradigm to a humanistic, relational paradigm occurred. Insurance policies are closely aligned to a modern paradigm that is 'structured, controlled, hierarchical'.<sup>6</sup>

In this story, subjective experiences have been extrapolated from real events. It is through these occurrences that postmodernism displaces a positivist ideology. A mutual understanding results from the relational narrative formed between the nurse and the insurance representative. The ensuing dialectic positioned Justin's advocates to consider all possibilities for recovery. Together, they deconstructed a pre-existing policy that had proved to be of no benefit to their patient. This concept can best be understood in the context of Justin's story by considering Bent's discussion of statements by Powers<sup>7</sup> and Reed<sup>8</sup> that 'all conceptual essences, even those of meaning or power, are rejected in favor of situated accounts,<sup>7</sup> where either/or problems are not solved but deconstructed in the search for a practical significance'<sup>8</sup> (p. 80).<sup>6</sup> The extension of

relational narrative by relational autonomy is one framework through which to accomplish this.

## An ethical framework

'Ethics' can be a dreaded word. There is always someone who is not satisfied either with the answer or the process by which it is decided. Parts of the traditional biomedical system are based on authority, rules, certainty and final answers. In a fast-moving clinical setting the sheer impracticality of spending the time haggling over points and tallying them up to make a final decision can drive practitioners back to the ward and the pressing work of patient care. A rationalist decision is made by the majority of a committee, who are often rational, modern thinkers. Yet, as Tisdale writes in *The sorcerer's apprentice* (p. 11–12),<sup>5</sup> one traditional ethics system 'is too small to contain the problem it hopes to solve. Ethics is the study of conduct and behavior, the study of response, antiphony, and echo. It is inherently fluid – fluid as in provisional.' This is a postmodern stance that is becoming increasingly familiar to nurses, and is clearly not authoritarian, objective or certain. In this stance there is no single solution for rational thinkers and no comfortable telos for relational thinkers. Each dilemma is absolutely unique; each behaviour evokes a provisional response; the narrative is fluid.

Justin's story demonstrates how a fluid conceptual framework can be created through combining two previously described intersubjective exchanges focusing on patient advocacy: Gadow's concept of the relational narrative<sup>1,2</sup> and Keller's concept of relational autonomy.<sup>3</sup> The following discussion shows how these two concepts can be extended into a learned skill that is practical in a nursing setting, as was shown in Justin's case.

In her most recent article, 'Relational narrative: the postmodern turn in nursing ethics',<sup>2</sup> Gadow recognizes three layers that are part of the ethical cornerstone of a philosophy of nursing (Table 1). The layers are identified as: subjective immersion, objective detachment, and relational narrative. (She has also identified these layers as premodern, modern and postmodern respectively (p. 3). For the sake of clarity the first three terms will be used, although the reader is cautioned that the two sets of terms are sometimes used interchangeably because of their similar characteristics.) According to Gadow, subjective immersion is characterized by certainty because it is unreflective. It is based on moral tradition, religion or other source outside the self that is 'powerful enough to resist reflection' (p. 5). Its corresponding era, premodernism, yields no ethical questions because the tradition provides both ethical appraisal of the situation and nursing action that is unarguable.

Detachment, the second layer, is also characterized by uncertainty in Gadow's view. It is a system of rational objectivity – 'one incontestable system of universal principles' (p. 7) – that respects individuals equally in all cases, paradoxically leaving little room for the vagaries of individuality. Distance is always maintained to provide objectivity and to avoid more than one interpretation of ethical questions. Its corresponding era, modernism, has been linked with such terms as logical positivism, reductionism, utilitarianism, universalism, authoritarianism, empiricism and paternalism. Although all individuals are respected equally, that

