

HEALING WHO WE ARE AND WHAT WE DO BEST –
TRAVERSING THE NUANCED COMPLEXITIES OF
HEALTH CARE TODAY

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BIOGRAPHY

Anita holds a doctorate in the empowerment of women as nurses from the University of KwaZulu-Natal and a master's degree in critical care nursing, an honours degree in nursing and an honours degree in philosophy (with a focus on ethics) from the University of the Free State. She is registered with the South African Nursing Council as a general, psychiatric and community health care nurse and midwife. She holds additional qualifications in critical care nursing, nursing education and nursing leadership and management.

Anita has been Professor in and Head of the Division of Nursing in the Faculty of Medicine and Health Sciences at Stellenbosch University since January 2015. From 2013 to 2014, she was Consultant in Strategic Matters at the same division. Before this appointment, she resided in Copenhagen, Denmark, where she was an

educational consultant and technical coordinator for an international programme on diabetes and depression, working with international organisations, such as the Dialogue on Diabetes and Depression initiative and the International Council of Nurses. This programme, comprising a group of multidisciplinary experts, presented workshops in seven countries in Africa from 2011 to 2012, with plans for further rollouts. During that period, she also held contractual appointments with the University of the Free State and the University of South Africa to supervise doctoral and master's students and provided research support to a private Danish training and development company.

Before this, Anita was Professor in and Head of the School of Nursing at the University of the Free State for six years, until January 2011. In 2009, she was instrumental in obtaining a substantial four-year grant from the Atlantic Philanthropies and successfully led the project of the School of Nursing to pursue three goals, namely the transformation of nursing programmes, the development of a state-of-the-art virtual health teaching and learning facility (called The Space) and the establishment of a self-sustaining continuing education unit.

Anita's experience includes working as a Nursing Advisor to the Ministry of Health in the United Arab Emirates, managing a large academic hospital and working as a senior staff member at a number of educational institutions, including a nursing college and the University of KwaZulu-Natal (as Associate Professor). She was appointed as an international consultant by the World Health Organization in a number of countries and by the Bahrain Ministry of Health and Dubai Health Care City for specific health care service assignments. In 2013, she was requested to do two more country-specific assignments for the World Health Organization in Oman and Saudi Arabia.

Her academic interests include software for qualitative data analysis, applied ethics, leadership, and simulation and technology in nursing education. She has presented and copresented more than 70 workshops and more than 38 papers at international, national and local level. Her publications include articles, consultancy reports and government or organisational position papers and directive documents focusing on ethics, leadership and management at a national level.

Anita is chair of one of two Health Research Ethics Committees in the Faculty of Medicine and Health Sciences at Stellenbosch University and serves on the Research Committee of the same Faculty (Senate Subcommittee C). Her current focus within the Division of Nursing at the University is the mentoring of staff, the building of relationships with all role-players, the strengthening of the doctoral programme and the re-establishment of the bachelors programme at the University.

On a personal note, Anita loves people, art and music.

ACKNOWLEDGEMENTS

Delivering an inaugural lecture is a daunting task - sharing the podium with many deeply respected and acclaimed medical and health scientists. Concepts normally used with ease, such as pathogen-associated molecular patterns, transcriptomic analysis, smooth bacilli, prototypes and genotypes, are sounding only remotely familiar.

However, within a 'healthy' Faculty of Medicine and Health Sciences, philosophical and qualitatively spiced discourse deserves an equal and, at times, opposing space. I am thankful to be able to provide such nursing and midwifery-infused care.

APPRECIATION

"Appreciation" is a word that carries worlds of meaning. I dedicate this meaning to all those who have made such a profound impression on my life, those who have supported and advised me, those who have cared for and with me, and those who have not been afraid to question or to draw lines and circles where necessary.

To the management and members of Stellenbosch University, the Faculty of Medicine and Health Sciences, the Department of Interdisciplinary Health Sciences, the Division of Nursing, colleagues, friends and family (core and extended): I feel privileged to be part of your lives and I thank you so much for enriching mine...

cum omni dilectione

HEALING WHO WE ARE AND WHAT WE DO BEST— TRAVERSING THE NUANCED COMPLEXITIES OF HEALTH CARE TODAY

PREAMBLE

The complex health and educational landscape that we travel through is filled with the heart and soul of research, ethics, caring and, most of all, the human beings that we were, are and wish to be. Along the way, we may share experiences, reflect on crowded platforms flashing by and, together, seek a destiny that may elude us. We will decipher elements of the rich contributions of philosophers, scholars and practitioners in diverse educational, health science, social science and other landscapes. To me, the poem *Travel* by Edna St Vincent Millay provides a backdrop to this existential¹ journey:

*The railroad track is miles away,
And the day is loud with voices speaking,
Yet there isn't a train goes by all day
But I hear its whistle shrieking.*

*All night there isn't a train goes by,
Though the night is still for sleep and dreaming,
But I see its cinders red on the sky,
And hear its engine steaming.*

*My heart is warm with friends I make,
And better friends I'll not be knowing;
Yet there isn't a train I wouldn't take,
No matter where it's going.*

BOARDING THE TRAIN: BROKE, BROKEN AND BREAKING

The health care system

Within any contemporary health care system, the complex construct of human rights frames the law, care and the realisation of well-being, dignity, equality and quality of life. A broken health care system is one that is not able to plan using the core tenets of the Constitution and the law (Heywood, 2014) or deliver on the expectations created by the Constitution and



Image 1: Edna St. Vincent Millay in Mamaroneck, New York, 1914, by Arnold Genthe (Source: Library of Congress, N.d.)

relevant laws. Such a system traditionally fails to provide for the growth and retainment of adequate human resources and neglects to “respect or fulfil the right of dignity of health workers” (2014:9).

Globally, health care, due to its multipolarity, complexity and fragmentation (Kickbusch & Reddy, 2014), is a concern. This holds true both for the macro and the micro level of health care and for higher education in general. Although South Africa is a leading proponent of human rights and has an advanced constitution, the presence of three fault lines in the health system has been

¹“Against the notion that the essence or nature of man (sic woman) determined the character and fate of every man (sic woman), the existentialist believes that each individual's existence is a unique and primary fact, and that his essence or essential character is the gradual and ever-changing product of his existence in the flux of time. A man's (sic woman's) essence is formed by his total past, to which he adds in every moment of his life.” (Durant & Durant, 1970)

highlighted by Rispel (2015:7). These are “tolerance of ineptitude and leadership, management and governance failures, lack of a fully functional district health system and a health workforce crisis”. These fault lines have been echoed in work by, for example, the Helen Suzman Foundation, the Health Systems Trust and the Office of Health Standards Compliance.

‘Broke’ is also a tongue-in-cheek reference to financial realities globally but specifically in South Africa; current financial woes are real, both globally and locally. The health care financing model in South Africa does not benefit a large proportion of South African society. According to the Insight Actuaries and Consultants (2016:3), structural inequity persists, with medical schemes catering for the upper income groups, even with so-called more affordable payment options. There is also still significant out-of-pocket payment for many medical scheme members. Most South Africans however use public sector services, which are charged through so-called means-tested user fees.

The planned national health insurance system hopes to address many such health care inequalities (Department of Health, 2015) but will require significant financial commitment and the active will, dedication and support of health care workers, administrative leadership, support staff and educators.

Sharing the human side of brokenness

Occupational health is a critical indicator of employee well-being but is seldom meaningfully assessed. This is especially true in terms of mental health to prevent, diagnose and treat the potential and real manifestations of stress, burnout and moral distress. According to Zweigenthal, London and Pick (2016), the current burden of occupational and non-occupational diseases reported amongst health care workers is high in South Africa. Such occupational diseases refer to both communicable and non-communicable diseases.

It has been found that occupational health outcomes vary across different categories of health care workers, inclusive of health care professionals (such as doctors, nurses and the whole range of therapists), laboratory personnel, general assistants and administrators in the health care sector. It has been postulated that the growing burden of such occupational diseases and the unfortunate natural progression that seemingly affects the total spectrum of health care workers in the health care context may lead to an increase in the development of occupational-related chronic health concerns and disabilities. This is unfortunately true, even in the face of

modern medical interventions. It speaks for itself that such disabilities may impact on the individual’s work performance within the health care setting and on service delivery in the long run (Zweigenthal, London & Pick, 2016).

The personal and human burden of the health care worker and, for that matter, that of the academic and researcher is often not at the forefront. The reason for this is that it could be seen as a weakness in the management of the haunting, limitless and often inhuman expectations of expertise and the application thereof. We should not err on errors. The personal suffering of health care workers and significant others is not considered. As unintentional as an error may be or how devastating reflection on it in quiet moments may be – could I have done more?

The work of Dr David Hilfiker, a family practitioner in Minnesota, came to public notice in the article “Facing our mistakes” in a 1984 issue of the *New England Journal of Medicine* (Second Opinion, 1989:92). Colleague responses, interestingly enough, fell into two camps. One group provided a kind of technical feedback that included advice on what to do next time, what not to do, how to prevent such a mistake in the future (through, for example, training and reading the latest treatment options) and so forth. The other group was sincerely appreciative of what he bravely shared and even provided life stories of own mistakes, of soul wrenching contemplation and of regret.

Leonard Cohen in his song *Anthem* provides a near-perfect refrain for brokenness:

*Ring the bells that still can ring
Forget your perfect offering
There is a crack, a crack in everything*

Despair and abuse

If one accepts that health care workers are the face of the health care system, one may deduce that all categories of employees are the real face of our universities and faculties of medicine and health sciences. The experiences of those whom we serve - communities and students - often mirror the perceived broken face of health care and academic endeavours. This may infuse us with a sense of despair, helplessness and loss but it may not end there. The hidden toll of such realities and expectations is difficult to know. If, for example, one accepts that mental health and wellness may be an effect, then the words of James Hillman, the Jungian analyst, that refer to depression as “hidden knowledge” are poignant.