**Table 1** Gadow's characteristics of philosophical layers

Layer	Nature of ethical dilemma
<p><i>Premodern: subjective immersion</i>  Immersion in belief  Myth, religion, family and community values  No thought of doing things another way  Unquestioning</p>	No ethical dilemmas because there are no questions
<p><i>Modern: objective detachment</i>  Rational, objective, empirical  Authoritative, paternalistic  Utilitarian, final answer sought  Rigorous inquiry, systematic procedures  Logical positivism, reductionistic  All individual cases regarded equally</p>	<p>Ethical dilemma is stepped outside of and viewed objectively  No more than one interpretation allowed</p>
<p><i>Postmodern: relational narrative</i>  Passionate engagement, relationship  Co-authorship, narrative  Situated perspective, safety  Uncertainty embraced, no absolutes</p>	Answers to ethical dilemmas are constructed and contingent and can be deconstructed according to changes in situation or interpretation

very quality demands that the same principle be applied in every case (as in Justin's case before negotiations with the insurance company began). Gadow points out that there is less certainty in this layer than is at first apparent. Interpretations of a principle can cause conflict in clinical settings; the application of a principle in some settings requires force; and universalism devalues the uncontrollable, as it did Justin's need for the emotional and physical benefits of cardiac rehabilitation although no coronary artery bypass operation was actually carried out.

Gadow's third layer, relational narrative – 'the words the nurse and patient compose together, the words of their engagement' (p. 10)<sup>2</sup> – yields ethical knowledge that is co-authored, contingent and contextual. This requires deep listening, a 'being there' that is sometimes thought to be self-sacrificing, but which in reality is mutual participation with specific guidelines for the nurse (which Keller provides). This layer corresponds to the postmodern era, which 'resists the modern drive for unity, order and foundations. Every form of order becomes a target for deconstruction' (p. 9)<sup>2</sup> from the social to the hermeneutic order. Meanings are assigned by individuals with no authoritative ground on which to stand, and are thus contingent on the ability to engage with another human being. Engagement between nurse and patient can yield a relational narrative that helps a patient to view a disability as a new ability, to assign an empowering meaning to an otherwise intolerably vulnerable circumstance (such as Justin's perceived loss of all

his athletic ability). Because the dilemma can change, no answer is certain or final.

An understanding of Keller's model of relational autonomy broadens and clarifies Gadwo's definition of the relational narrative of engagement and makes it easier to apply clinically. Keller places relational autonomy within the relational narrative as a responsibility of the practitioner.<sup>3</sup> Gadwo alludes to relational narrative as a 'safer home, existentially, than would be found in subjective or objective certainty [which] would cost the nurse and patient their relationship' (p. 11).<sup>2</sup> Keller, building on Meyers<sup>9</sup> and Davion,<sup>10</sup> points out *how* relational narrative is a safer existential home using the concept of relational autonomy. In her article, 'Autonomy, relationality, and feminist ethics', Keller<sup>3</sup> defines relational autonomy in three parts: self-governance, being able critically to reflect on whether one can take responsibility for an action while being true to oneself; and the ability to learn and use this skill among friends and other social contacts (an intersubjective, relational exchange). Relational autonomy within a relational narrative allows the use of moral judgement in deciding what care to give and renders 'self-immolating care' (p. 159)<sup>3</sup> an argument against care ethics that is applicable only to those who deliberately choose it. Keller discusses Meyers' emphasis on relational autonomy as a learned skill. She suggests that a possible way to learn it is, when faced with an ethical dilemma, to picture a variety of solutions with a friend; imagine the results of carrying them out; and rely on feelings of self-respect for the decision chosen. The question to be answered is: 'Can I live with this?' The thoughtful integrity of the nurse on hearing the expressed desires of the patient (or physician or insurance company) becomes a carefully crafted synthesis between premodern, modern and postmodern ethical thought. The nurse learns to move with fluidity among layers of ethical thought while maintaining both autonomy and engagement by practicing Keller's steps. All taking part are potentially strengthened as the joint question becomes: 'Can we live with this?' This provides the fluid framework Tisdale (p. 11)<sup>5</sup> asks for, in which the patient and the practitioners of all layers of thinking may work in harmony – from unquestioning belief to objective empirical thought to authored, contingent and contextual engagement – and, through this intersubjectivity, provide a shared, and thus safer, existential home. Keller's steps were followed in Justin's case.

## Application of the framework

Family, community belief system, tradition, religion and myths are a few examples associated with immersion, the first philosophical layer. Premodern immersion in Justin's story is depicted clearly through several characters. The extended family believed that the best medical treatment was available only from 'recognized' large medical centres. Thus, Justin's father pushed to have him treated elsewhere. The cardiovascular surgeon consented with hesitation to the outpatient exercise programme, stating: 'He doesn't have longer than six months but go ahead and give it to him if it makes him feel better.' Operating room and telemetry unit nurses treated the situation with dismal attitudes, leaving Justin and Melissa feeling isolated. Kathy also felt little support but was unable to let Justin go without a push for an insurance payment for the programme.