Image 2: Leonard Cohen, King's Garden, Odense, Denmark, By Takahiro Kyono (Source: Flickr, Aug. 2013)

Another important concern relates to experiences of abuse. Abuse is essentially a subjective experience that is mostly emotional, physical and/or sexual following a verbal and/or non-verbal action of others or the self. Complex expectations, such as a heavy clinical and academic load, coupled with intricate research, personal development and, often, complex leadership and managerial expectations, approach the edges of abuse - at the very least, expectations that are completely unrealistic.

As the abused, we may feel that we have lost value as a human being (being humiliated) and that we are uncared for and we often suffer from unintentional events that are "nurtured and legitimized by the structural and cultural contexts in which the encounter takes place" (Brüggermann, Wijma & Swahnberg, 2012:130).

Courage

Health carers, academics and support staff do not often reflect on courage. We may have narratives of spontaneous and 'slightly thoughtless' courage, such as rescuing a baby tortoise in the middle of a busy road. Here, however, the reference is related to a different kind of courage - courage that refers to a careful and deep intellectual and moral reflection of a complex and painful situation. The goal is most often to benefit those we truly care for or about (Hamric, Arras & Mohrmann, 2015). Courage, in this context, is demanding, exposing

and often threatening. Asking a tough but relevant question in a high-level meeting or pursuing a morally and intellectually sound new initiative in the face of adversity and political digression is what such courage is made of. The concern is that, if one needs to exhibit such courage routinely to deal with daily health care, research and educational practices, it could become draining (Hamric *et al.*, 2015; Oakley, 2015) and, most probably, eventually lead to some form of lethargy and/or burnout.

The human being is this Night, this empty nothing which contains everything in its simplicity - a wealth of infinitely many representations, images, none of which occur to it directly, and none of which are not present (Hegel, Jena Lectures on the Philosophy of the Spirit, 1805).

HUMAN DIGNITY - RIGHTFUL AND NECESSARY?

If we take one step back, we may postulate that one of the most critical and fundamental drivers for the healing and restoration of human beings rests in the essence of human dignity.

The concept: Philosophical beginnings

Human dignity is a complex and ambiguous concept and its eclectic nature may be due to its early religious origins. However, currently, human dignity is widely discussed within the pages of theological, ethical and law journals, where it is considered to be fundamentally linked to human rights.

Historically, in the Roman and Greek civilizations, dignity was seen as worth, status or rank and superiority and was linked to the concept of dignitaries; it was thus perceived as having an elevated and privileged meaning. In the Middle Ages, dignity was linked to personhood and love for one's neighbour, reflecting clear religious roots, especially Christianity (see the works of Thomas Aquinas). The so-called Age of Enlightenment stood proud through philosophers such as Kant, Rousseau and Hume. Kant used the concept of *human* dignity sparingly and referred to dignity in the context of moral worth or value; he emphasised dignity as a critical moral imperative, the imperative of reason (thus rationality) being the requirement for respect for all human beings. Wollstonecraft also strongly related dignity to reason but extended it to social acceptability, with respect for *all* human beings, inclusive of women. In the age of postmodernity, human dignity has become a tool for gaining self-esteem and political influence (Donnelly, 2015; Lebeck, 2004; Zylberman, 2016). This is in part due to the 1948 United Nations Declaration of Human Rights, which has directly linked rights and dignity.

The concept: Controversies

On the one hand, the concept of human dignity is often considered controversial. Some philosophers agree that the concept is often devoid of meaning and/or used in overbearing ways (Baumann, 2007; Jacobson, 2009). Pinker indicates that it is no more than the “smell of the bread” or “the cover of the book” (2008:31), whilst Macklin (2003) argues that it is essentially useless, as it adds no more than respect or autonomy.

On the other hand, the concept of human dignity is also considered morally meaningful, especially in the context of the violation thereof and the degradation of human beings. It essentially relates to ‘the other’ and is brought to fruition in the context of ‘one another’ and ‘the other’. Inherently, part of us belongs to each of us, to all of us and, essentially, equally to all of us. Dignity could then be argued as essentially being prescriptive, whilst respect could be considered to be a consequence of dignity (Baumann, 2007).

Human dignity, human rights and science

Human dignity and human rights bring forth ‘the chicken or the egg’ question in terms of which came first. It is acknowledged that human dignity plays a definite role in human rights, bioethics and law (Adorno, 2009; Jacobson, 2009; Waldron, 2009). It is indeed considered to have a critical link with human rights. Mann (1994) considers human dignity not only as being central to human rights and health but also as being essential to explaining the link between the two. Human dignity emphasises the relationships between society’s failures and successes, the experiences thereof mediating the goals of human rights and health status at both the individual and the collective level (Mann, 1994; Jacobson, 2009). It is also argued that human dignity can be violated but not lost (Baumann, 2007).

Adorno (2009) states that the principle of human dignity asserts the primacy of the human being over science. Herein, he continues, lie two foundational rules. The first is that science is not an end in itself but is a way of enhancing the welfare of individuals and society. The second is that human beings should not be reduced to tools to the benefit of science. Instead, members of society should contribute in some way to the so-called common good in a way of their choosing.

Human dignity and social dignity

A meaningful qualitative, grounded study by Jacobson (2009) reported that human dignity could be divided into two types, namely dignity-of-self and dignity-in-

relation. Jacobson considers dignity-of-self as a quality of self-respect and self-worth that is portrayed by attributes such as confidence, integrity and dignity and dignity-in-relation as referring to how respect and value are transferred and conveyed via both individual and collective behaviour. Human dignity also seemingly encompasses the historical sense of dignity as adhering to status or rank, all other things being equal (Formosa & Mackenzie, 2014). Nussbaum (2004) also emphasises the relationship between respect and human dignity: to respect, one needs to understand dignity; to understand dignity, one needs to understand respect. Bendik-Keymer (2010) reflects on Nussbaum’s work and outlines the ‘concept family’, which consists of human dignity, respect and wonder.

In conclusion, human dignity is a concept that exists in close moral relationship with human rights and respect and is a necessary and critical part of being human. It finds its way into each and every encounter. Human dignity furthermore has remnants of status or rank, and the contemporary interest in dignity is to counterbalance the traditional positions of status and of rank.

HEALING WHO WE ARE AND WHAT WE DO BEST

Although one could focus on a range of concepts, strategies and models whilst reflecting on healing who we are and on what we do best, my choice would be to ponder on those that, throughout my own life and work, have meant so much to me in taking care of foreign places, familiar spaces and unique scholarly and leadership embraces. Bolduc (2001:65) states that:

I have a very basic need as a human being - a need to be loved and cherished for who I am. Not for what I look like. Not for what I accomplish or produce. Not for what I have to give. My deepest need as a person, the need I believe I share in common with all of humanity, is the need to be truly known, and once known, loved and accepted unconditionally”.

This down-to-earth statement sets the scene for what I believe are some of the critical ingredients of healing - person-centredness, compassion, *communitas* and resilience - accepting that healing is about restoring wholeness (Pellegrino, 1983). In essence, care and caring are worthwhile only if provided by a carer who is also cared for (Seager, 2014).

Person-centredness

Person-centredness as a critical way of being is first found in the work of Rogers (1961). Since then, it has become

a popular but complex and multi-faceted phenomenon (Hughes, Bamford & May, 2008; Leplege, Gzil, Cammelli, Lefevre, Pachoud & Ville, 2007; McCance, McCormack & Dewing, 2011; Ross, Tod & Clarke, 2014). Fundamentally, it refers to the truth that human beings are more than the sum of their parts - they are a unified whole. Within person-centredness, consciousness is a shared reality (Girenok, 2013), with the relational qualities of personhood considered as being important. Here again, respect makes a critical contribution (Leplege *et al.*, 2007).

Person-centredness requires value-based endeavours that appreciate meaning and substance. It is comfortable with relationship, involvement or participation and context (Greenfield *et al.* 2014; Sethare, Couper & Wright, 2014; Kitson, Marshall, Bassett & Zeitz, 2013. Kitwood, (1997) and McCormack (2001, 2003) consider person-centredness essentially as relational with the self, others and the world and as thriving on recognition, respect and trust.

Human beings also have a self-identity and free will in their interaction with others and with the environment, essentially enabling them to make free choices (even of self-destruction) - such choices inadvertently determining character (Wallace, 1985). Human beings can also reflect on such choices and integrate such reflection in further life decisions and experiences. The essences of free will compared to the less free or controllable physical and political realities that we face as human beings have been incorporated in the nursing theories of, for example, Orem, Parse and Roy (Green, 2009).

Human beings are often portrayed as and are expected to be competent and self-sufficient. Nussbaum (2004) considers this emphasis on the so-called perfection of human beings as fictitious. In essence, human beings are dependent and vulnerable.

Focus on person-centredness has grown in stature, often in the context of patient-centredness. Expressions of personhood such as speech, mannerisms and touch have critical meaning in the space of health caring and health carers. Kitson *et al.*, (2013:9) highlight the centrality of five themes in a substantial narrative review. These are an emphasis on the human experience, respect for and the expression of valued beliefs, an integrated approach to care, better communication, and shared decision making.

My argument would be that the concept of person-centredness is sufficient and relatively clear and that we can do without the multitude of variations such as

patient-centred care and learner-centred care. It is also true, however, that person-centredness is used quite flippantly without the true nature and consequences thereof being addressed. Lip service to the concept is a real concern, whilst the possibility of an over-indulgence in self-centredness is also possible. True value-based person-centredness is considered an enabling factor in humane care and thus a critical part of or pre-requisite for compassion.

Compassion

Sinclair, Torres, Raffin-Bouchal, Hack, McClement, Hagen, & Chochinov (2016), in their scoping review of compassion in health care literature over the last 25 years, have found a proliferation of studies and reviews focusing on or related to compassion in the last 5 years. Major themes identified are around the nature of compassion, the development and erosion of compassion, important interpersonal qualities, skills and actions required for compassion and the resultant outcomes of compassionate care. This may be due partly to the fact that health care providers are consistently being reminded that caring has become a matter of concern, that compassion is decreasing, being degraded and even lacking. Such statements have often been made within and across countries where I have lived and/or worked.