In Arthur Frank's autobiography, *At the will of the body*, he writes about his

experience of living with cancer. He acknowledges how important it is for the medical and nursing staff to share emotions with patients who are experiencing terminal diagnoses. He writes: 'Anybody who wants to be a caregiver, particularly a professional, must not only have real support to offer but must also learn to convince the ill person that the support is there' (p. 70).<sup>11</sup> This example is a demand that caregivers should go beyond the stages of immersion and detachment to develop a relational narrative, and that the nurse is clear about her relational autonomy, her ability to maintain self-respect during an ethical dilemma.

Modern ethics is a move away from immersion to rational objectivity,<sup>2</sup> the second philosophical layer. Examples of detachment occur throughout this narrative. The chemotherapy treatment was one. Having critical decisions to make with regard to a treatment plan, Justin was flown to a large cancer centre institute, where 'state of the art' drugs were prescribed for chemotherapy. Although anxious to return home, he instead 'stuck it out', because this centre is the 'Mecca' for cancer treatment, but he never developed a relational, caring narrative with any caregiver there.

Beneficence, the assumption that the professional knows best, is a virtue associated with modern objectivity. The cardiac rehabilitation staff's claim that 'exercise will strengthen and improve your health', to a degree demonstrates a paternalistic viewpoint. When Justin, Melissa and Kathy discussed Justin's choice to participate, his attitudes and opinions were finally taken into consideration, prompting a relational narrative to occur. A typical dialogue sounded like this:

*Kathy:* Good news! The insurance finally came through! Justin can participate in the entire programme!

*Melissa:* I don't know, Kathy. He might not be up to it any more. He's lost a lot of energy.

*Kathy:* No problem. That's what this programme is designed for. He'll build up strength in no time.

*Melissa:* (still doubtful) His strength is OK, if he would just get up. But he seems depressed to me . . .

*Kathy:* (finally addressing Justin) Justin, what do you think?

Lastly, the attitude of third party payers reflects a utilitarian attitude. Again a modern perspective is evident. What is best for the majority of individuals, with little harm to 'others' echoes the detachment of the insurance company in Justin's situation. This translates into: 'Although Justin may benefit from the programme, there are many other beneficiaries needing the resources that are covered benefits.' Whether they would be efficiently, effectively or even used at all did not take away their status as covered benefits. The challenge became, how could the cardiac rehabilitation centre provide the requested services when they were not part of his insurance package? In addition, a dearth of scientific knowledge proving that exercise would benefit Justin's condition served to limit further Justin's chances of receiving benefits.

## The relational narrative in postmodern terms

Although an important relational narrative existed between Justin, Melissa and Kathy, it is not *the* narrative emphasized here. The actual narrative of focus is the dialogue that occurred between Kathy and the insurance agent. The refusal by the insurance company to reimburse a clearly necessary treatment because it was not in the plan was modern in nature. However, Kathy and the insurance agent (acting with relational autonomy) did not see this reply as acceptable. A typical exchange here would be:

*Kathy:* This man is so motivated; he's an athlete and used to physical exercise but afraid he'll never be able to do it again. I am afraid the normal postsurgical depression will deepen into a depression that could be averted with this therapy. His wife is very supportive. It won't be a waste of money. I can say that for sure.

*Annie (insurance agent):* Let me see if I can find some loopholes into which he fits. You know I can't just grant authority.

*Kathy:* Yes, I know. But you can see how it might be worth it for this man? It will be therapeutic in several ways. The exercise should help him to maintain his stamina throughout the chemotherapy. By giving Justin this therapy I believe we may see less depression and a better response to the chemotherapy.

*Annie:* Yes, I see. I can tell how much you care and how convinced you are. Let me see what I can do. It may not be anything, though, so don't get your hopes up.

*Kathy:* Thank you for your time! Hopefully there will be a way.

Together, Kathy and Annie's efforts and rallying behind a treatment plan that Justin desired is considered postmodern in nature. They believed that Justin would benefit in numerous ways. Based on several first-hand experiences Kathy had been involved with in the past, she had witnessed individuals who had been diagnosed with heart disease and cancer exercising in a supervised programme. She saw what appeared to be significant results concerning overall health status correlated with a structured exercise regimen. With participation in an exercise programme these individuals maintained muscle mass, strength and weight while undergoing chemotherapy. In the end, the efforts undertaken to obtain reimbursement for the exercise programme equated to the 'deconstruction' of an existing insurance policy.

The positive outcome of this story contradicts the popular conception of medical insurance companies as intransigently greedy. It is to be hoped that the weight of public opinion is beginning to have its effect on the medical insurance industry. Justin's story demonstrates the possibility that policies of wisely managed insurance companies can be deconstructed for the benefit of an individual.

Another layer of significance involves the potential role of the nurse in the future. It is clear from this story that nursing can play a major role in the planning and securing of health care benefits for patients through the use of autonomy within relational narratives. Other ethical decisions can also be influenced by using the more flexible, fluid ethical model described here. Justin's story illustrates the dynamics of relational narratives involving several ethical decisions. Some should be considered before closing his story.

As mentioned earlier, Justin was a young corporate worker, productive and athletic. Would the pursuit of benefits have been as aggressive had Justin been unemployed, unpleasant or even physically unattractive? Furthermore, in a society



where youth is regarded highly, consider the impact of a similar situation had the patient been an elderly individual. Some might ask, although the programme was desired by Justin, Melissa and the cardiac rehabilitation staff, was it medically necessary for him? There is also the real question of whether, given the finite resources available and Justin's condition and prognosis, was cardiac rehabilitation cost-effective from the insurance company's perspective or even from the general perspective of allocating health care dollars wisely? The answers to these questions require the use of the addition of Keller's relational autonomy to Gadow's relational narrative to produce a compassionate and responsible engagement (Table 2).

## The ethical framework reviewed

The authors have attempted to show how these, and countless other ethical questions, all unique and therefore impossible to fit into a single rational, objective formula, can be dealt with by the use of relational narratives and exchanges using both Gadow's and Keller's concepts. This was illustrated through the story of a real person. Because postmodern thought dictates that all individuals are unique and situated, the only way to know what they know is to hear their personal narratives, to 'walk in their souls', to 'compose together the words of their engagement' (p. 11).<sup>2</sup> Gadow affirms that a relational narrative seeks good for both parties; therefore, it is a relational ethic as well. Keller describes the 'wide latitude' a nurse has in deciding how to exercise her or his autonomy in participating in

**Table 2** Characteristics of a fluid model of nursing ethics

Ethical stance	Characteristics	Examples
Subjective immersion	No ethical question	Justin's extended family 'Your plan doesn't pay.'
Objective detachment	One interpretation of ethical question	'State of the art' drugs 'Exercise will help you'
Relational narrative	Answers to ethical question cocreated, contingent	Narrative between Kathy and Justin, Melissa and doctors
Relational autonomy within relational narrative	Responsibility of practitioner; fluid movement and synthesis between all ethical stances 'Can we live with this?' is the ethical question	Kathy's refusal to accept insurance limitations, which led to narrative involving family, doctors, insurance agent, insurance medical director, etc. Included but was not limited to ethical solutions from all stances above

ethical questions (p. 160).<sup>3</sup> Far from being a contaminant of objectivity and moral certainty, autonomy within the relational narrative is critical in the ethical decision-making process, providing the subjective data that has been missing for so long. Keller puts the necessary restraint on the moral agents involved by insisting that autonomy and self-respect are mutually enhancing, whether alone or in a relational narrative, and are practised in the context of self-governance. Objective and subjective stances work together. Indeed, the simplicity of this framework is that, simultaneously, the preferred methods of all eras can flourish on the same hospital floor, with fluidity and in relative harmony. Justin's narrative, with all those who inhabit it, is a clear example of relational autonomy practiced within a relational narrative. This cohabitation need not be at the expense of the nurse, the patient or the ethics committee. Because no perfect answer is required, there is no deadline to meet. One must try responsibly to 'sing in perfect pitch with that individual patient's song, [for your] melody reaches God' (p. 119).<sup>12</sup>

## Addendum

Justin's managed care insurer could have denied his cardiac rehabilitation treatment. This would have been a safe corporate choice. Because of the relational narrative between the nurse and the insurer, a different course was taken. Justin is alive today, two years after the cardiac rehabilitation following surgery for sarcoma and his third course of chemotherapy. He has returned to full-time work and makes regular use of the outdoor pool and biking territory near his new home.

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