Compassion refers to the humane quality of being concerned about and understanding the suffering of others, with strong focus on the sufferer. It also entails an optimistic wanting to do something about the suffering. Compassion is thus relational in nature and the compassionate person recognises suffering or pain, feels or engages with the suffering and, lastly, acts to relieve such suffering (Sinclair *et al.*, 2016; Van der Merwe, 2006; Van Lieshout, Titchen, McCormack & McCance, 2015; Von Dietze & Orb; 2000). Fundamentally, we are thus directly moved by another person's suffering or pain. For meaningful compassion, however, time is needed - time for the compassionate person to be present and to develop and to sustain compassion (Sinclair *et al.*, 2016).

Imbedded in the concept of compassion is an ability to discern between boundaries of the self and others and a well-developed and rational sense of fairness or justice. Compassionate behaviour is specific to a situation in response to a problem or challenge and its intensity or seriousness - when something can be done. The most challenging aspect of compassion is to keep it alive and healthy in severely challenging situations (Seager, 2014). The day-to-day realities of care, teaching and learning, and research are all relational practices that entail such driven and demanding challenges.

Compassion sits somewhat uncomfortably with pity, sympathy and empathy but is essentially about action with and towards the one who suffers.

- Pity entails a somewhat negative and hierarchical connotation, where the so-called object of pity is suffering but is also considered weak or inferior.
- Sympathy could be described as being moved spontaneously by the suffering of another, without thinking or explanation, and often experiencing the sorrow and sadness of the moment.
- Empathy is popular in the formalised therapeutic world, where one is able to mirror and reflect on another's emotions. Empathy is considered a process that harnesses both our intellectual or cognitive domain (that of understanding) and our emotional domain to share in the experience and feelings of the sufferer (Kerasidou & Horn, 2016). It contains an element of detachment and protection for the health carer, whilst aiding better understanding (Van der Merwe, 2006, Von Dietze & Orb; 2000). How realistic this is in practice remains a concern.

If one applies compassion to healing who we are and to what we do best, one can argue that compassion is an important value and moral action that we are all capable of and need. Compassion has been confirmed to relate positively not only to the successful treatment of patients but also to the reduction of burnout and the enhancement of healthiness in health care providers (Lamothe, Boujut, Zenasni, & Sultan, 2014).

In my opinion, one cannot easily fake compassion or pretend to be compassionate. Compassion is the inherent moral quality or virtue of all humanness rooted in value judgments. As such, it may make us feel warm and cared for or leave us cold and sad in critical encounters:

On this occasion, indeed our last philosophical encounter, Herbert [Marcuse] told me: Look, I know wherein our most basic value judgments are rooted: in compassion, in our sense for the suffering of others. (Habermas, 1985:77)

The concept of *communitas* is an evolving concept but essentially refers to the pleasure and appreciation of the members of a group sharing common experiences with one another - lives, experiences and opportunities (Turner, 2012) - a togetherness that includes all. The sharing of truthful expressions of compassion would make a meaningful common experience for all of us who are stretched and strained in contemporary health care and academic life.

Collaboration for better research

The complex and nuanced world of health care (and higher education) calls for different ways of understanding cause and effect and of predicting and influencing outcome meaningfully (Hood, 2015). Health professionals find homes in a range of research paradigms, with the positivist research paradigm preferred by our medical colleagues, whilst, for example, the post-positivist and interpretivist paradigms preferred by, for example, nurses, midwives and occupational and speech therapists. There is, at times, a disrespect for qualitative research per se, even though it is well developed and has a set of guidelines that would not fall short of those for quantitative research.

Qualitative research has come to fruition and is increasingly being utilised in, for example, PhD studies and research projects to provide pragmatic, informed and relevant answers to complex questions. Researchers believe that the methodology provides depth and breadth to such studies due to the combination of different research approaches. There is a clear realisation that a combination of quantitative and qualitative research provides greater depth, more holistic answers and a better understanding of complex phenomena (Lund, 2012; Maxwell, 2016; Wheeldon, 2010).

This combination has now developed into a "third force", where mixed methods research is defined as research where a researcher or a group of researchers combines and integrates elements of quantitative and qualitative research. It is believed that such an approach enhances the depth and breadth of understanding, meaning, verification and support (Johnson, Onwuegbuzie & Turner, 2007:123).

The important argument to be made here is that professionals need to combine forces to research the intricate complexities of health and of medical and health sciences. Nursing and midwifery have a proud tradition of scholarship in qualitative and mixed methods research and are referenced by eminent scholars in this area. Examples of nurse researchers that come to mind are Janice Morse, Dawn Freshwater and Margarete Sandelowski.

CONCLUSION

In this journey, we have moved beyond the brokenness of the health care system and the health carer to human dignity as a central construct. Healing who we are and what we do best (which is essentially caring) may find meaning when we are aware of our own feelings (the result of self-reflection) and use strategies such as debriefing, coaching and the spontaneous sharing of experiences. Healing or restoration is hard work and does not flourish in an environment that does not provide trust in and space for human dignity, person-centredness and compassion. I wish to illustrate the concept of restoration through the beautiful ancient art of kintsugi.

Kintsugi means 'golden joinery' or 'repair with gold' and describes the art of repairing broken ceramics by enhancing and emphasising the fault lines with solid gold (Osamura & Nakada, 2011). This Japanese art focuses on not discarding broken items (brokenness) but on repairing brokenness with grace and beauty. The broken pieces are included in the original work of art in a way that further beautifies the object.

According to Lakeside Pottery in the USA, kintsugi is said to have originated in the 15th century when a famous Japanese shogun broke a favourite Chinese tea bowl and sent it back to China to be repaired. The bowl was repaired with metal staples, however, which was customary for that time. The shogun was disappointed with the aesthetic quality of the work and requested a Japanese craftsman to provide a better solution. The solution was the birth of Kintsugi. The philosophy of kintsugi is closely linked to wabi-sabi, a philosophy that, amongst others, accepts transience and imperfection.

The above inherent philosophy of not rejecting our brokenness, whether real or perceived, but of carefully beautifying it in acceptable ways is meaningful. Meaningfulness rests in the ability to embrace human dignity in all its forms and to value person-centredness as a way to reach out to, to engage with and to caringly repair hurt, hopelessness and division. It is not so much about the destiny but about the journey:

*My heart is warm with friends I make,
And better friends I'll not be knowing;
Yet there isn't a train I wouldn't take,
No matter where it's going.*
(Travel by Edna St Vincent Millay)



Image 3: Tea bowl stoneware with clear crackled glaze stained by ink and with gold lacquer repairs, possibly Satsuma-ware, possibly from the Kagoshima prefecture in Japan, dating from the 17th century Edo period. Gift of Charles Lang Freer, F1904.323. (Source: Kaplan, 2015).

REFERENCES

- Adorno, R. 2009. Human dignity and human rights as a common ground for a global bioethics. *Journal of Medicine and Philosophy*, 34(3):223–40.
- Baumann, P. 2007. Persons, human beings and respect. *Polish Journal of Philosophy*, Fall, 2:5–17.
- Bendik-Keymer, J. 2010. From humans to all of life: Nussbaum's transformation of dignity, in Flavio Comim, F. & Nussbaum, M. (eds.). *Capabilities, gender, equality: Towards fundamental entitlements*. New York: Cambridge University Press.
- Bolduc, K.D. 2001. Embracing our brokenness. *Journal of Religion, Disability & Health*, 4(4):65–76.
- Brüggermann, A.J., Wijma, B. & Swahnberg, K. 2012. Abuse in health care: A concept analysis. *Scandinavian Journal of Caring Sciences*, 26: 123-132. DOI:10.1111/j.1471-6712.2011.00918.x.
- Cooper, A. 2015. The doctor's political body: Doctor–patient interactions and socio-political belonging in Venezuelan state clinics. *American Ethnologist*, 42(3):459-474.
- Department of Health. 2015. *National health insurance for South Africa – Towards universal health coverage*. Pretoria: Department of Health. Version 40.
- Djulgovic, B., Hozo, I. & Ioannidis, J.P.A. 2015. Modern health care as a game theory problem. *European Journal of Clinical Investigation*, 45: 1–12. DOI:10.1111/eci.12380.
- Donnelly, J. 2015. Normative versus taxonomic humanity: Varieties of human dignity in the Western tradition. *Journal of Human Rights*, 14: 1–22. DOI:10.1080/14754835.2014.993062.
- Durant, W. & Durant, A. 1970. *Interpretations of life – A survey of contemporary literature*. New York: Simon & Schuster.
- Düwell, M. 2011. Human dignity and human rights, in Kaufmann, P., Kuch, H., Neuhäuser, C. & Webster, E. (eds.): *Humiliation, degradation, dehumanization – Human dignity violated*. New York: Springer. Chapter 15.
- Edmeston, M. 2012. Beyond band-aids: Reflections on public and private health care in South Africa in Antonie, F (ed.): *Focus 67 – State and Nation: 41-46*. Parktown: Helen Suzman Foundation.
- Formosa, P. & Mackenzie, C. 2014. Nussbaum, Kant, and the capabilities approach to dignity. *Ethical Theory and Moral Practise*, 17:875–892. DOI: 10.1007/s10677-014-9487-y.
- Girenok, F. 2013. On philosophy. *Metaphilosophy*, 44(1–2):0026–1068.
- Green, C. 2009. A comprehensive theory of the human person from philosophy and nursing. *Nursing Philosophy*, 10:263–274.
- Greenfield, G., Ignatowicz, A.M., Belsi, A., Pappas, Y., Car, J., Majeed, A., & Harris, M. 2014. Wake up, wake up! It's my life. Patient narratives on person-centredness in the integrated care context: A qualitative study. *BMC Health Services Research*, 14:619 <http://www.biomedcentral.com/1472-6963/14/619>
- Habermas, J. 1985. Psychotic Thermidor and the rebirth of rebellious subjectivity. In Bernstein, RJ (Ed.): *Habermas and modernity*. Cambridge: Polity.
- Hamric, A.B., Arras, J.D. & Mohrmann, M.E. 2015. Must we be courageous? *Hastings Center Report*, 45(3):33–40. DOI: 10.1002/hast.449.
- Heywood, M. 2014. The broken thread: Primary health care, social justice and the dignity of the health worker. *Public Positions Theme Event: Briefing Paper, 1 September 2014*. University of the Witwatersrand: WiSER, History Workshop and Wits Political Studies Department.
- Hood, R. 2015. How professionals experience complexity: An interpretative phenomenological analysis. *Child Abuse Review*, 24(140–152). DOI: 10.1002/car.2359.

- Hughes, J.C., Bamford, C. & May, C. 2008. Types of centredness in health care: Themes and concepts. *Med Health Care and Philosophy*, 11:455–463.
- Insight Actuaries and Consultants. 2016. Challenges and opportunities for health finance in South Africa: A supply and regulatory perspective. *FinMark Trust*, April.
- Jacobson, N. 2009. A taxonomy of dignity: A grounded theory study. *BMC International Health and Human Rights*, 9(3). DOI: 10.1186/1472-698X-9-3.
- Johnson, R.B., Onwuegbuzi, A.J. & Turner, L.A. 2007. Toward a definition of mixed methods research. *Journal of Mixed Methods Research*, 1(2):112–133.
- Kaplan, H. 2015. Friday fave: Tea bowl. *Bento – Art outside the box*. Smithsonian Institution. 13 February 2015. [Online]. Available: <http://bento.si.edu/from-the-collections/japanese-art/friday-fave-tea-bowl/> [2016, August 15].
- Kaufmann, P., Kuch, H., Neuhäuser, C. & Webster, E. (eds.). *Humiliation, degradation, dehumanization – Human dignity violated*. New York: Springer.
- Kerasidou, A. & Horn, R. 2016. Making space for empathy: Supporting doctors in the emotional labour of clinical care. *BMC Medical Ethics*, 17:8. DOI: 10.1186/s12910-016-0091-7.
- Kickbusch, I. & Reddy, K.S. 2014. Global health governance – The next political revolution. *Public Health*, 129:838–842.
- Kitson, A., Marshall, A., Bassett, K. & Zeitz, K. 2013. What are the core elements of patient-centred care? A narrative review and synthesis of the literature from health policy, medicine and nursing. *Journal of Advanced Nursing*, 69(1):4–15. DOI: 10.1111/j.1365-2648.2012.06064.x.
- Kitwood, T. 1997. *Dementia reconsidered: The person comes first*. Milton Keynes: Open University Press.
- Kyono, T. 2013. Leonard Cohen, King's Garden, Odense, Denmark [Online]. Available: <https://www.flickr.com/photos/75972766@N02/sets/72157641169672904> [2016, August 16].
- Lakeside Pottery and Restoration Studio. 2016. *Kintsugi: Golden joinery* [Online]. Available: <http://lakesidepottery.com/index.html> [2016, July 31].
- Lamothe, M., Boujut, E., Zenasni, F. & Sultan, S. 2014. To be or not to be empathic: The combined role of empathic concern and perspective taking in understanding burnout in general practice. *BMC Family Practice*, 2014, 15:15.
- Lebech, M. 2004. What is human dignity? *Maynooth Philosophical Papers: 59-69*. Kildare, Ireland: Faculty of Philosophy, Maynooth University.
- Lepège, A., Gzil, F., Cammelli, M., Lefève, C., Pachoud, B. & Ville, I. 2007. Person-centredness: Conceptual and historical perspectives. *Disability and Rehabilitation*, 29(20–21):1555–1565.
- Library of Congress. N.d. Edna St. Vincent Millay in Mamaroneck, New York, 1914 [Online]. Available: <http://www.loc.gov/pictures/item/agc1996000549/PP/> [2016, August 15].
- Lund, T. 2012. Combining qualitative and quantitative approaches: Some arguments for mixed methods research. *Scandinavian Journal of Educational Research*, 56(2):155–165.
- Macklin, R. 2003. Editorial: Dignity is a useless concept – It means no more than respect for persons or their autonomy. *British Medical Journal*, 327:1419–1420.
- Mann, J.M., Gostin, L., Gruskin, S., Brennan, T., Lazzarini, Z. & Fineberg, H.V. 1994. Health and human rights. *Health and Human Rights*, 1(1):6–23.
- Maxwell, J.K. 2016. Expanding the history and range of mixed methods research. *Journal of Mixed Methods Research*, 10(1):12–27.

- McCance, T., McCormack, B. & Dewing, J. 2011. An exploration of person-centredness in practice. *Online Journal of Issues in Nursing*, 16(2):1. DOI: 10.3912/OJIN.Vol16No02Man01.
- McCormack, B. 2001. *Negotiating partnerships with older people – A person-centred approach*. Ashgate: Basingstoke.
- McCormack, B. 2003. Researching nursing practice: Does person-centredness matter? *Nursing Philosophy*, 4:179–188.
- Nussbaum, M. 2004. *Hiding from humanity: Disgust, shame, and the law*. Princeton NJ: Princeton University Press.
- Oakley, J. 2015. Practitioner courage and ethical health care environments. *Hastings Center Report*, 45(3):40–42. DOI:10.1002/hast.454.
- Osamura, K. & Nakada, T. 2011. Widespread contact dermatitis caused by urushiol in kintsugi. *Contact Dermatitis*, 65(6):361–362.
- Padarath, A., King, J., Mackie, E. & Casciola, J. (eds.). 2016. *South African Health Review 2016*. Durban: Health Systems Trust. [Online]. Available: <http://www.hst.org.za/publications/south-african-health-review-2016> [2016, July 30].
- Pakaluk, M. 2007. The dignity of the human person in the philosophy of John Rawls. Conference on “*The Philosophical Foundations of Human Dignity*”, Washington D.C., March 8, 2007.
- Pellegrino, E. 1983. The healing relationship: The architectonics of clinical medicine, in Shelp, E. (ed.). *The clinical encounter: The moral fabric of the patient–physician relationship*. Dordrecht: Reidel Publishing.
- Pinker, S. 2008. The stupidity of dignity. *The New Republic*, 28–31.
- Rispel, L. 2015. Revolutionary health policy in praxis: Analysing the progress and fault lines of 21 years of health sector transformation. Inaugural lecture delivered at the University of the Witwatersrand. 28 September, Johannesburg.
- Rogers, C.R. 1961. *On becoming a person*. London: Constable.
- Ross, H., Tod, A.M. & Clarke, A. 2014. Understanding and achieving person-centred care: The nurse perspective. *Journal of Clinical Nursing*, 24:1223–1233. DOI: 10.1111/jocn.12662.
- Seager, M. 2014. Mind as a dimension & compassion as a relationship issue. *Journal of Compassionate Health Care*, 1:3. Second Opinion. 1989. *Facing brokenness: An interview with David Hilfiker*. p. 92. Academic OneFile. [2016, July 27].
- Setlhare, V., Couper, I. & Wright, A. 2014. Patient-centredness: Meaning and propriety in the Botswana, African and non-Western contexts. *African Journal of Primary Health Care & Family Medicine*: 6(1): OI: 10.4102/phcfm.v6i1.554. <<http://www.phcfm.org/index.php/phcfm/article/view/554/829>> [2016, August 17].
- Sinclair, S., McConnell, S., Hagen, N., Chochinov, H., Norris, J., Hack, T., Bouchal, S. & McClement, S. 2016. Compassion: A scoping review of the healthcare literature. *BMC Palliative Care*, 15(1):1–16.
- Sinclair, S., Torres, M., Raffin-Bouchal, S., Hack, T.F., McClement, S., Hagen, N.A. & Chochinov, H.M. 2016. Compassion training in healthcare: What are patients’ perspectives on training healthcare providers? *BMC Medical Education*, 16:169. DOI:10.1186/s12909-016-0695-0.
- Turner, E. 2012. *Communitas – The anthropology of collective joy*. New York: Palgrave Macmillan.
- Van der Merwe, A.S. 2006. Compassion in nursing – Still a *raison d’être*? Inaugural lecture delivered at the University of the Free State. 10 August, Bloemfontein.
- Van Lieshout, F., Titchen, A., McCormack, B. & McCance, T. 2015. Compassion in facilitating the development of person-centred health care practice. *Journal of Compassionate Health Care*, 2(5). DOI: 10.1186/s40639-015-0014-3.

- Von Dietze, E. & Orb, A. 2000. Compassionate care: A moral dimension of nursing. *Nursing Inquiry*, 7(3):166–174.
- Waldron, J. 2009. Dignity, rank, and rights. The Tanner Lectures on Human Values delivered at the University of California. April 21–23, Berkeley.
- Wallace, W. 1985. Nature as animating: The soul in human sciences. *The Thomist*, 49:612–648.
- Wheeldon, J. 2010. Mapping mixed methods research: Methods, measures and meaning. *Journal of Mixed Methods Research*, 4(2):87–102.
- Zweigenthal, V., London, L. & Pick, W. 2016. The contribution of specialist training programmes to the development of a public health workforce in South Africa, in Padarath, A., King, J., Mackie, E. & Casciola, J. (eds.). *South African Health Review 2016*. Durban: Health Systems Trust. Chapter 5 [Online]. Available: <http://www.hst.org.za/publications/south-african-health-review-2016> [2016, July 30].
- Zylberman, A. 2016. Human dignity. *Philosophy Compass*, 11(4):201–210, DOI: 10.1111/phc3.12317.